Second Edition

Human Trafficking

Guidebook on Identification, Assessment, and Response in the Health Care Setting

MASSACHUSETTS MEDICAL SOCIETY
Committee on Violence Intervention and Prevention

MASSACHUSETTS GENERAL HOSPITAL
Human Trafficking Initiative/Freedom Clinic

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Preface

Human trafficking is both a criminal act and a human rights violation that affects individuals and communities worldwide, including in urban, suburban, and rural areas of Massachusetts and across the United States. As a health issue, trafficking affects people of every age, gender, sexual orientation, race, nationality, class, religion, ability, and immigration status. Although the full impact of trafficking on the health of our patients, communities, and society at large is only just beginning to be understood, it is clear that the physical and psychological trauma caused by human trafficking is both substantial and consequential.

The Massachusetts Medical Society (MMS) Committee on Violence Intervention and Prevention and the Massachusetts General Hospital (MGH) Human Trafficking Initiative have worked in partnership to develop the second edition of *Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting*. This guidebook provides an overview of human trafficking, describes its clinical manifestations, and offers guidance for health professionals regarding identification, assessment, care, and follow-up.

The objectives of this guidebook are to educate health care providers about human trafficking, offer practical instruction regarding identification and response, and provide resources for patient referral and ongoing professional education. Achieving these objectives will support the provision of culturally-aware trauma-informed care, advance health-related scholarship in the field, and strengthen the health sector's evolving contributions to global efforts directed at responding to, and ultimately, preventing human trafficking.

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The MMS Committee on Violence Intervention and Prevention extends its gratitude to the Massachusetts Medical Society (MMS) and its members and leadership. The MMS has been a steadfast supporter and advocate for violence prevention and cessation long before the establishment of the Committee in 1992. We particularly thank the MMS staff liaison Candace L. Savage, Senior Public Health Outreach Manager in the Department of Health Policy, Public Health, and Education. Preparation and publication of this guidebook would not have been possible without her consistent professionalism, steady hand, and expertise.

The Massachusetts General Human Trafficking Initiative would like to extend its most sincere gratitude to the past leadership of the MGH Department of Emergency Medicine, Alasdair K. T. Conn, MD, David F. M. Brown, MD, and Ann L. Prestipino, MPH, all of whom have been champions for integrating anti-trafficking efforts into clinical practice; Thomas F. Burke, MD and Roy Ahn, ScD, MPH, pioneers in the understanding of human trafficking as a global public health issue; and current department leadership, Michael J. VanRooyen, MD, MPH (Chair), Ali S. Raja, MD, MBA, MPH (Executive Vice Chair), and Robert Seger, MBA (Executive Director), who have been consistent advocates for the continued advancement of this work. We are grateful for their courageous leadership, inspiring vision, and unwavering support.

We also acknowledge and thank Mr. Chris Twichell, Senior Illustrator and Designer, Brand and Product Marketing, who read a near-final draft of the original edition of this guidebook in order to design illustrations, most of which have been retained in this guidebook. In addition, we extend our gratitude to Misty Horten, Senior Layout Designer, Shared Services and Operations at the Massachusetts Medical Society, who reviewed the topic and discussed the nuances of human trafficking with us in order to design the cover and interior pages of this 2nd edition.

Finally, we are most indebted to all who have experienced human trafficking, whose honest and personal accounts and lived experience serve to educate, inspire, and reinvigorate our commitment to this work day after day. This guidebook would not exist were it not for their courage, strength, and resilience.

To those both named and unnamed, we extend our most humble admiration and gratitude.

**External peer reviewers provided input to a near-final draft of this guidebook. Their participation as reviewers should not be construed as an endorsement of the guidebook's content or final format.*

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Introduction

Human trafficking — one of the most egregious forms of purposeful, intentional exploitation of vulnerable individuals — has become increasingly recognized in the health setting.[1-4] All health care providers, particularly those engaged in primary care, emergency services, reproductive health, mental health, occupational medicine, pediatrics, and dental care, are well-positioned to identify and respond to individuals experiencing trafficking as well as those at risk who have not yet been actively exploited. The provision of sensitive and compassionate care to patients who are at risk for, or who have had current or past lived experience with, trafficking can promote prevention-focused and trauma-informed clinical and public health responses.

Even though their personal freedom, choices, and movements are often tightly controlled and may be hidden from view, a surprising proportion of persons with experiences of trafficking report having been able to access medical services while under the control of their traffickers.[5,6] Health care providers who are educated about the risk factors and clinical manifestations of human trafficking and who can respond compassionately, efficiently, and effectively can play a key role in addressing this age-old yet poorly recognized problem.[7,8]

The purpose of this guidebook is to provide:

- An overview of human trafficking as a health issue
- Information about the clinical presentations of the major forms of trafficking
- Guidance for clinicians to identify, assess, and respond to the needs of persons experiencing trafficking who present in the health care setting
- Resources for patient referral and assistance
- Guidance for ongoing education

The topic of trafficking in persons generates strongly held and, at times, ideologically informed opinions among laypeople and experts alike. Productive dialogue and progress in terms of service provision and policy formulation can prove challenging, particularly regarding issues related to undocumented individuals, illegal labor, the commercial sex industry, gender nonconforming populations, and reproductive health concerns. This guidebook acknowledges the strongly and, at times, fervently held opinions held by some valued colleagues and partners while maintaining an ideologically neutral, trauma-sensitive, strengths-based, and human rights-focused approach to care. In addition, difficulty accruing accurate and reliable epidemiologic and clinical data, combined with the demand for rapid evolution of clinical practice in this field, means, of necessity, that clinical guidelines such as these are at least in part based on "practice-based evidence," as opposed to evidence-based practice. It is anticipated that future editions of this guidebook will reflect adjustments in recommendations based on emerging scholarship.

Overview and Dynamics

A. Definitions

Accurate and precise definitions are important for determining a problem's scope, characteristics, and risk factors, for developing both research and action agendas, and for anchoring complex discussions.

Three legally accepted definitions of human trafficking are offered in this guidebook, all of which describe the exploitation of vulnerable individuals for the purpose of commercial gain.

1. United Nations Definition of Human Trafficking (the "Palermo Protocol")[9]

The United Nations (UN) defines human trafficking, also called "trafficking in persons," as:

> *"The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."*

2. The United States Trafficking Victims Protection Act[10,11]

The Trafficking Victims Protection Act (TVPA), passed by the United States (US) Congress in 2000 and reauthorized in 2003, 2005, 2008, 2013, 2017, 2018, and 2022 (partial reauthorization), defines "severe forms of trafficking" as follows:

- The recruitment, harboring, transportation, provision, or obtaining, patronizing, soliciting, or advertising of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age
- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery

3. Commonwealth of Massachusetts Trafficking Definitions

The Commonwealth of Massachusetts defines human trafficking as encompassing sex trafficking, labor trafficking, and organ trafficking — three distinct but related criminal acts. Notably, the Massachusetts definition of sex trafficking is broader than the federal TVPA definition, using the phrase 'by any means' instead of 'force, fraud, or coercion.' In addition to involvement in commercial sexual acts, the definition can also encompass coerced involvement in sexually explicit performances and in the production of "unlawful pornography," defined separately under Massachusetts law. The Massachusetts labor statute also uses the phrase "by any means," but describes the prohibited activity as "forced services." In this regard, an element similar to "force, fraud, or coercion" is implied for labor trafficking. The Massachusetts statutes that define sex, labor, and organ trafficking can be accessed via these links, respectively:

- malegislature.gov/Laws/GeneralLaws/PartIV/TitleI/Chapter265/Section50
- malegislature.gov/Laws/GeneralLaws/PartIV/TitleI/Chapter265/Section51
- malegislature.gov/Laws/GeneralLaws/PartIV/TitleI/Chapter265/Section53

B. Elements Common to All Definitions

All definitions described in this guidebook share three key elements: ***Act***, ***Means***, and ***Purpose***, as detailed in Figure 1.

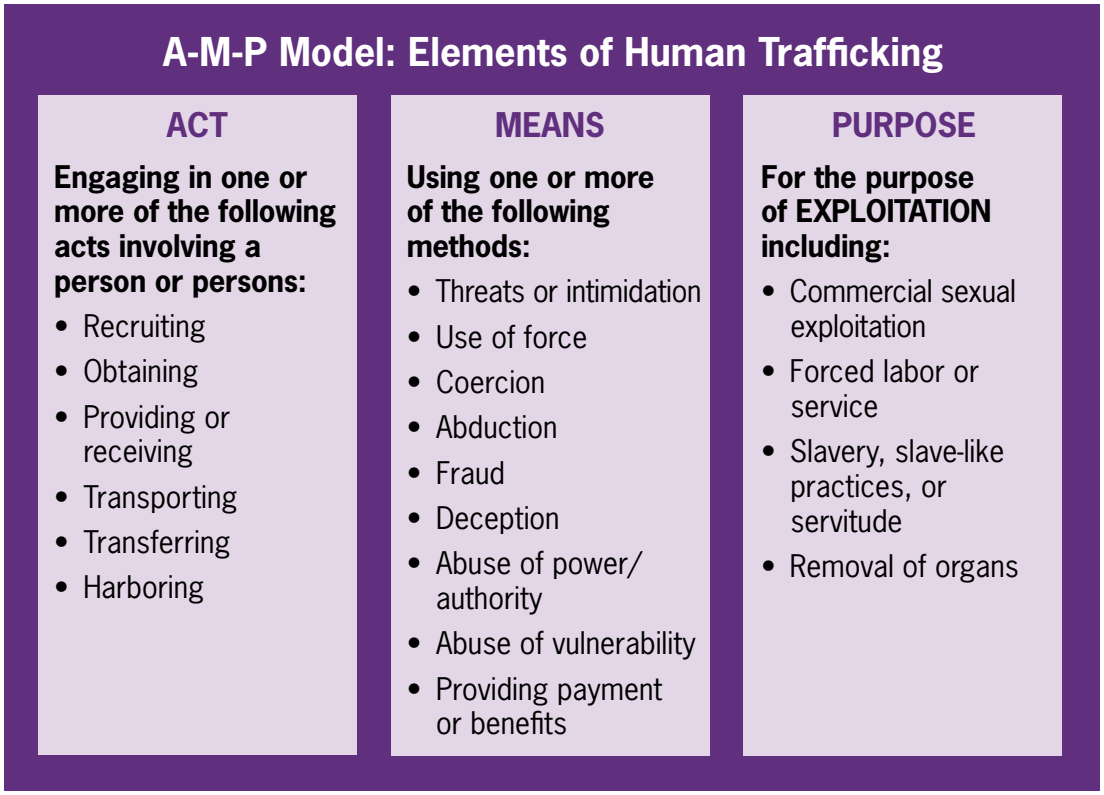
"**Act**" refers to the procurement or obtaining of a human being.

"**Means**" refers to the manner by which a person is acquired, or by which control over a person is asserted or maintained.

"**Purpose**" describes the reason or intent behind the exploitation of a person.

To meet international and federal legal criteria for human trafficking, all three elements must be satisfied. An important exception applies to victims* of sex trafficking who are minors, who, by virtue of their age, are deemed by statute as incapable of providing consent to their own exploitation. Thus, in the case of persons under the age of 18, the "means" condition does not apply and need not be satisfied.

Figure 1: Three Key Elements of Human Trafficking — Act, Means, and Purpose



(Source: Adapted from the United Nations Office on Drugs and Crime: unodc.org/unodc/en/human-trafficking/crime.html and unodc.org/e4j/ru/tip-and-som/module-13/key-issues/international-legal-frameworks-and-definitions.html)

*The term "victim" is used in legal and law enforcement settings to describe victims of crime.

C. Trafficking versus Smuggling

Although human trafficking and human smuggling are often confused, they are distinct crimes with different characteristics.[12] Smuggling is a discrete, voluntary transaction in which an individual is transported across an international boundary in exchange for payment. The act of smuggling is, therefore, a crime against a *state*, rather than a crime against a *person*. While smuggling always involves crossing international borders, human trafficking can occur across borders as well as within a country, and can even take place within a geographic area as small as a neighborhood or even a single home or apartment. While the act of smuggling concludes once the destination is reached, trafficking normally involves ongoing coercion, control, and exploitation, which in some cases might become evident only after arriving at the agreed-upon (or sometimes different) destination. In both trafficking and smuggling, violations of the human rights of people experiencing trafficking and of migrants involved in smuggling must be addressed. Legal distinctions notwithstanding, however, smuggled and trafficked individuals alike may present for health care with similar needs for treatment and services.[13]

D. Who Experiences Trafficking?

Human trafficking is a local issue as well as a global problem. As mentioned previously, people can be trafficked across international borders, as well as within a country, from city to city, or even within a single neighborhood. Trafficked individuals in the United States can be US citizens or foreign nationals, whether documented or undocumented.[14] They may be adults, adolescents, or even children, including newborns, and can align with any gender identity.

E. Types of Trafficking

The UN, US, and Massachusetts definitions of trafficking underscore the varied and widespread nature of this phenomenon. Individuals may be trafficked for commercial sexual exploitation; as labor in industries such as agriculture, mining, textiles, fisheries, restaurants, factories, and construction; as domestic servants in private homes; and even for the provision of organs or other vital tissues. Additional forms of human trafficking include bonded labor (for example, to pay off an artificially inflated "debt" for transportation, training, housing, sustenance, or even "required uniforms") and forced criminal activity (for example, transporting illegal drugs or weapons, panhandling, or selling stolen goods). Children may be trafficked into any of the activities described above. They can also be exploited as child soldiers, members of begging and peddling rings, "mail-order brides," or in illegal adoption processes.[15,16]

1. Sex Trafficking

Individuals of any age and gender can become involved in sexually exploitative enterprises that meet the legal definition of trafficking. The spectrum of sex trafficking includes street prostitution, brothel-based work, internet-based sex work, live or virtual pornography, or coerced employment in sexualized jobs such as hostesses, exotic dancers, strippers, escorts, and massage parlor workers, or as "companions" at truck stops.[17-19]

Although sex trafficking can affect persons of any age, the main targets of sex trafficking are children (persons younger than age 18) and young adults, some of whom were first trafficked as children.[20] Minors are at particular risk, especially when they grow up in disadvantaged, dysfunctional, or abusive environments that intersect with structural inequities such as racism, sexism, homophobia, and transphobia.

1a. Commercial Sexual Exploitation of Children

Involvement of any person under the age of 18 in online or in-person sexual activities for payment or in the exchange of sex for anything of value is termed "Commercial Sexual Exploitation of Children" (CSEC). While exploitation of children that meets the legal definition of trafficking often takes place under the control of one or more traffickers, it also can occur independent of a third-party trafficker. CSEC can encompass not only child sex trafficking but also the mail-order bride/child marriage industry, stripping/performances in sexual venues, and online sexual exploitation, typically involving the recording and disseminating of child sexual abuse images and other material. In addition, "runaway" children (regardless of sex or gender identity) may resort to engaging in "survival sex," through which sexual acts are traded for shelter, food, drugs, or protection. Such acts are also considered to be components of CSEC.[21]

Online child sexual exploitation has increased since the COVID-19 pandemic began, believed to be related to increased time online, decreased supervision, and pandemic-associated emotional and financial uncertainty.

Child sexual abuse material (CSAM), a subset of online sexual exploitation, is defined as visual depictions of the sexual abuse or exploitation of anyone under age 18.[21] CSAM is exploitative by virtue of the victim's age as well as the nature of the abuse that is at its core. Just as children are, by definition, unable to provide consent for involvement in sexual activities for payment, children under the age of 18 are never able to consent to being portrayed in sexualized images or videos.[22] Online CSAM typically utilizes media such as photos, videos, or livestreaming, which are often broadcast or shared via the Internet. For this reason, revictimization can endure indefinitely.

In 2023, nearly 36 million reports of suspected or apparent CSAM were filed with the National Center for Missing and Exploited Children (NCMEC), an increase of four million (12.5%) from the prior year. Compared to data reported in 2022, NCMEC described more than a doubling of reports of children enticed or forced into engaging online in sexually explicit acts in 2023 (80,524 in 2022 compared to 186,819 in 2023, using similar methodology).[23,24]

In May 2023, the US Surgeon General issued a Surgeon General's Advisory on social media and youth mental health, citing disturbing rates of online sexual exploitation of cisgender female and transgender/gender-diverse youth via social media.[25] A troubling trend concerns increased reports of "sextortion," a form of cyberbullying or cyberstalking that involves blackmailing victims by using threats to release sexual images of them online if the extorter's demands for money or additional sexually explicit material are not met. Perpetrators of sextortion fuel fear and anxiety in victimized youth by emphasizing the destructive, life-changing impacts they will experience upon the release of their nude or sexually compromising imagery.[26] Previous research found that 24% of child sextortion victims reported seeking mental health assistance as a result of their experience, with some describing feeling "mentally tortured."[27] At the extreme, affected individuals may be driven to suicide as the only way they feel they can escape the severe psychological stress associated with sextortion.[28-31]

An additional emerging concern is the use of photo manipulation and artificial intelligence (AI) to generate "deepfake" CSAM (fake sexual imagery in the likeness of a child) for use in sextortion schemes.[26] An investigation by the Stanford Cyber Policy Center found hundreds of known images of CSAM in an open dataset used to train popular AI image generation models. This dataset has produced photorealistic AI-generated nude images, including images of minors. Removal of the identified source material is in progress; however, challenges posed by the rapid expansion and adaptation of AI and related technologies are only just beginning to be identified.[32]

2. Labor Trafficking

The US Department of Health and Human Services Office of Refugee Resettlement describes three types of exploitative practices linked to labor trafficking:[33]

- *Bonded labor*, or *debt bondage*, occurs when an individual's labor is demanded in order to repay a loan or other form of debt "in which its terms and conditions have not been defined or in which the value of the victim's services as reasonably assessed is not applied toward the liquidation of the debt." The victim, therefore, remains entrapped in a coerced labor situation with unlawful and often exorbitant debts that continue to accrue over time.
- *Forced labor* occurs when a person is "forced to work against their own will, under the threat of violence or some other form of punishment." Typically, the person's "freedom is restricted, and a degree of ownership is exerted." As described earlier, forced labor can occur in almost any industry, most notably in agriculture, landscaping, manufacturing, hospitality, janitorial and other service industries, restaurants, domestic settings, peddling, and begging.
- *Child labor trafficking* involves the use of force, fraud, or coercion to compel a person under the age of 18 to engage in any type of forced labor.[34] Child labor trafficking impacts both US citizens and residents, as well as youth who are brought to the US for labor, commonly in the agriculture, food and meat processing, entertainment, and service sectors, as well as for drug smuggling and selling, and other "illicit" activities.[35,36]

Some US labor trafficking victims are citizens or lawful residents. Others enter legally on temporary work visas for specific industries or jobs (e.g., for seasonal hotel, restaurant, or agricultural employment). Still others are in the US without proper documentation.

Recruitment into the trafficking sphere can appear deceptively similar to the legal recruitment of workers for jobs in the formal or informal sector. Once recruitment and transportation (if necessary) to the destination have occurred, traffickers use violence, threats, lies, and coercion to force people to work against their will for the traffickers' financial gain. In these situations, the forced labor might — or might not — be within the industry for which the individual was originally recruited.[37-39]

Labor trafficking differs from labor exploitation in that the former involves force, fraud, or coercion that entraps victims in exploitative and abusive situations to which they did not consent and from which they cannot escape without the risk of harm. Affected individuals may perceive they are in an adverse or even exploitative situation but may be unaware that their situation meets legal criteria for trafficking, may be unaware of their legal rights, may fear being beaten or deported if they seek help, or even feel there is no clear way to seek help.[40]

Although US-based research has historically spotlighted the trafficking of foreign-born nationals brought into the country, the labor trafficking of US citizens is increasingly being recognized and studied. A 2014–2016 study among homeless youth in the US highlighted the emergence of forced drug dealing and fraudulent commission-based sales as significant forms of labor trafficking.[41]

A separate study surveyed 240 US citizens and lawful residents aged 15 years and older who had experienced at least one abusive work situation across a range of labor industries, including construction, food services, janitorial services, and retail services.[42] Among those surveyed, the following findings were reported:

- 83% reported being subjected to deceptive and exploitative labor practices.
- 60% reported at least one incident of threat, intimidation, or manipulation through fear.
- 59% reported at least one incident of physical or communicative freedom restriction.
- 33% reported at least one incident of abuse of a sexual nature in the workplace.

Finally, a proportion of individuals reported both labor and sex trafficking or labor trafficking and co-occurring sexual abuse.[41,42]

3. Organ Trafficking

Like other forms of human trafficking, organ trafficking is becoming increasingly recognized as a global health problem. While precise prevalence statistics are not available, cases of organ trafficking are thought to occur throughout the world. The most commonly trafficked organ is the kidney.[43]

The UN Global Initiative to Fight Human Trafficking[44] subdivides its definition of organ trafficking into three categories:

1. Victims are forced or deceived into surrendering or donating an organ.
2. Victims, who may formally or informally agree to sell an organ, are not paid for the organ or are paid less than the promised price.
3. Vulnerable individuals are treated for an ailment that may or may not exist. In the process of "treatment," one or more organs are removed without the victim's knowledge or consent.

The term "transplant tourism" has been coined to describe a phenomenon whereby wealthy recipients from developed nations travel to less developed countries to receive an organ transplant. Organs tend to move from donors living in resource-limited settings ("organ-exporting countries") to recipients in developed nations ("organ-importing countries"). Individuals who are financially unstable or living in extreme poverty in a developing country may be approached to sell their organs — or, in some cases, are misled and never paid — through an elaborate black market of intermediaries seeking to profit from illegal organ sales. In some cases, individuals are transported to developed nations for the purpose of organ harvesting.[45,46]

F. Epidemiology

Reliable incidence and prevalence data regarding human trafficking are difficult to determine. In addition to definitional, data accrual, and collection bias challenges, precise estimates remain elusive due to the clandestine and also varied nature of human trafficking, fear of disclosure, stigma, shame, fear of retribution, and fear of deportation.

Most available estimates come from border security, immigration, migration, or criminal justice sources, rather than from health sector research or community-based agencies that serve those experiencing human trafficking. Data limitations pose challenges in terms of advancing basic research, delineating trends over time, developing evidence-based and trauma-informed practice guidelines, anticipating personnel and capital requirements for health service delivery, and developing strategies geared toward prevention.[47]

Even when derived from reliable and respected sources, prevalence estimates tend to be higher than actual incidence data generated from arrests, prosecutions, and convictions. For example, the International Labor Organization's 2021 analysis estimates the global prevalence of labor trafficking at 50 million.[48] However, when incidence and apprehension data provided by foreign governments based on country-specific legal definitions of labor trafficking are used, the 2024 *US Department of State Trafficking in Persons Report* identified 133,943 victims globally in 2023, resulting in 18,774 trafficking-related prosecutions and only 7,115 convictions.[15]

In the US, human trafficking statistics are collected by the Department of Justice, Bureau of Justice Statistics' (BJS) Human Trafficking Reporting System. BJS data, in turn, are compiled from state and local law enforcement agency investigations of human trafficking allegations reported through the FBI's National Incident-Based Reporting System. From this dataset, BJS reports that in FY 2021,

2,027 persons were referred to US Attorneys for human trafficking offenses, representing a 49% increase in reports over a decade. The prosecution and conviction rate also increased over this 10-year interval.[49] It is important, however, to recognize that these data are reflective of cases reported *and* investigated at the federal level only and almost undoubtedly underestimate the true incidence and prevalence of human trafficking in the United States.

Over the last decade, the US-based National Human Trafficking Resource Center fielded nearly 400,000 "signals," including telephone calls, online reports, emails, webchats, and text messages originating from all fifty states, the District of Columbia, and US territories. Calls have included "drop-a-dime"-style tips about potential trafficking situations, requests for service referrals, and calls for crisis assistance. In 2021, through its National Human Trafficking Hotline (NHTH), 51,073 signals were received, 13,277 of which were from people experiencing trafficking. From these signals, 10,360 cases were identified, involving 16,710 victims (some cases were reported by multiple callers or involved multiple victims). The vast majority of contacts (7,499) concerned sex trafficking, 1,066 contacts involved labor trafficking, and 400 were related to both sex and labor trafficking.[50,51]

In addition to national summaries, NHTH data provide state-specific information. In 2021, 339 Massachusetts-specific signals were received, 134 of which were from affected individuals or survivors in 93 separate cases involving 143 victims (again, some cases were reported by multiple callers or involved multiple victims). Similar to national statistics, the majority of reports (72) concerned sex trafficking, with labor trafficking, sex and labor trafficking combined, and "unknown" accounting for the remainder. Eighty-three percent of Massachusetts victims in all categories of trafficking were female, and 28% of all victims were minors.[52]

Importantly, these data indicate that trafficking in persons has been reported in all fifty states, the District of Columbia, and US territories. What remains unclear is the extent to which these data serve as an accurate proxy for the true incidence and prevalence of human trafficking. It is reasonable to assume that greater public awareness of sex trafficking may result in a disproportionately large number of reports of sex trafficking to the hotline, even though globally, labor trafficking is thought to be more prevalent.

G. Trafficking Determinants

Human trafficking is influenced by both 'push' and 'pull' factors (Table 1). Push factors drive people to leave their homes or current situations, while pull factors attract them to new locations or circumstances.[53,54] Of note, poverty is a push factor at every level of the social-ecological model (see Figure 2), as economic adversity affects individuals, relationships, communities, and society at large.

Figure 2: The Social-Ecological Model[55]

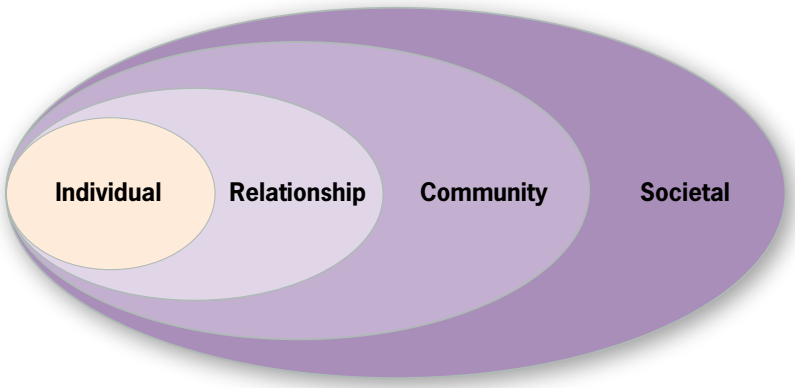


Table 1: Key Determinants for Human Trafficking

Social-Ecological Level	Push Factors	Pull Factors
Individual	• Young age • History of maltreatment, neglect, and other adverse childhood experiences (ACEs) • History of involvement in child welfare services • History of involvement in juvenile justice services • Difficulty meeting basic needs (food insecurity, housing instability, insecure employment or unemployment) • Limited education, illiteracy • Mental health challenges • Poverty	• Perceived glamour and anonymity of "city life" • Prospect of future fame or success • Desire for material comforts • Sense of responsibility to provide for family
Interpersonal	• Physical or sexual abuse by family members or others • Exposure to or witnessing violence in the home • Exposure to child sexual abuse material (CSAM) or violent pornography • Requests from family members for economic assistance • Gender discrimination (especially against girls) • Familial intolerance of gender identity or sexual orientation • Persuaded, coerced, or sold by family • Children in the care of "trusted" individuals • Peer influences • Desire to please "boyfriend" or other person portrayed as a "romantic" partner • Need to belong, desire for kinship • Poverty	• Seduction by romantic partner • Misplaced trust in assurances or promises made by others • Deception, "bait and switch" job promises • Peer networks within which commercial sex is traded
Community	• Limited access to quality education • Criminalization of youth via "school to prison pipeline" • Poor employment opportunities • Regional political conflict • Religious persecution • Corruption • Poverty	• Consumer goods perceived as deserved or needed but "just out of reach" • Promise of employment at destination • Promise of quality education
Society	• Lack of opportunity • Political and civil unrest • Armed conflict • Gender inequality, especially systematic devaluation of women and children • Cultural attitudes or beliefs (e.g., homophobia, transphobia, xenophobia) • Systemic and historical racism • Religious discrimination or persecution • Systemic corruption • Climate change effects, including decreased crop yields and accelerating natural disasters • Poverty	• Globalization • Demand for labor in destination areas, particularly migrant labor in "3D" sites (dirty, dangerous, difficult) • Prospect of high pay for commercial or transactional sex • Promise of a lucrative career • Influence of TV, radio, and the Internet • Societal expectations of children and women to take care of family

In general, people at highest risk are those who have any of the following vulnerabilities:

- Financial (due to poverty, indebtedness, economic exploitation, homelessness, runaway youth, or migrant status, especially if undocumented)
- Emotional (due to current or past abuse, chaotic family environment, prior removal by child protective services)
- Social identity (due to being a member of a traditionally stigmatized group based on race, ethnicity, religion, culture, politics, sexual orientation, gender identity/expression, or disability)

Intersecting risk factors can further amplify vulnerability. For example, LGBTQ+ youth are more likely to feel ostracized at home and in the community, leading to disproportionate rates of homelessness. Once homeless, these individuals are twice as likely to be sex trafficked compared to non-LGBTQ+ youth.[56] Homeless, runaway,[†] transgender youth, and those with a history of foster care placement within the child welfare system[‡] are at especially high risk of being commercially sexually exploited, including needing to engage in survival sex.[21,57]

Although traffickers were already using social media platforms to identify and groom targets before the COVID-19 pandemic, the pandemic further worsened the problem of human trafficking in the United States. Pandemic-associated restrictions disrupted a broad range of in-person social relationships, exacerbated individual and family relational and financial vulnerabilities, and destabilized emotional well-being for many. These sudden changes ushered in an environment in which online communication became the dominant form of social interaction, including in the provision of health care. As a consequence, pandemic-related social restrictions inadvertently facilitated human trafficking while making it more difficult for health care providers to detect individuals at risk.[58] Of note, compared to the year immediately prepandemic, NCMEC reported a 28% increase in child sexual exploitation tips during the first year of the pandemic.[17]

H. The Perpetrators of Human Trafficking

1. Who Are the Traffickers?

Traffickers can be almost anyone, including individuals of any gender, US citizens or foreign nationals, individual operators, or members of small or large organized crime networks.[60,61] While some traffickers may be complete strangers to those who ultimately become trafficked, others are known to and respected by affected individuals as well as their families. Traffickers frequently gain access to victims and their families through offers of employment, education, or a more stable future — promises that are often exaggerated or fabricated. Male traffickers may employ tactics such as the "boyfriend" approach, using seduction as a lure, or the "daddy" approach, offering kindness, emotional support, financial aid, and material goods, or a combination of these methods.

[†]Massachusetts General Law, malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section39h, provides information on custodial protection of a child. A parent, legal guardian, or custodian with custody of the child may file a Child Requiring Assistance (CRA) application stating that the child is a runaway (ages 6–18) who repeatedly runs away from the home of the parent, legal guardian, or custodian.

[‡]The term "child welfare" is an umbrella term that refers to all forms of family support and child assistance that support families and caregivers to help keep children safe. Child welfare services include child protective services, which focus on investigation and intervention in cases of suspected child maltreatment and neglect. Some but not all children receiving child protective services are placed into foster care. While involvement in the foster care system has been associated with an increased risk for trafficking, prior maltreatment in any context is cause for concern, as more than half of the cases of domestic minors sex trafficked in 2016 involved youth living in a parent's home.[59]

Traffickers can be, but are not limited to:

- Friends or acquaintances
- Family members
- Intimate partners
- Neighbors and other community members
- Persons affiliated with local or regional civic or religious organizations
- Representatives of "employment" agencies
- Agents of industry, restaurant, or entertainment establishments
- Small business owners and managers
- Large factory or company owners and managers
- Migrant and temporary labor brokers
- Agricultural growers and crew leaders
- Individual and agency employers of domestic workers
- Pimps
- Brothel and fake "massage" business operators
- Gang and criminal network members
- Medical and health care brokers (for organs and tissues)
- Others

2. Coercive Tactics Used by Traffickers

After identifying a target, traffickers use calculated methods to exert power and maintain control, exploiting individual, familial, and cultural vulnerabilities.[17,61] Coercive tactics used by traffickers include:

- **Physical violence:** Beating, branding, tattooing, cigarette burns, forced drug use, strangulation, sleep deprivation, starvation, physical restraint, and even systematic torture
- **Sexual violence:** Rape, including group or gang rape, forced participation in sexually violent, denigrating rituals, and coerced sexualized work such as exotic dancing, webcam pornography, and prostitution sometimes masquerading as massage services
- **Threats and intimidation:** Threats of violence against family members, "display" beatings of others, brandishing weapons, blackmail, and extortion
- **Physical and social isolation:** Solitary confinement, restricting communication with family, friends, and others
- **Deprivation:** Restriction or removal of water, food, medication, clothing, bedding, money, identification documents, visa/passport, and other necessities
- **Emotional degradation:** Shame and humiliation, forced isolation, restriction of movement, threats of expulsion or deportation, fostering uncertainty and confusion by perpetrating acts of violence that alternate with expressions of seeming kindness
- **Deception:** False promises of love, fame, a better life, employment, secure housing, money, or legal status
- **Economic exploitation:** Confiscating or hiding a person's assets, including personal belongings, wages, savings, tickets for return transportation, and creating marked-up "charges" for minimal subsistence

Traffickers also may move targeted individuals frequently and confiscate their passports and other important identification documents, often under the guise of "keeping everything in a safe place." Such tactics are intended to manipulate and control the movements and independence of those who are exploited, thus restricting their ability to form friendships and other supportive relationships, obtain information, or identify sources of potential help. Such acts ensure that affected individuals remain under the control of traffickers and their associates.

This Sex and Labor Trafficking Power and Control Wheel was adapted from the Domestic Abuse Intervention Project's Duluth Model Power and Control Wheel, available at www.theduluthmodel.org. © Copyright Polaris Project, 2010. All Rights Reserved.[62]

I. Barriers to Disclosure in the Health Setting

Although several studies outline barriers to health care *access* for individuals affected by trafficking, peer-reviewed literature concerning barriers to *disclosure* is sparse. Richie-Zavaleta et al. reported on sex trafficking victims' experiences with US health care and determined that only 38% of respondents disclosed their situation in the health care setting. The most common reasons for not disclosing were embarrassment and shame (52%), not being asked directly (48%), fear of what the trafficker would do to them or their family (33%), lack of private space in which they could disclose (24%), appointment too rushed (19%), trafficker present during the encounter (19%), wanting to disclose but not trusting the health provider (14%), and other reasons (10%).[63]

Even when provided with a trauma-informed, safe, and supportive environment in the health care setting, individuals experiencing trafficking often do not disclose their situation — even when asked directly. Some choose not to disclose due to fear, stigma, and shame, while others may not fully understand the concept of coercive control or even recognize that they are trafficked. Some trafficked persons may believe (or have been manipulated into believing) that they are willing and even vital partners of the trafficker, for example, by engaging in commercial sexual activity to "help pay the bills" during tough economic times, or that they (along with their trafficker) are "in this together." Others may engage in bringing in younger, less experienced people into a trafficking ring in exchange for higher status or better treatment.

Affected individuals may not be aware that safe and supportive alternatives to their current situation may exist and that they have both legal and human rights. Some individuals, regardless of whether they self-identify as being trafficked, may be so fearful that they or their loved ones might be harmed if they disclose that they choose to remain in an unsafe, albeit relatively predictable, environment. In some cases, these fears are well-founded, as the movements and actions of trafficked persons may be monitored so closely (by cell phone, electronic ankle or wrist bracelets, other GPS locators, or direct observation by the trafficker or associates) that they make a deliberate decision *not* to disclose. Whether employed continuously or intermittently, strategies such as monitoring, tracking, stalking, and frequent changes in location are often used by traffickers to reinforce instability, engender fear, and deter attempts to obtain assistance or break free. In some cases, monitoring strategies may be so covert and effective that affected individuals may end up believing their traffickers are able to predict or anticipate their next moves or even know what they are thinking.[64]

The pervasiveness of social stigma may also function as a powerful and overarching barrier to disclosure, even when individuals are presented with what otherwise might be perceived as a safe opportunity and venue for disclosure. For persons experiencing trafficking, the implications of being judged as having character flaws or "constitutional" weaknesses (physical or mental), culpability in their ordeal, or enjoyment of any experiences of forced sexual encounters may serve as deterrents to disclosure.

Transgender and gender-diverse individuals may face additional barriers to disclosure in the health care setting due to prior experience with, or anticipation of, discriminatory treatment, such as derogatory comments, misgendering, and deadnaming.[§] Indeed, early insights from the 2022 US Transgender Survey reveal that nearly one in four transgender people (24%) avoided obtaining health care in the 12 months prior to taking the survey because of anticipated discrimination. Of those who did see a health care provider in the last 12 months, nearly half (48%) reported at least one negative experience that they attributed to being transgender, such as "being refused health care, being misgendered, having a provider use harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them."[65]

Some individuals experiencing trafficking are reluctant to disclose because they fear being pressured to cooperate with law enforcement or to participate in legal proceedings against their trafficker to avoid being prosecuted for participating in unlawful acts associated with their exploitation. This is a particularly difficult issue for undocumented victims, who are required by law to cooperate with investigation and prosecution as a precondition to qualifying for legal or immigration assistance but do not qualify for witness protection and thus fear retaliatory harm to themselves or their loved ones. In addition, some may fear feeling triggered or re-traumatized by reliving their past when asked, at times repeatedly, to disclose details of abusive or traumatic events that have transpired. Conversely, others who have

[§]Deadnaming: calling a person by their birth name after they have changed their name as part of a gender transition.

achieved safety and stability might prefer to leave their trafficking situation "in the past" and thus choose not to disclose because they no longer consider themselves to be "victims."[66] Figure 3 summarizes factors that influence the willingness of trafficked individuals to disclose their situation to health care providers.

Figure 3: Factors That Influence Willingness to Disclose Experiences with Trafficking

- Stigma and shame
- Feeling overwhelmed or frightened
- Fear of not being believed
- Fear of harm to themselves, coworkers, friends, or family members
- Fear of being released back to the trafficker
- Fear of being sent back to an abusive or otherwise adverse environment
- Fear of deportation
- Fear of being penalized for prior criminal record
- Fear of criminal exposure for acts undertaken while trafficked
- Prior unsuccessful attempts to leave or escape
- Uncertainty regarding geographic location
- Young age and limited life experience
- Cultural or religious prohibitions against speaking up
- Physical or mental illness or disability
- Sexual orientation, gender identity, or lifestyle
- Unfamiliarity with the health care system
- Distrust of authority figures, including those in health care
- Inability to speak privately and confidentially with a health care provider
- Perception that health care providers are unwilling or unable to help
- Fear that confidential disclosure will be shared or result in harm
- Prior negative experiences (self or coworker) following attempts at disclosure or help-seeking
- Language barriers combined with the unavailability of a trusted professional interpreter
- Lack of money to pay for medical care
- Lack of safe options post-disclosure

Some persons experiencing trafficking may be acutely aware that they are being exploited or trafficked, may wish to escape the situation, and may know that disclosure to a trusted figure, such as a health care provider, can be a first, essential step toward safety. Even so, it is not uncommon for individuals to make deliberate choices not only about *whether* to disclose, but also about *when*, *what,* and especially *to whom* they disclose, even when inquiry is done in a sensitive and trauma-informed manner. Just as is seen in intimate partner violence disclosure, some trafficked individuals may prefer disclosing

to a provider of the same sex, gender, or ethnicity, or of a similar age, while others might make different choices. Some might also want to "test" the health care setting by making repeated visits before deciding if it would be safe or advantageous to disclose. These decisions, which on the surface seem as if they might impede timely disclosure, can be important steps toward autonomous decision-making and are critical prerequisites for exiting exploitation and moving toward independence.

As is the case with any form of deliberate exploitation, disclosure of human trafficking can be a pivotal, personal, and inevitably momentous and life-changing decision that each affected person must make on an individual basis. The decision to disclose, while sometimes appearing to take place "in the moment" during the course of an empathetic and supportive encounter in the health care setting, is often a proactive and courageous decision made by a trafficked individual. Disclosure typically occurs in response to careful, patient, sensitive, and trauma-informed inquiry done in a safe and private setting, affording the patient the best opportunity to make decisions that work for their current and future situation.[67]

The health care provider's goal should not be to "get a disclosure" from a patient suspected of being trafficked or otherwise abused. Instead, the provider should, in the process of delivering needed medical care, strive to create a climate in which each and every patient can feel safe, secure, cared for, validated, and empowered to share information. Disclosure might occur at a later date if the patient does not feel "ready" in the immediate clinical setting. Therefore, each individual clinical encounter should be used as an opportunity to build rapport and foster trust, "keeping the door open" to allow for potential future disclosures.

Health Effects of Human Trafficking

Health care providers may encounter individuals experiencing sex, labor, and/or organ trafficking in the course of providing care to patients of any age, race, socioeconomic status, or gender identity. Clinicians should thus be aware of the wide-ranging health effects of trafficking, which can vary considerably from individual to individual. The following summary is offered for general guidance and should not be considered exhaustive.

A. Physical Health

1. Physical Trauma

Affected individuals may suffer from a range of acute and chronic physical afflictions, which can vary depending on the type of trafficking, as well as the particulars of each individual situation.[2,3,7,8,13,66,68,69,70] Injuries may include:

- Intentional as well as accidental burns
- Branding, tattoos, and other permanent stigmata of "ownership"
- Bleeding and bruising due to blunt force trauma or workplace injury
- Firearm and knife wounds
- Recent or healed fractures
- Strangulation injuries or a disclosure of strangulation in the absence of physical findings
- Traumatic brain injury
- Dental or plastic surgery emergencies
- Neuropathies and other effects of restraint or torture
- Musculoskeletal injuries
- Occupational vision and hearing impairment from lack of protective gear
- Skin, nervous system, and respiratory ailments from exposure to industrial or agricultural chemicals
- Effects of prolonged sun, heat, or cold exposure
- Scarring, deformity, loss of function, and pain from prior injuries

2. Reproductive Health

In addition to physical injuries, individuals affected by sex trafficking or by coincident sexual abuse in the context of labor trafficking can suffer from the physical and mental health effects of:

- Rape or gang rape
- Intentional or inadvertent genital and reproductive organ trauma
- Recurrent urinary tract infections
- Sexually transmitted infections (e.g., chlamydia, gonorrhea, human papilloma virus, hepatitis B and C, and HIV, among others)
- Restricted access to contraception, including barrier contraception (e.g., condoms)
- Pregnancy, including repeated or unwanted pregnancy
- Forced abortion or complications from repeated/poorly performed abortions
- Restricted access to safe abortion

Left unaddressed, trafficked individuals may be at risk for infertility, chronic pelvic pain, cervical cancer, liver failure, HIV-AIDS, and other conditions.

B. Developmental Health

Trafficked children and adolescents face heightened risks to their physical, cognitive, and emotional development. These risks include:

- Inconsistent general pediatric and well-child care
- Lack or interruption of routine childhood immunizations
- Long-term effects of inadequate treatment of common childhood diseases
- Delayed physical and cognitive developmental milestones
- Stunted growth, vitamin deficiencies, and other consequences of chronic malnutrition
- Impaired social skills

C. Chronic Health Conditions

In addition to the specific physical health problems listed, trafficked individuals generally lack access to most forms of non-acute care (primary, preventive, and anticipatory care, including routine immunizations, vision and hearing screening, cancer screening, dental care, and diagnosis and treatment of common, episodic, or chronic illnesses). Moreover, experiencing violence and abuse, particularly chronically, can lead to somatization, immune system dysfunction, and a host of inflammatory conditions. As a result, even in the absence of acute traumatic injuries, patients may present for — or *with* — neglected or chronic health conditions such as:[13,63,71,72]

- Malnutrition
- Growth delay
- Vitamin deficiencies
- Dental caries
- Headaches
- Dizzy spells
- Fatigue/Exhaustion
- Memory problems
- Weight loss
- Heart disease
- Asthma
- Abdominal complaints
- Chronic pain syndromes
- Substance use disorders
- Acute infectious diseases usually prevented through routine immunization
- Chronic infectious diseases such as tuberculosis, intestinal parasites, and hepatitis
- Scarring, especially from unattended prior injuries or skin infections

D. Mental Health

As a result of the constant fear, psychological manipulation, and physical, sexual, and emotional abuse experienced while trafficked, affected individuals can experience a range of mental health sequelae, such as:[73]

- Poor self-esteem
- Shame
- Anxiety
- Fear
- Depression
- Self-harm
- Suicidal ideation

Exploited persons may also suffer from:

- Traumatic stress
- Panic attacks
- Sleep disturbances
- Dissociative disorders
- Suicidal behavior and attempts
- Post-traumatic stress disorder

The effects of cumulative trauma experienced by affected individuals extend far beyond the time under their traffickers' control by disrupting coping mechanisms, undermining self-confidence, and inhibiting the ability to form and maintain healthy and trusting relationships.[74,75] Complex trauma-like behavior that includes features similar to those seen in torture survivors is far from uncommon.[76] These effects can be long-lasting, posing obstacles to navigating an often complex web of health, legal, housing, social service, and employment systems designed to help affected individuals reintegrate into society. When such challenges cannot be understood and adequately supported, the risk of revictimization increases.

E. Legacies of Prior Traumatic Experiences

Many who have experienced trafficking carry the additional burden of antecedent trauma, such as child neglect and/or maltreatment, physical and/or sexual abuse, exposure to violence in the home or community, intimate partner violence, political or religious persecution, or other forms of trauma over the lifespan. These adverse experiences are associated with an increased risk of mental illness and physical ailments, including heart disease, liver disease, and even cancer later in life.[77] Health care providers should consider the physical and mental effects of prior trauma, along with undiagnosed or untreated preexisting conditions, when addressing the complex needs of trafficked individuals.

Assessment and Evaluation of At-Risk Individuals

A. Guiding Principles of Assessment and Care

In order to maximize their ability to address human trafficking, health providers should:

- Utilize a patient-centered, resilience-focused, trauma-informed, human rights-oriented, and culturally and linguistically appropriate approach to the care of ***all*** patients (not just those who are suspected of being trafficked).
- Collaborate with and seek advice from colleagues within the health sector who have been engaged in anti-trafficking or other violence prevention work, as well as with those who have lived experience of trafficking.
- Partner with advocates, social service providers, case managers, and others from outside the health sector to ensure wraparound referral services and achieve a more effective overall response to human trafficking.
- Play an active role in self-directed, practice-specific, system-wide education and training about human trafficking.

1. Patient-Centered Care

It is important for health care providers to focus on the patient's priorities and needs when delivering care. Clinicians should act with sensitivity and compassion and, avoiding opinion and judgment, treat injuries and illnesses related to trafficking, promote comprehensive primary health care, and offer culturally and linguistically appropriate community-based resources and referrals.

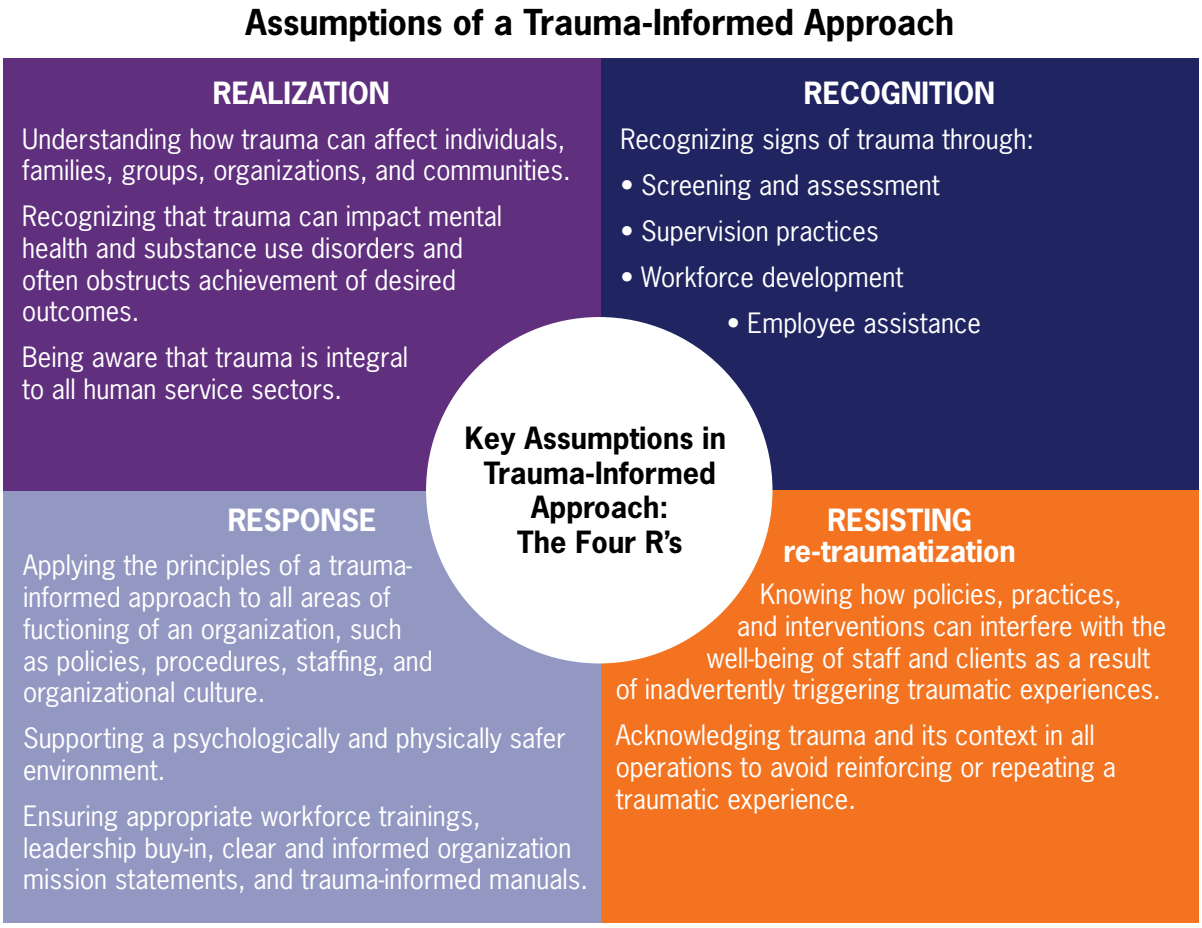
2. Trauma-Informed Care

As the US Substance Abuse and Mental Health Administration (SAMHSA) states, "Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety."[78] Because of the coercive, exploitative, and purposefully disempowering nature of human trafficking, routine, customary, and seemingly innocuous actions inherent to ordinary medical practice — such as asking a patient to disrobe for an exam, performing a gynecological exam, or even engaging in typically mundane activities such as measuring blood pressure, cardiac auscultation, or abdominal palpation — can be perceived as anxiety-provoking and even threatening. As a result, interactions with health providers can be re-traumatizing, triggering intense feelings of fear, vulnerability, loss of control, and shame.

Effective and compassionate medical practice for patients who may be trafficked or otherwise traumatized should incorporate principles of trauma-informed care (TIC) — a strengths-based framework that acknowledges the prevalence and impact of traumatic events throughout the lifespan and preserves or restores a sense of safety, agency, and reclamation of control and autonomy over one's life and decisions.[79-81]

The TIC approach assumes that all patients seen in clinical settings may have experienced some degree of trauma in their lives. This approach to the provision of care acknowledges that traumatic experiences can influence the way patients perceive their environment and interact with others, including health care providers. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, developed in 2014, provides a strengths-based framework — the "Four R's" — for developing a trauma-informed care approach to patient care.[82]

Figure 4: The Four R's



(Substance Abuse and Mental Health Services Administration. Practical guide for implementing a trauma-informed approach. SAMHSA Publication No. PEP23-06-05-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023. https://store.samhsa.gov/sites/default/files/pep23-06-05-005.pdf)

The "Four R's" (Figure 4) framework for trauma-informed care calls for health professionals to (1) **R**ealize the pervasive nature of trauma and its impact across the lifespan, (2) **R**ecognize the signs and symptoms of trauma, (3) **R**espond by using knowledge about trauma to inform care that is safe, supportive, and patient-centered, and (4) **R**esist inadvertent retraumatization of patients through uninformed policies, practices, and procedures. In addition to demonstrating respect, empathy, patience, and acceptance, the trauma-informed approach can help providers respond sensitively and effectively to trauma survivors who may feel threatened by medical encounters of all types — even for routine health care. When services are trauma-informed, the provision of care promotes psychological safety and autonomy by building trust, maintaining transparency, fostering collaboration, and encouraging self-care and shared decision-making. Similar to the use of universal precautions to prevent the transmission of blood-borne infections during medical procedures, clinicians who employ trauma-informed care practices assume the possibility of current or past abuse in *all* patients and adjust the way they care for patients accordingly.

B. Indicators in the Clinical Setting

Anti-trafficking experts have identified specific indicators of human trafficking.[70,72] The presence of any of the indicia listed below should heighten a health provider's suspicion that some form of human trafficking or other serious coercion might be taking place:

- Delayed presentation for medical care
- Discrepancy between the stated history and the clinical presentation or observed injury pattern
- Scripted, memorized, or mechanically-recited history
- Stated age older than visual appearance
- Reluctance or inability to speak on one's own behalf
- Subordinate, hypervigilant, or fearful demeanor
- Inability to produce identification documents
- Frequent relocation; unstable or insecure address
- Documents in the possession of an accompanying party
- Accompanying individual who answers questions for the patient or otherwise controls the pace and content of the encounter
- Companion or accompanying individual who insists on providing translation
- Companion who refuses to leave
- Evidence of a lack of care for previously identified or obviously existing medical conditions
- Tattoos or other marks or insignias that may indicate a claim of "ownership" by another
- Evidence of current or past physical violence, including torture
- Recurrent sexually transmitted infections
- Unintended or rapid repeat pregnancy
- Repeated or forced abortion

In addition, labor trafficking should be suspected in patients of any age — with or without evidence of legitimate employment — who offer vague references to a challenging work situation and with any of the following:

- Overuse injuries
- Chemical exposure
- Evidence of extreme temperature exposure or other environmental or adverse climate exposure
- Injuries or ailments that could result from a lack of proper protective gear
- Excessively long work hours
- Malnutrition or dehydration resulting from restricted access to food/drink
- Signs of sleep deprivation
- Other signs of physical abuse

The above indicators are especially pertinent when interacting with patients whose primary language is different from the provider's and for whom professional interpretation services are difficult to access.

Commercial sexual exploitation of children (CSEC) should be suspected if children or adolescents (or, in certain circumstances, young adults) present with any of the following features:

- Presentation for care with non-guardian or unrelated accompanying adults
- Access to material possessions that one would reasonably doubt the patient could afford
- Unusual familiarity with specific sexual terms and practices
- Large number of sexual "partners"
- History of school truancy or recurrent episodes of running away
- Unusual or fearful attachment to a cell phone or other device that can be used for monitoring or tracking[83]
- Reluctance to talk about a particular tattoo**

Pediatric-age indicators may also signal incipient exploitation of a minor who has not yet been trafficked but who may be in the "grooming" phase (e.g., being lured and manipulated in preparation for commercial sexual exploitation).

C. Taking a History

1. The Rationale for Inquiry

To date, limited evidence is available to guide inquiry about human trafficking in the health care setting. Two scoping reviews highlight gaps between availability and validation of screening tools in the peer-reviewed literature.[85,86] Validated screening tools vary by type of trafficking identified, validation measure reported, care setting, and each tool's acceptability, reliability, and feasibility.[85] Labor trafficking is particularly underrepresented, as most published tools are geared toward sex trafficking. In addition, the diversity of trafficked persons with respect to age, race, ethnicity, gender, physical ability, and psychological profile has not been captured adequately by available instruments. The lack of consensus in the academic and legal worlds regarding definitions and terminology also adds its own set of challenges.[86]

**The issue of tattoos in the context of human trafficking and health care is multilayered and complex.

- In modern western society, tattoos and other forms of body art, once thought of as markers of criminal gang membership, have become increasingly popularized as ways people express themselves or signify important events or relationships. In short, tattoos can be wearable and often unique works of body art.
- Worldwide, people with Indigenous heritage may view tattoos as central to their identity. Facial or body tattoos can be worn not just as personal expressions of artistic preference but also to communicate deep — and until very recently, forcibly suppressed — historical, cultural, or sacred messages, or as representations of deep and proud identity. Specifically, tattoos can signify family lineage, cultural heritage, meaningful life events, accomplishments, rites of passage, sacred rituals, or a connection to the spirit world. Recent efforts directed toward reconciliation and redress in many regions have welcomed active efforts within Indigenous communities to reclaim lost or suppressed Indigenous rituals, including those surrounding tattooing. That said, some, and perhaps many, Indigenous individuals prefer to keep these practices private, within their own chosen circles of trust, and would not want to share them with — or even be asked about them by — outsiders.[84]
- In the context of known or suspected human trafficking, tattoos may be present for any of the reasons outlined above, or they might be deliberate and coerced indicators of "ownership" (branding, as it were) by the trafficker. The very act of being tattooed, therefore, can be traumatic, with subsequent visual reminders being highly and repetitively triggering for a person experiencing trafficking and other coercive situations.

Clinicians should remain mindful and respectful of the cultural and often private meanings of tattoos in all people, especially those with Indigenous heritage, many of whom have made deliberate decisions to withhold sharing information about their cultural backgrounds and practices with healthcare providers. When human trafficking is suspected, care should be taken when asking about tattoos and other permanent symbols to inquire in a culturally humble and trauma-sensitive manner.

Nevertheless, scholarship regarding identification and assessment has been advancing steadily. The Vera Institute of Justice published a tool that can be used to help criminal justice and social service providers distinguish adult victims of sex and labor trafficking from victims of other related crimes of coercion.[87-89] Although this tool may show some promise for its intended use and users, its efficacy in the health care setting has yet to be established. In addition, a single validated, 6-item screening instrument, with a sensitivity of 92% and specificity of 73%, has been published to assist in inquiry about commercial sexual exploitation of adolescents.[90] A sample questionnaire utilizing these questions is available online. Of note, adolescents, in particular, may be more willing to report involvement in CSEC on paper or in electronic form, in comparison to being asked in person by a health care provider.

In addition, established practice-based guidance gleaned from health care, social service, advocacy, and law enforcement colleagues with expertise in human trafficking identification and intervention, as well as existing scholarship in related fields (particularly intimate partner violence, sexual assault, and child abuse/neglect), can be used to inform specific questions that can be used by health care providers for assessment, intervention, prevention, and policy formulation.

Since there is no established evidence base to support universal inquiry about trafficking in the clinical setting, the recommendations offered in this guidebook pertain to inquiry and assessment of individuals whose situations have raised suspicion about trafficking or other commercial exploitation, particularly in the context of the indicators noted previously.

2. Framing Inquiry in Context

Individuals who are trafficked rarely self-identify in the clinical setting. Trauma survivors, in general, report that disclosure may be more likely if the health care provider is perceived to be knowledgeable about abuse and violence, nonjudgmental, respectful, supportive, and employs a trauma-sensitive approach to evaluation and treatment.[91,92] For this reason, establishing a trusting, caring relationship should be the primary goal of the patient encounter when inquiring about trafficking and, by extension, for all encounters for which a trauma-informed approach is warranted. It is in this context that identification or disclosure is more likely to occur, and in a manner that may reduce the risk of retraumatization.

Additionally, given emerging awareness within the health care setting about the impact of adverse childhood experiences and other traumatic exposures on later physical and mental health and well-being, some experts recommend embedding specific questions about trafficking within a larger and more general conversation about coercion, abuse, and violence from a lifespan perspective, once a trusting relationship has been established.[93,94] Although repeated visits may be needed to establish a relationship of trust in some clinical settings, just a few minutes may be needed to establish rapport, especially when trauma-informed care practices are utilized in the urgent care or emergency care setting.

Once rapport has been developed with the patient, and confidentiality (along with its limits) has been communicated clearly, questions about possible human trafficking and other forms of coercive control can be asked. Inquiry about any sensitive topic, and especially about human trafficking, should be framed carefully, gently, and nonjudgmentally.

3. Initial Questions

The items below are offered as examples of questions that can be asked; they should not be considered to be a verbatim checklist or applicable to every case of human trafficking. Additional guidance on

how to ask about human trafficking is available from numerous sources, including federal agencies such as the US Department of Homeland Security, the US Department of State, and the US Department of Health and Human Services (HHS).

Ideally, health care providers should familiarize themselves with risk factors and indicators relevant to their scope of practice as well as individual patient and situational characteristics. Using these insights, providers should be better able to pursue a conversational-style assessment, asking questions as appropriate and following up on responses and disclosures with sensitivity and competence. The importance of establishing rapport prior to taking a history merits emphasis, since some of these questions would not normally arise during the course of routine or ordinary medical evaluation.

Sample questions, offered as examples, include:

- ✓ How many hours per day (or week) do you work?
- ✓ What kind of time off do you have?
- ✓ Can you come and go as you please during your time off?
- ✓ Are you paid for the work you do? Are you getting paid the amount agreed upon?
- ✓ What are your working/living conditions like?
- ✓ Where do you live, sleep, and eat?
- ✓ Do you have to ask permission to eat, sleep, or use the bathroom?
- ✓ Has your passport or any other identification or documentation been taken away from you?
- ✓ Are there locks on the doors and windows where you work or sleep so you cannot get out?
- ✓ Can you quit your job or situation if you want to?
- ✓ What do you think might happen if you try to leave your job or situation?
- ✓ Have you been threatened or harmed in any way by your employer or by an associate of your employer?
- ✓ Have you been sexually harmed in any way by your employer or by an associate of your employer?
- ✓ Has anyone threatened or harmed your family?
- ✓ Has anyone ever forced you to have sex when you didn't want to?
- ✓ Have you ever exchanged sex for food, shelter, drugs, or money?
- ✓ Have you been required or forced to perform sex acts for work or to pay off a debt?
- ✓ Have you ever run away from home or from a program? What did you do in order to survive during that time?

Additional general questions, potentially relevant to both labor and sex trafficking, include:

- ✓ Do you feel that people are controlling you and forcing you to do things you don't want to do?
- ✓ Do you feel afraid of or uncomfortable around people in your everyday life or work setting?
- ✓ Would you know how to seek help if you needed it?
- ✓ Are you afraid of what might happen if you try to get help?

As with other forms of interpersonal abuse and violence, many people who experience human trafficking report that they want emergency department providers to ask about their situation, as long as

inquiry is done in a manner that emphasizes confidentiality and privacy, encourages autonomy/choice, and uses language that is direct, sensitive, and nonjudgmental.[95] Inquiry and assessment for human trafficking should be done in a private and confidential setting that supports the dignity and promotes the safety of at-risk individuals. Providers should assure at-risk individuals that all information that is disclosed will be kept confidential to the extent possible, explaining any limits imposed by mandated reporting and other legal requirements.

In some cases, an individual who is trafficked may present for care accompanied by a trafficker or by a trafficker's accomplices or collaborators. For this reason, health care providers should make efforts to separate patients from any and all accompanying persons, as well as from potential tracking or listening technology, such as cell phones or GPS trackers. At times, professionals may need to be creative and thoughtful about how to separate patients from potential traffickers safely.[96]

When the services of an interpreter are needed, care should be taken to work with a trained, professional interpreter or telephone interpretation service, rather than a family member, friend, or other accompanying individual. These steps should be undertaken in a private and confidential manner to preserve patient privacy and confidentiality. *For reasons of safety, inquiry about trafficking or about any other form of abuse should be deferred unless privacy can be assured*. Please see the following Section G. Guidelines When Language Interpretation Is Required for further information about language interpretation.

As is true in cases of sexual assault, intimate partner violence, and child maltreatment, health care providers should refrain from asking questions that extend beyond information required for treatment planning or for making a decision about notifying appropriate authorities, should the situation fall under mandatory reporting requirements.

The National Human Trafficking Training and Technical Assistance Center and the Department of Health and Human Services published the *Adult Human Trafficking Screening Tool and Guide* (AHTST) in 2018. While not yet validated in the peer-reviewed literature, the AHTST provides screening tips and principles and a set of eight questions derived from expert advisory consensus that can guide conversational evaluation for both labor and sex trafficking in adults.[97,98]

D. Performing the Physical Examination

1. Basic Principles of Physical Assessment

The physical examination should be performed carefully, adhering to trauma-informed care principles and guided by the patient's history and clinical presentation. Forensic evaluation and evidence collection should be offered in cases of sexual violence or other forms of trauma, especially if a sexual assault occurred within the 120-hour window defined by Massachusetts guidelines. Forensic evaluation and evidence collection should be performed with the patient's consent and in conjunction with any applicable mandated reporter responsibilities using a state-approved sexual assault evidence collection kit. The services of sexual assault/forensic nurse examiners, specifically trained in forensic evaluation and evidence collection, and accompanied by trained medical advocates from a sexual assault crisis center for emotional and logistical support and follow-up, should be accessed when available.

2. The Trauma-Informed Physical Exam

Visiting a medical office can be triggering for those who have experienced any sort of abuse or exploitation, especially sexual trauma. Trauma-sensitive approaches, tailored to the clinical setting, may enable patients to collaborate in their own care, allowing for and promoting agency and autonomy.

At all stages of the visit, for example, during registration, check-in, rooming, history and physical, and follow-up communication, attention should be paid to assuring respectful care and to mitigating apprehension resulting from power dynamics discrepancies. The physical examination, and in particular, the gynecologic exam, can be especially difficult for some patients. A trauma-informed physical examination employs language and behaviors intended to help create a sense of safety and autonomy for all patients.

Before the exam, it is important to assess non-verbal cues, identify concerns, establish a plan that prioritizes patient preferences, and offer a chaperone. During the exam, health care providers should describe exam components in simple, clear language, request permission before engaging in each section of the assessment, remain within eyesight, be sensitive to draping and modesty, "check in" periodically with the patient, and act with efficiency and professionalism. After the exam, the provider should thank the patient for coming in for care (and for their courage if a disclosure has been made), review findings, and answer questions in a manner that conveys empathy and compassion.[99]

A physical exam performed in a sensitive and respectful manner can serve as a crucial first step toward healing a ruptured connection between mind and body. Undergraduate and graduate medical education that incorporates principles of trauma-informed care before, during, and after the physical examination can help instill trauma-informed practice habits that become integral to the development of professionalism in young clinicians.[99-102]

3. Conducting the Physical Examination

Abuse and violence, including that resulting from human trafficking, should be suspected when any of these physical findings are noted:

- Evidence of acute or chronic trauma, especially to the face, torso, breasts, or genitals
- Bilateral or multiple injuries
- Evidence consistent with rape or sexual assault
- Occupational injuries not linked clearly to legitimate employment
- Injuries that do not match the patient's history, or for which the explanation is inconsistent
- Circumscribed or patterned injuries that indicate a purposeful injury with a foreign object (e.g., cigarette or belt loop)
- Any injury involving a minor
- Injury involving a disabled individual whose injuries are inconsistent with their disability (e.g., a tibial fracture in someone who is unable to ambulate)

In pregnant individuals, additional signs include:

- Any injury, particularly to the abdomen or breasts
- Vaginal bleeding
- Signs of fetal distress

The physical exam can also be guided by the literature on child abuse, elucidating patterns of bruising that may raise concerns for abuse, termed the TEN-4 criteria (Torso, Ears, Neck: bruising in at least one area in patients younger than four years of age, or any bruising in an infant younger than four months of age).[103] TEN-4 criteria have been subsequently expanded as TEN-4-FACESp, which includes the frenulum, angle of the jaw, cheek (fleshy part), eyelid, sclera, and patterned injuries.[104]

E. Documentation

Detailed and accurate documentation in the medical record is essential for optimal patient care and can also be a source of invaluable information should the patient seek legal redress. In some cases, documentation can potentially substitute for, or supplement, a health care provider's personal testimony in court.

1. Documenting Disclosure and Other Findings from the Patient Interview

The patient's medical history, along with additional spoken disclosures, should be documented in writing, in an unbiased manner, and to the fullest extent possible using direct, unaltered quotes from the patient. Personal opinions or judgmental statements about the patient's affect, demeanor, or the veracity of their disclosure should be avoided.

2. Documenting Physical Findings

Physical findings should be documented carefully and accurately using written descriptions, labeled and annotated freehand sketches, and, with the patient's permission, digital or film photographs. Some positions, such as the knee-chest position for visualizing vaginal or hymenal tissue, may be uncomfortable or triggering for the patient. Reasons for seeking specific photographic documentation and the right of the patient to decline should be clarified before commencing any form of documentation. Consent for photographic documentation should be obtained and noted prior to taking any photographs. Efforts should be made to ensure optimal lighting and positioning of the patient. The date and time each photograph was taken should be noted. The identity of the photographer, as well as a statement verifying that the photos are *accurate, unaltered, and obtained with the patient's consent,* should accompany photographic documentation.

Photographic documentation should include at least one image that shows the patient's face, and the injury or lesion measured with a ruler or other common object, such as a coin. Additional photographs can document close-up views of each relevant injury or lesion. Follow-up photographs, taken serially over 7–10 days, can document the timeline of progression or healing of ecchymoses and other visible signs of injury.

The words "suspected human trafficking" as a finding, diagnosis, or problem should be included in the chart when appropriate.

3. Documentation Caveats

Trafficking-specific diagnosis codes can enhance data collection and analysis as well as service provision and can assist in legal proceedings. At the same time, the use of trafficking-specific diagnosis codes can be potentially problematic. Providers should take precautions when documenting suspected or confirmed trafficking, as new patient portal technologies can make clinical notes viewable by malign entities exerting coercive control by forcing a person to log on or share password access. Even when providers choose to make their notes nonviewable, trafficking-specific ICD codes[††] might still be visible on a medical bill or visit summary, potentially compromising patient privacy and safety.

[††]The *International Classification of Diseases, 10th Revision, Clinical Modification* (ICD-10-CM) is a diagnostic classification system used in the medical documentation of diseases, symptoms, abnormal findings, health-related social circumstances, and external causes of illness and injury. Thirteen ICD-10-CM codes for classifying human trafficking, drafted by the American Hospital Association's Central Office on ICD-10 in partnership with Catholic Health Initiatives and the Massachusetts General Hospital's Human Trafficking Initiative, were included for the first time ever in the 2019 ICD-10-CM Update. Following their presentation in June 2018 to the ICD-10-CM Coordination and Maintenance Committee — a federal interdepartmental committee comprised of members from the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention — the new trafficking-specific codes garnered wide support and were approved and entered into effect on October 1, 2018. Find more information on ICD-10 Coding for Human Trafficking at https://www.aha.org/factsheet/2018-factsheet-icd-10-coding-human-trafficking.

Another concern is related to stigma. Diagnoses entered into electronic medical records are retained in the patient's chart and thus endure over time, accessible to future providers. Should patients encounter inadequately trained or insufficiently sensitive providers during future visits or in other hospital systems, a diagnosis code of "human trafficking" could potentially lead to victim-blaming and stigma.

Lastly, if medical records are subpoenaed for legal proceedings, both diagnosis codes and visit notes potentially can be introduced into evidence in child custody, immigration, or criminal proceedings. Even though confidentiality and privacy protections are purposely incorporated into electronic medical record systems, such caveats should inspire clinicians to approach documentation sensitively, proactively, and carefully but should not deter the provision or documentation of trauma-sensitive care for patients experiencing human trafficking.

The National Human Trafficking Training and Technical Assistance Center summarizes these concerns in its online guide, ICD-10 Codes for Human Trafficking.[105] The International Centre for Missing and Exploited Children and HEAL Trafficking have put together guidelines for clinicians regarding documentation in electronic health records.[106-113]

F. The Role of Sexual Assault Nurse Examiners

Sexual assault nurse examiners (SANEs) are nurses with certified training to take a detailed, trauma-informed history, collect forensic physical evidence while maintaining chain of custody, and testify in court proceedings. SANEs may be certified as either SANE-A (adult/adolescent), SANE-P (children), or both.[114-116]

SANE programs provide the following benefits:

- Ensure optimal collection of forensic evidence
- Facilitate provision of post-assault reproductive health care (e.g., emergency contraception and HIV and other "post-exposure" sexually transmitted infection prophylaxis)
- Improve reporting to police and the subsequent filing of charges
- Increase conviction rates and yield longer average sentences for offenders
- Facilitate comprehensive community-based referrals for survivors
- Improve psychological recovery for survivors[117]

Some states offer analogous forensic evidence training and certification to physicians and physician assistants, in which case the certification is termed Sexual Assault Forensic Examiner (SAFE). In addition, child abuse pediatricians have formal expertise in conducting forensic evaluations of pediatric patients.

On-site forensic evidence collection professionals may be unavailable in some locations, particularly in rural or other underserved regions. In such situations, the responsibility for conducting such evaluations falls to the attending physician or advanced practice provider, with the assistance of telehealth or other support.

G. Guidelines When Language Interpretation Is Required

Patients have a right to understand the care they are receiving and the questions they are being asked. Providers must therefore ensure that interactions in the health care setting are conducted in a culturally and linguistically appropriate manner.[118,119] If a provider is unable to provide care in the patient's primary language, the services of an objective, third-party professional interpreter should be sought.

Health care providers should refrain from allowing accompanying persons (e.g., friends, relatives including children, or other accompanying individuals) to serve as interpreters, as these individuals might be the traffickers themselves, their associates, or might unintentionally compromise confidentiality by disclosing sensitive or confidential information to third parties. Moreover, stigma and shame might impede disclosure if a translator from the patient's own local community is relied upon for language interpretation. Health care providers should remain sensitive to potential cultural, age, sex, or gender issues that might affect a patient's comfort with a particular interpreter. In all cases, clinicians should strive to respect the wishes and preferences of their patients.[120,121]

Professional medical interpreters normally receive regular training about patient privacy and confidentiality, particularly in regard to highly sensitive issues such as abuse and violence. Local interpreters should be screened for any ties to the community and/or trafficker that could place at-risk individuals in discomfort or potential further danger.

Accessing in-person professional interpretation services may prove challenging in remote health care settings or in areas with limited resources. In such instances, remote telephone or video interpretation services should be sought.

Meeting the Needs of Trafficked Individuals

A. Immediate Care Considerations

The time periods immediately prior to and following disclosure can be emotionally difficult and potentially dangerous for the trafficked individual. The importance of establishing and instituting trauma-informed care as well as trauma-informed *systems*, with patient, staff, and site safety in the forefront at all times, cannot be overemphasized.[122]

Patients who are trafficked or otherwise exploited may require immediate as well as long-term medical and psychological care, along with forensic assessment, safety planning, case management, and communication with law enforcement. Health care providers can play a pivotal role in initiating the healing process by providing some medical services directly and by assuring that appropriate referrals are made for medical, safety, and case management issues that fall outside of the individual provider's scope of practice.

1. Emergency and Comprehensive Health Care

Since each patient's situation is different, immediate as well as follow-up medical, reproductive, and mental health care should be tailored, as appropriate, to each patient's age, sex, gender, clinical situation, immediate needs, and expressed priorities. A trauma-informed and culturally sensitive approach to assessment, intervention, referral, and follow-up should be utilized at all times, regardless of whether trafficking or other abuse has been disclosed.

2. Risk Assessment and Safety Planning

Once trafficking has been disclosed, the health care provider can play an invaluable role in helping patients assess their own personal risk, determine danger and communicate safety concerns, initiate discussion about safety planning, and make referrals to appropriate case management services for more detailed safety planning and case management.

Important determinants in assessing risk are the patient's level of fear and their own appraisal of both immediate and future safety needs. The following additional indicators of escalating risk should be explored with each patient:

- Increase in the frequency or severity of threats or assaults
- Increasing or new threats of homicide or suicide by the trafficker
- Presence, availability, brandishing, or prior use of a firearm or other lethal weapon
- New or increasingly violent behavior by the trafficker or associate(s)

Although the provider should be familiar with the general elements of safety planning, detailed safety planning and related case management tasks are best undertaken by those with specific expertise in this area: advocates, social workers, and case managers.

To develop an initial safety plan, it is important to work with the affected individual to assess their perceived level of danger, their existing supports, and the resources needed to leave (or, alternatively, to remain as safe as possible while still in the trafficking situation if leaving is either not desired or not possible). If safety is an immediate concern, hospital security and/or law enforcement should be contacted, assuming patient consent and according to the established institutional protocols and legal requirements for reporting.

General principles of safety planning include determining:

- Assistance, documents, or resources the patient may need if they remain in the current trafficking situation, regardless of the reason
- Action planning for reducing harm, including identifying, in conjunction with the patient, warning signs of impending danger, immediate actions that can be taken, and long-term strategies and resources for increasing safety
- Resources and supports that may be needed if an attempt to leave is undertaken
- Resources and supports that can be leveraged in case the patient decides to take further action at some point in the future

Again, detailed, individualized safety planning is best undertaken by advocates, social workers, and case managers in close coordination with the patient. These expert partners are generally equipped with the time and expertise needed to address each patient's immediate, short-term, and long-term needs and to arrange for appropriate integration and follow-up with known and trained community-based resources.

3. Case Management

Effective case management should be tailored to each patient's individual situation and to the person's current and anticipated needs. Plans should incorporate coping and harm reduction strategies if leaving is not possible or not perceived as beneficial at the time, immediate "exiting" considerations if leaving is being contemplated or is in process, and proactive, long-range anticipatory guidance to maximize safety, independence, and self-determination for the foreseeable future, whether or not exiting a trafficking situation is accomplished. Although clinical health providers should be aware of the elements of case management, outlined below, these complex and dynamically evolving tasks are best undertaken by referral to or collaboration with a community-affiliated advocate, case manager, or social worker who can work closely with community-based agencies dealing with issues faced by people who have experienced trafficking.

Optimal case management incorporates elements of:

- Housing
  - Immediate safe shelter
  - Planning for stable, longer-term housing
- Resources for daily living
  - Food
  - Clothing
  - Personal items
  - Access to communication (including a telephone with internet and text capacity)
  - Access to transportation
- Health care
  - Immediate, emergency, or urgent care
  - Comprehensive primary care
  - Mental health care
  - Reproductive care
  - Dental care
- Financial considerations
  - Money to access immediate necessities (food, clothing, shelter, prescribed medications, child care needs if applicable)
  - Funds for intermediate needs (longer-term housing, furnishings, transportation)
  - Long-term financial literacy assistance (budgeting, banking, saving)
- Employment assistance
  - Job search help
  - Clothing appropriate for job interviews and subsequent employment
  - Interview coaching and practice
  - Guidance for maintaining productive employment
- Life skills capacity building
  - Financial literacy
  - Social and acculturation support
- Language assistance
  - Interpretation assistance
  - English as a Second Language (ESL) support
- Legal and documentary assistance
  - Retrieval or reconstitution of identification documents (birth certificate, passport, visa, etc.)
  - Visa and immigration assistance
  - Repatriation and reintegration assistance if desired

- Basic education (a critical issue for children and young adults)
- Community and family support, including assistance for safe and successful integration into a new community, relocation if requested, or repatriation and reintegration to original settings if desired

If specialized, personalized case management cannot be initiated, the provider should make efforts to inform the patient about the general categories of case management noted above. The patient should be encouraged to contact a local or statewide hotline (see Resources) or the National Human Trafficking Resource Center hotline at (888) 373-7888 to work with a resource specialist for individualized assistance. A private, safe space at the health care facility should be provided so that the patient can place these calls privately and confidentially. Patients should be reminded that contacting hotlines or working with advocates, social workers, or case managers can better inform and empower them to make educated decisions that work best for them and *in no way commits them to a particular course of action*. Quite often, the same information needs to be provided more than once.

B. Elements of Comprehensive Health Care for Those Experiencing Human Trafficking

In addition to bearing the medical and psychological burdens of the abuse they suffered prior to and while being trafficked, affected patients have comprehensive health care needs similar to those of non-exploited individuals. Health care services for those with experiences of human trafficking, therefore, should include the following, as appropriate:

- **Primary care:** a supportive, longitudinal relationship with a primary care-focused physician or advanced practice provider (nurse practitioner or physician assistant) for both illness- and prevention-focused primary health care
- **Mental health care:** screening and treatment for mental health concerns, including depression, anxiety, and PTSD, with a focus on complex and multi-abuse trauma. Treatment may need to extend beyond the limits imposed by public and private benefit plans
- **Cancer screening:** routine age- and sex-appropriate cancer screening and surveillance for early detection of breast, cervical, prostate, testicular, colorectal, and other forms of cancer
- **Violence and abuse exposure:** inquiry and assessment for intimate partner and other forms of family and relationship-focused interpersonal violence, including the adult effects of adverse childhood experiences
- **Substance use evaluation and treatment:** as indicated
- **Anticipatory guidance:** regarding growth and development, life skills, healthy relationships, and parenting
- **Immunizations:** as indicated for age
- **Reproductive care:** including contraception and family planning services, and cancer screening
- **Dental care:** with a focus on reversing signs of abuse and neglect, restoring oral health, and encouraging preventive dental care
- **Hearing, vision, and nutritional assessment and care:** as indicated by age and need

Care should be taken to ensure that all health care is delivered in a trauma-informed, nonjudgmental, and culturally sensitive manner.

1. When Follow-Up Cannot Be Assured

Some patients may be unwilling or unable to return for ongoing or follow-up care. For this reason, the provider should strive to do as much as reasonably possible for the patient while in their care. Additionally, they should assure patients that they are believed, that they do not deserve to be abused or coerced, that they are not to blame in any way for what has happened, and that the health care system's door is "always open" as a source of safe, confidential, and supportive care.

Reporting to and Communicating with Law Enforcement and Child Protection Authorities

A. Adult Patients

Health care providers are neither required nor permitted to report suspected human trafficking involving a competent adult victim without the patient's express consent. Accordingly, providers must refrain from involving law enforcement and/or social service personnel — such as housing/shelter services, legal services, and case management — **without first obtaining explicit informed consent from the patient**.

Breaches of privacy not only can adversely affect the provider-patient relationship but also can strip patients of the autonomy they both deserve and need in order to make informed decisions for their own safety and future. Moreover, disclosure to outside authorities without explicit consent can produce ripple effects across all victim support systems, reinforcing distrust and diminishing patients' and community members' future willingness to access assistance and support. Thus, difficult as it may be, as in cases of intimate partner violence, health care providers must follow the lead of the patient — including respecting the decisions of those who decide *not* to contact law enforcement or accept referrals to other services. Exceptions include situations impacted by legal reporting obligations, such as abuse/neglect of adults with disabilities, abuse/neglect of minor children of trafficked adults, and injuries resulting from burns, firearms, or knives (see sections below). This guidance also does not address the reporting of threats of imminent harm to third parties or involuntary psychiatric hospitalization for patients at imminent risk of serious self-harm.

B. Minors in Need of Protection

In the Commonwealth of Massachusetts, health care providers who, in their professional capacity, have reasonable cause to believe a minor is suffering physical or emotional injury resulting from sexual exploitation or human trafficking are required to file a "51A" report with the Screening Unit at the appropriate Department of Children and Families (DCF) Area Office (8:45 a.m.–5:00 p.m., weekdays) or by calling the Massachusetts DCF Child-At-Risk Hotline, (800) 792-5200 (evenings, weekends, holidays).[123,124] A report must be phoned in and then followed up within 48 hours with a written report regardless of whether the child's legal guardians are the perpetrators, meaning that pimp-controlled or gang-controlled minors can also be assisted through the current mechanism of mandatory reporting in Massachusetts. Reports must include information learned from the minor. If it is determined that a child is a victim of sexual exploitation and/or human trafficking, DCF will send what is known as a "discretionary referral" to the office of the appropriate District Attorney (DA).

In Suffolk County, a DA referral will also be sent to the Support to End Exploitation Now (SEEN) Case Coordinator, who will activate an appropriate multidisciplinary response team on behalf of the child within 48 hours of receiving the DA referral. After filing a report, providers in Suffolk County should alert the SEEN Case Coordinator at the Children's Advocacy Center of Suffolk County at (617) 779-2146.

In locations outside of Suffolk County, this role is undertaken by a Commercial Sexual Exploitation of Children coordinator (CSEC coordinator). A complete list of CSEC coordinators for the Commonwealth of Massachusetts can be found here.

Using age- and developmental stage–appropriate language combined with a trauma-informed approach, health care providers should strive to treat minors with respect and patience — explaining the reasons a report needs to be filed, describing the process, validating patients' reactions, fears, and questions, and highlighting their strength and resilience in such adverse circumstances. Such an approach not only can be empowering to those who have been chronically deprived of agency and self-esteem, but also may help to engender trust and promote recovery. When engaging with vulnerable or victimized youth, care should be taken to build a relationship with the patient, conveying to the child that the provider is experienced in addressing the situation and has the time and interest to deal with it. When eliciting a history of abuse from a minor, open-ended questions should be used, with engaged silence following each question to allow the child or youth to ponder the question and formulate a response. Strong emotional reactions should be avoided to prevent inadvertently conveying a message that the child said or did something bad or wrong, thus inhibiting their future engagement with care.[125] Child Protection Teams should be consulted in facilities where such teams are available. Such teams can assist in ensuring the minor's physical and emotional safety and well-being in the immediate phase following the identification and reporting of suspected trafficking. Relevant Massachusetts definitions and statutes related to children who are sexually exploited are described in Box 1.

Box 1: Relevant Massachusetts Definitions‡**

"Sexually exploited child": any person under the age of 18 who has been subjected to sexual exploitation because such person:

1. is a victim of the crime of sexual servitude pursuant to Section 50 of Chapter 265 or of the crime of sex trafficking as defined in 22 United States Code 7105;
2. engages, agrees to engage or offers to engage in sexual conduct with another person in return for a fee, in violation of subsection (a) of Section 53A of Chapter 272, or in exchange for food, shelter, clothing, education or care;
3. is a victim of the crime, whether or not prosecuted, of inducing a minor into prostitution under by Section 4A of Chapter 272; or
4. engages in common night walking or common streetwalking under Section 53 of Chapter 272.

"Human trafficking victim": a person who is subjected to the conduct prohibited under Sections 50 or 51 of Chapter 265. (See notes below.)

‡MA G.L. c. 265 § 50. (a) Whoever knowingly: (i) subjects, or attempts to subject, or recruits, entices, harbors, transports, provides or obtains by any means, or attempts to recruit, entice, harbor, transport, provide or obtain by any means, another person to engage in commercial sexual activity, a sexually-explicit performance or the production of unlawful pornography in violation of chapter 272, or causes a person to engage in commercial sexual activity, a sexually-explicit performance or the production of unlawful pornography in violation of said chapter 272; or (ii) benefits, financially or by receiving anything of value, as a result of a violation of clause (i), shall be guilty of the crime of trafficking of persons for sexual servitude and shall be punished by imprisonment in the state prison for not less than 5 years but not more than 20 years and by a fine of not more than $25,000.

**MA G.L. c. 265 § 51. (a) Whoever knowingly: (i) subjects, or attempts to subject, another person to forced services, or recruits, entices, harbors, transports, provides or obtains by any means, or attempts to recruit, entice, harbor, transport, provide or obtain by any means, another person, intending or knowing that such person will be subjected to forced services; or (ii) benefits, financially or by receiving anything of value, as a result of a violation of clause (i), shall be guilty of trafficking of persons for forced services and shall be punished by imprisonment in the state prison for not less than 5 years but not more than 20 years and by a fine of not more than $25,000.

Although the crime of human trafficking itself does not fall within Massachusetts mandatory reporting requirements when the victim is a competent adult, health care providers should be aware that certain indicators or information they may hear and/or observe may fall within other mandated reporting obligations. For example:

- MA GL c. 112, § 12A: "Reports of Treatment of Certain Wounds, etc.; Exceptions; Penalty." Physicians must report to specific authorities listed in the statute any injuries resulting from firearms, burns covering more than five percent of the body surface, and wounds caused by knives or other sharp/pointed instruments… [if] in [their] opinion, a criminal act was involved."
- MA GL c. 119, § 51A: "Reporting suspected abuse or neglect; mandated reporters; collection of physical evidence; penalties; content of reports; liability; privileged communication." A report of suspected child abuse or neglect is required to be filed when a competent adult victim is the caretaker of a child or children, and the children are exposed to certain acts and/or threats regardless of whether the children are abused themselves, as in the following examples:
  - An alleged perpetrator made threats to kill a caretaker, child(ren), or themself, and the caretaker fears for their own safety or for the safety of their child(ren).
  - A child was physically injured in an incident in which the caretaker was the target.
  - A child was coerced to participate in or witness the abuse of a caretaker.
  - An incident involved the use or threatened use of a weapon, and the caretaker believes the perpetrator intended to or has the ability to cause harm.

C. Disabled Adult Victims

- Under MA GL c. 19c, § 10, health care providers are required to report suspected abuse of disabled adults, unless the disabled adult patient invokes doctor/patient privilege to maintain confidentiality of communications with the provider.[126] Under Massachusetts law, a disabled person is defined as "a person between the ages of eighteen to fifty-nine, inclusive, who is a person with an intellectual disability as defined by Section 1 of Chapter 123B, or who is otherwise mentally or physically disabled and as a result of such mental or physical disability is wholly or partially dependent on others to meet his [sic] daily living needs."[126,127] Again, health care providers should follow their institution's existing internal procedures for handling such situations or contact the Disabled Persons Protection Commission's 24-hour hotline at (800) 426-9009 or use Video Relay Services (VRS) or MassRelay (711) for hearing-impaired callers.

D. Competent Adults Who Are Temporarily Not Capable of Providing Informed Consent

When a patient is or appears to be an adult and is temporarily incapable of providing informed consent due to present circumstances, such as intoxication, health care providers should follow their institution's existing internal procedures for handling such situations.

Recognizing that there may be situations of apparent imminent danger that lie outside of mandatory reporting requirements, providers should defer to the internal procedures of their practice or health organization, acting within the accepted ethical and professional boundaries of medical practice. In some cases, it may be helpful to contact the organization's administration, risk management, or legal department, or seek outside expertise on the matter. If/when such situations arise, it is important to interact with patients in a dignified and respectful manner, using a trauma-informed approach, and to be as honest and transparent as possible in regard to the reasons for any action taken. Providers can also be a valuable source of support and information, including by offering vital help and hotline

resources, including the National Sexual Assault Hotline at (800) 656-HOPE (4673) or online by accessing RAINN (the Rape, Abuse, and Incest National Network), the National Domestic Violence Hotline at (800) 799-SAFE (7233), or the National Human Trafficking Hotline at (888) 373-7888.

Legal and Immigration Considerations

Domestic as well as international victims of the crime of human trafficking have specific legal rights under federal and state law. Accessing these rights is often impeded by fear or mistrust of law enforcement, judicial, and other authority figures. Mistrust stems from factors such as endemic complicity and corruption in the country or region of origin, social media disinformation, and deceptive messages by traffickers and their associates alleging threats of arrest or deportation if law enforcement authorities are approached for any reason. As a result, many victims, especially those who are noncitizens, may be unaware of their legal rights and available legal supports and, as a consequence, reluctant to disclose to or seek help from law enforcement personnel, attorneys, or service providers.

Fortunately, many people experiencing trafficking and other forms of trauma do not perceive US health care providers as particularly threatening or corrupt, thus affording a unique opportunity to provide information and support and to serve as a conduit for referral to vital advocacy and case management services, including culturally competent and trauma-sensitive legal assistance. Thus, health care providers should pay special attention to situations in which they believe a patient may be trafficked, with extra effort made to ensure that privacy and confidentiality, appropriate language assistance, and trauma-sensitive practices are utilized at all times. Some patients may remain guarded even in spite of this due to fear of deportation. In such situations, it is important to maintain an open

and welcoming demeanor, which can create a climate that supports eventual disclosure and help-seeking. Importantly, this situation does not apply if mandated reporting is required, such as in the case of child or elder abuse.

A. Immigration Relief for Noncitizens

Immigration relief may be available for undocumented or nonpermanent resident victims of trafficking in the United States. This relief includes (but is not limited to) the following remedies created by the Trafficking Victims Protection Act (TVPA):

- **Continued Presence:** "Continuous Presence" (CP) is a temporary status for victims of severe trafficking in persons that gives access to employment authorization, as well as government benefits to the same extent as a refugee.[128] CP is intended to provide legal temporary status and stability so that the victim can remain in the country to assist with investigation and/or prosecution. CP status lasts for one year and can be renewed or revoked. Only a federal law enforcement agency can apply for CP on behalf of a victim. When state or local law enforcement officials identify a victim of human trafficking, they must coordinate with federal law enforcement partners to submit an application for CP. Importantly, CP can be applied for even if a victim is too traumatized to initially cooperate. If the totality of evidence indicates the individual is a trafficking victim, the process is still valid.
- **T-visa:** Victims of severe trafficking in persons who meet eligibility criteria can apply for T nonimmigrant status (otherwise known as a T-visa).[129] Receipt of a T-visa provides an individual with lawful status and the ability to apply to become a lawful permanent resident. This special class of visa, available to sex and labor trafficking victims, also provides employment authorization and an opportunity for certain family members to join the victim in the United States under a category known as "derivative status." T-visa recipients may also be eligible to access federal benefits to the same extent as refugees.
- **U-visa:** U-visas may be available to individuals who have suffered substantial physical or mental abuse as a result of having been the victim of certain criminal activity, including but not limited to trafficking.[130] Like recipients of T-visas, U-visa recipients are eligible for work authorization, may apply to bring certain family members to join them in the United States, and may eventually apply to become lawful permanent residents. Unlike T-visa recipients, U-visa recipients are not eligible to receive benefits to the same extent as refugees; however, they may be eligible for other types of state and federal benefits.

Eligibility for these forms of relief is determined by the individual circumstances surrounding the victimization and the specific eligibility requirements of the type of relief sought. Notably, each of the three remedies requires varying degrees of cooperation with law enforcement as part of the criteria for eligibility. These requirements can pose substantial barriers for noncitizen victims who may associate law enforcement with the threat of deportation, especially in border and asylum situations. Required cooperation with law enforcement can also be triggering, exacerbating previous trauma experienced by the victim. As stated above, even if initial cooperation is a barrier, these recourses can still be pursued at a later date if the patient wishes. For these reasons, victims of trafficking who are considering legal immigration relief should work with a trained and skilled attorney or legal advocate.

Thus, when health care providers assess that a patient who is not a US citizen or a legal permanent resident may be trafficked, they should speak with the patient alone to communicate sensitively yet clearly that they have legal rights and that support is available. Health care providers can then work together with a legal advocate or case manager, or they can contact a hotline resource for further assistance.

Working Collaboratively

No single discipline or sector can successfully meet all the needs of people who have experienced trafficking. Given the complex challenges faced by trafficked persons as they transition to safety and recovery, response protocols need to be trauma-informed, comprehensive, and coordinated across disciplines and systems. In the immediate phase, affected individuals may require basic assistance such as food, clothing, housing/shelter, and physical protection. Over time, many may benefit from accessing a wider range of services, including legal services, long-term housing, life skills training, language and literacy education, employment training, medical care, substance use and addiction treatment, and trauma therapy.[††] Coordinated efforts among law enforcement, health, and social service providers are paramount to the successful provision of comprehensive, wraparound services to assist those who have managed to exit trafficking. To this end, effective case management should be viewed as a cornerstone of intervention, with health care as just one of the many components that need to be addressed.

Health care providers should avail themselves of experts and resources already available and in place for individuals who have experienced other forms of abuse and hardship (e.g., intimate partner violence, child maltreatment, elder abuse, sexual assault, homelessness, addiction, etc.) to develop patient-centered, culturally appropriate, and trauma-informed services in the health care setting (see Resources on page 40). Finally, partnerships across systems with local and regional anti-trafficking stakeholders should be actively pursued as a means to expand expertise, benefit from the advice of experts, and facilitate collaborative, proactive, and ultimately, effective and compassionate care.

Self-Care, Resources for Life-Long Learning, Leadership Opportunities, and Prevention

A. Self-Care: Addressing the Risk of Vicarious Traumatization

Providers caring for traumatized patients may suffer from vicarious trauma, also known as indirect or secondary trauma, which can lead to emotional exhaustion, compassion fatigue, and burnout.[131] In order to work effectively with patients who have experienced significant trauma, health care providers should strive to understand their own histories of trauma and triggers and employ self-care practices that will support and nurture their physical, mental, emotional, social, and professional well-being. Such practices include self-reflection, values clarification, peer check-in, debriefing, reflective writing, meditation, yoga, exercise, psychotherapy, and other forms of counseling, among others. The importance of self-care cannot be overstated, as this will reduce the risk of occupational burnout — a syndrome characterized by disengagement, depersonalization, a sense of low personal accomplishment, and decreased career satisfaction.[132] Effective self-care can enable providers as well as support staff to continue to work with traumatized patients in creative, meaningful, compassionate, and fulfilling ways while accessing counseling and support for themselves as needed to ensure optimal physical and mental health.

[††]The Office on Trafficking in Persons (OTIP) of the U.S. Department of Health and Human Services (Administration for Children and Families, Washington, DC) promotes a holistic, public health understanding of human trafficking. With special attention to individual vulnerabilities (e.g., adverse childhood experiences, discrimination, displacement, homelessness, substance use disorders) and the disproportionate impact of trafficking on underserved populations, OTIP advocates for low-barrier wraparound programs to deliver quality, trauma-informed, and patient-centered services that mitigate harm, improve health outcomes, and facilitate the long-term recovery of individuals who experience human trafficking. Find more information on OTIP at https://www.acf.hhs.gov/otip/about.

B. Opportunities for Ongoing Education and Training

The health sector can play a critical role in advancing anti-trafficking efforts across all sectors of society and in mitigating the adverse effects of trafficking for those who have been affected. Preparing for a more effective health sector response requires not only increased awareness among health care providers about human trafficking but also training on how to identify and assist those who present for care. It is vital that practicing health care providers, providers in training, and health professional students become educated about identification, inquiry and assessment, trauma-informed care, and coordination with law enforcement and community-based social service providers. Human trafficking should be integrated into the education and training of health professional students as well as graduates in residency and fellowship training.[133,134] Continuing education about human trafficking could be offered to health care providers in practice, or made a recommendation or requirement for re-licensure. As an example of such an effort, the Florida Medical Association offers an online educational module on human trafficking.[135] Finally, academically based initiatives (e.g., the Massachusetts Medical Society Committee on Violence Intervention and Prevention, and the Massachusetts General Hospital Human Trafficking Initiative, collaborators in developing this guidebook) can provide both standardized and customized education and training about human trafficking for clinicians and hospital administrators.

C. Leadership Opportunities: Health Care Providers as Agents of Change

Health care providers can serve as effective change agents in a larger societal response to human trafficking. As modeled in the fields of sexual assault, intimate partner violence, child maltreatment, elder abuse, disability rights, and addiction, health professionals can leverage their positions of leadership and respect within communities, hospital organizations, professional societies, and public policy circles to:

- Inform policy formulation when medical perspectives are relevant
- Advocate for advances in law and practice
- Provide essential legal testimony when needed
- Join community and state-wide collaboratives, commissions, and other leadership-focused initiatives
- Advocate for prevention

D. Preventing Human Trafficking

The medical and public health community can take advantage of prevention opportunities at the individual, interpersonal, community, and societal levels, using established frameworks such as the Social-Ecological Model and the Spectrum of Prevention.[55,136] As in the parallel case of intimate partner violence, health professionals can collaborate effectively, in an interprofessional manner, with advocates, social workers, law enforcement, community stakeholders, and persons with lived experience to address and prevent abuse utilizing a lifespan approach. People who have successfully exited human trafficking have also emphasized the need to improve public education, including via social media, about the scope and effects of human trafficking, risk factors, common grooming techniques, and ways to access help.[137] Collaborative initiatives can examine and then systematically address the social determinants of trafficking from a prevention-focused policy perspective. By tackling determinants such as child maltreatment, gender inequality, homophobia, transphobia, racism, xenophobia, unsafe migration, interpersonal violence, and poverty, medical professionals can contribute their expertise to

help modify the very environments and settings that predispose individuals to becoming trafficked. Finally, future research may improve our understanding of the role of intersectional identities in trafficking, informing prevention strategies tailored to varying levels of risk and designed to target specific factors of vulnerability.

Resources

Massachusetts

Boston Police Department: Human Trafficking Unit (Boston)
Phone: (617) 343-6533
Law enforcement response and referral to community-based victim services.

Commonwealth of Massachusetts Interagency Task Force on Human Trafficking
Website: mass.gov/fighting-human-trafficking
Addresses all aspects of human trafficking from a policy perspective.

My Life My Choice (Boston)
Website: mylifemychoice.org
Phone: (857) 991-1159
Offers survivor-led programs, peer mentoring, and advocacy for survivors of human trafficking.

SafeLink — Statewide Hotline
Website: casamyrna.org Hotline: (877) 785-2020
Statewide 24/7 toll-free domestic violence hotline. Hotline advocacy services are multilingual, with access to translation services in more than 130 languages. Services include safety planning, supportive listening, direct connection to Massachusetts domestic violence shelter programs, and referrals to community services.

Massachusetts Office for Victim Assistance
Website: mass.gov/mova
Advocacy and services for crime victims, including victims of human trafficking. Also provides survivor-informed policy development, fund administration, training, and individual assistance.

Children's Advocacy Center of Suffolk County — Support to End Exploitation Now (SEEN)
Website: suffolkcac.org/what-we-do/seen
Phone: (617) 779-2146
Coordinates activities of public and private partner agencies to assist child victims of commercial sexual exploitation through forensic investigation, treatment, case coordination, training and policy advocacy.

International Institute of New England (IINE)
Website: iine.org/about-iine/who-we-serve Provides and facilitates services for victims of human trafficking.

Safe Exit Initiative (SEI)
Website: safeexitinitiative.org This organization, located in Worcester, supports individuals with experience in the sex trade, whether they choose to stay involved, are in the process of exiting, or have already exited. SEI is dedicated to ending the sex trade by addressing the systemic causes of exploitation that include racial and gender inequities, most prominently.

EVA (Education, Vision, Advocacy) Center
Website: evacenter.org Survivor led, the EVA Center offers continuous and comprehensive exit services, information, and resources for individuals impacted by the sex trade.

AMIRAH, Inc.
Website: amirahinc.org Located north of Boston, AMIRAH provides a refuge for those seeking to break free from exploitation and heal in community. Offering exit and after-care opportunities, AMIRAH is a multi-pronged service organization providing mid-term housing through its Rapid Re-Housing program, economic mobility and stability planning, long-term housing navigation, comprehensive case management, peer care navigation, and community support.

CSEC Coordinators for the Commonwealth of Massachusetts
Website: maphn.org/resources/Documents/MA_CSEC_Coordinators_List_May_2022.pdf

National

Health, Education, Advocacy, Linkage (HEAL) Trafficking
Because Human Trafficking is a Health Issue
Website: healtrafficking.org
Email: info@healtrafficking.org
Heal Trafficking is an integrated network of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a health perspective

Polaris Project: National Human Trafficking Resource Center Hotline
Website: polarisproject.org/human-trafficking
24-Hour Hotline: (888) 373-7888 (voice or TTY)
24-Hour Text: BeFree (233733)
The hotline fields tips about potential trafficking situations, provides urgent and non-urgent referrals for services, and offers technical assistance and comprehensive antitrafficking resources. Also offers resources for service providers and law enforcement (including health professional specific training).

Trafficking in Persons and Worker Exploitation Task Force Line
Website: justice.gov/actioncenter/crime.html#trafficking
Hotline: (888) 373-7888 (voice and TTY)
Funded by the US Department of Justice

National Center for Missing and Exploited Children (NCMEC)
Website: missingkids.com/home
24-Hour Hotline: (800) 843-5678
Provides services, resources, training, and technical assistance to assist child victims of abduction and sexual exploitation, their families, and serving professionals.

CyberTipline
Website: missingkids.com/CyberTipline
Hotline: (800) THE-LOST
Offers leads and tips regarding suspected crimes of sexual exploitation committed against children.

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