White Paper: Recognizing Child Trafficking as a Critical Emerging Health Threat

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ABSTRACT

Human trafficking is a pandemic human rights violation with an emerging paradigm shift that reframes an issue traditionally seen through a criminal justice lens to that of a public health crisis, particularly for children. Children and adolescents who are trafficked or are at risk for trafficking should receive evidence-based, trauma-informed, and culturally responsive care from trained health care providers (HCPs). The purpose of this article was to engage and equip pediatric HCPs to respond effectively to human trafficking in the clinical setting, improving health outcomes for affected and at-risk children. Pediatric HCPs are ideally positioned to intervene and advocate for children with health disparities and vulnerability to trafficking in a broad spectrum of care settings and to optimize equitable health outcomes. J Pediatr Health Care. (2021) *35*, 260–269

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Human trafficking (HT) is a pandemic human rights violation (Scannell et al., 2018) with an emerging paradigm shift reframing an issue traditionally seen through a criminal justice lens to that of a public health crisis, particularly for children (Greenbaum et al., 2018; Speck et al., 2018). Globally, it is estimated that eight million children and youth are trafficked annually, 5.7 million for labor and another 1.8 million for sex (Reid et al., 2018). The International Labour Organization estimates one in four of the 21 million worldwide victims of forced labor are children (International Labour Organization, 2018). The United Nations Office on Drugs and Crime found that children comprise 33% of 40,000 identified victims of trafficking (Greenbaum & Brodrick, 2017). HT is a growing problem in the criminal industry with estimates of more than 40 million people currently victimized worldwide (Gordon, Fang, Coverdale, & Nguyen, 2018). The number of HT victims in the United States is unclear, although Polaris (2018a) estimates the total number of victims easily ascends into the hundreds of thousands when including both adult and child sex and labor trafficking victims. Over the past decade, the National Human Trafficking Resource Center (National Human Trafficking Resource Center, 2019) reported more than 40,000 cases of domestic HT with the majority originating in California, Texas, Florida, Ohio, and New York (Joint Commission, 2018). Women and girls account for up to 99% of victims in the sex trafficking industry and 58% of victims in other categories, including forced labor (International Labour Organization, 2018; Owens et al., 2014).

Child trafficking (CT; with the term CT encompassing both labor and sex trafficking) is both underreported and understudied. In a recent literature review, a mere 9.7% of over 22,000 articles reviewed specifically addressed

CT (Sweileh, 2018). Accurately collected estimates of CT incidence and prevalence do not exist, partly because of the illicit nature of trafficking, underreporting of victims, and absence of both standardized terms and a consolidated common database. Existing evidence reports potential victims of CT present in all health care environments, creating an opportunity for pediatric health care providers (HCPs) to act as first responders in prevention efforts, victim identification, and treatment referral (Polaris, 2018b; Sinha, Tashakor, & Pinto, 2019). The Joint Commission issued a Quick Safety bulletin in June 2018, urging health care environments to identify potential victims of HT (Joint Commission, 2018). Although well-designed evidence-based CT education has an important role in effectively equipping clinicians, awareness among HCPs remains low (Barron, Moore, Baird, & Goldberg, 2019; Sprang & Cole, 2018; Donahue, Schwien, & LaVallee, 2019; Fraley, Aronowitz, & Jones, 2018; Katsanis et al., 2019; Lutz, 2018; Recknor & Chisolm-Straker, 2018; Sinha et al., 2019; Viergever, West, Borland, & Zimmerman, 2015). Misconceptions regarding the nature and scope of trafficking persist and impede efforts to improve outcomes. Although the United States is one of the most significant locations for CT victims (Joint Commission, 2018), many U.S. HCPs mistakenly believe that trafficking mainly occurs internationally and rarely affects U.S. residents, although most of those affected in the United States are American citizens and not foreign nationals (Viergever et al., 2015). Most notably, up to 88% of child and adult victims encounter at least one HCP without being identified as trafficked (Greenbaum et al., 2018; Reid, Baglivia, Piquero, Greenwald, & Epps, 2018). Child victims present in a variety of clinical environments, but most HCPs do not receive adequate training on identification or referral services appropriate to the pediatric population (Greenbaum et al., 2018; US Department of Health and Human Services [USDHHS], 2019).

Children and adolescents who are trafficked or are at risk for trafficking should receive evidence-based, trauma-informed, and culturally responsive care. The purpose of this article was to engage and equip pediatric HCPs to effectively respond to CT in the clinical setting as a critical effort to improve health outcomes for affected and at-risk children.

BACKGROUND

CT is an illicit enterprise, making accurate analysis difficult because there are few uniform mechanisms for data collection. In particular, sex trafficking is often hidden and difficult to detect (Rajaram & Tidball, 2018). Moreover, affected children and adolescents often do not self-identify as victims or may not seek services for fear of criminal prosecution, deportation, stigmatization, and/or blame. Many consider victim identification as the "tip of the iceberg," and some argue that lack of attention to CT creates an environment that allows traffickers to evade criminal detection and prosecution (Rajaram & Tidball, 2018).

The Victims of Trafficking and Violence Protection Act, now referred to as the Trafficking Victims Protection Act, was established in 2000, defining HT at the federal level for the first time. Child sex trafficking (CST), also known as commercial sexual exploitation of a child or domestic minor sex trafficking, involves youth under the age of 18 years who are obtained, harbored, transported, advertised, recruited, solicited, or enticed to engage in commercial sexual exploitation (e.g., exotic dancing, massage parlors, escort services, pornography production, prostitution, pornography, or any other sex-related work) for some form of payment, either in money or goods. It is important to note that this includes all types of commercial sex work for victims under the age of 18 years, even in the absence of force, fraud, or coercion, which are elements required for prosecution in adult victims (USDS, 2019). Contrary to common misconceptions, not all children in CST entered through stranger coercion or abduction. Sprang & Cole (2018) found that approximately 31% of child victims were subjected to sexual acts, and 25% of children engaged in pornography related to family member coercion, typically involving selling the child for money, drugs, food, shelter, or something else of value. Child labor trafficking (CLT) involves forcing a child into labor acts through physical or psychological threats or debt bondage. Service, domestic (i.e., hospitality industries, such as hotels), and agricultural industries are most likely to involve CLT (Reid et al., 2018).

RISK FACTORS FOR CHILD TRAFFICKING

Emerging research forms a consensus of commonly identified risk factors (Table 1). The varied nature of CST and CLT make the creation of a singular risk profile difficult (Reid et al., 2018); therefore, pediatric HCPs should know individual risk categories and include these in the routine assessment of youth. This information is particularly relevant to pediatric HCPs because many victims enter trafficking during adolescence. In a survey of 913 survivors of CST and CLT from Florida state records, Reid et al. (2018) found 47% entered trafficking at the age of 13–14 years, 15% entered at the age of 15 years, and 29% entered at the age of 12 years or younger.

Although some risk factors of CST and CLT overlap, other risk factors are more distinct. The most significant risk factor for CST is childhood trauma, especially experiencing sexual abuse (Choi, 2015; Reid et al., 2018). The longer or more frequent the abuse, abuse perpetrated by father figures, co-existing emotional or physical abuse, and penetrative sexual abuse confer the greatest risk (Choi, 2015). The actual reasons for these connections remain speculated; however, it is believed that neurologic changes from toxic stress, damage to interpersonal skills caused by abuse, and emotional numbing that frequently occurs after abuse provide susceptibility to CST and/or CLT (Choi, 2015). The landmark Adverse Childhood Experiences (ACEs) study of more than 17,000 subjects (Centers for Disease Control [CDC], 2019) examined categories of abuse, neglect, and household dysfunction experienced before the age of 18 years. ACEs are associated with downstream health consequences occurring over the life span, including the adoption of health-averse behaviors, disrupted neurodevelopment, cognitive impairment, chronic disease burden, disability, and premature death. Higher ACE scores reveal a graded dose-response risk for adverse health

TABLE 1. Risk factors for child trafficking

Individual	Relational	Community or societal
Age: early to middle adolescence	Parental substance abuse	Social isolation or bullying
Runaway status	Parental abuse or neglect	Sexualization of children
Identification as LGBTQI	Family conflict, disruption, or dysfunction	Indigenous or first nations children
Foster care placement	Forced out of their homes by family members	Recent immigration or migration
Juvenile justice system involvement	Family domestic violence	Gang involvement
Substance abuse or misuse	Single-parent families	Children from impoverished communities
Mental illness	Children with a deceased parent	Underserved neighborhoods and communities
High ACE score		Underresourced schools
Survivors of abuse or neglect		Lack of awareness of CT
Intellectual and other disabilities		Lack of available resources to respond to CT
Immigrant or refugee status		

Note. *ACE, adverse childhood events; CT, child trafficking; LGBTQI, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex.*
Source: Choi, 2015; Niegarten, 2018; Reid et al., 2018; United States Department of State, 2019.

outcomes and should be considered when encountering a child at risk for trafficking.

Gender is also a particular CST risk factor because female survivors outnumber male survivors; however, people of all genders and sexual orientations are sexually trafficked. Youth who identify as lesbian, gay, bisexual, transgender, queer, or intersex (LGBTQI) have a higher risk of CST than their heterosexual peers (Choi, 2015). Because child survivors of maltreatment are more likely to run away, they may have a compounded risk because homeless youth and runaway youth are at a significant risk for a trafficking experience (Chisolm-Straker, Sze, Einbond, White, & Stoklosa, 2019) because of shelter, food, and resource insecurity. It is estimated that the United States has one to almost three million homeless youth. Approximately 20% of U.S. teens run away from home at some point during adolescence. Of these, one-third are recruited into CST within days, and almost 90% are sexually exploited within 3 months (Niergarten, 2018). Although youth substance abuse and mental illness are known risk factors for CST, it is unclear whether these conditions occurred before trafficking or are the result of surviving trafficking (Choi, 2015).

Environmental influences on the likelihood of CST and/or CLT include single-parent families, poor family interpersonal relations, dysfunctional family systems, unsafe or insecure living conditions, placement in foster care or juvenile justice, and significant financial insecurity (Choi, 2015; Niegarten, 2018; Zimmerman, Hossain, & Watts, 2011). These circumstances make children more vulnerable to sexual grooming lured by money, a feeling of being loved, or having somewhere "safe" to go. In addition, financial insecurity and unsafe living conditions may result in parental decisions to offer them for domestic labor, making the children vulnerable to debt bondage (Toney-Butler & Mittel, 2019).

HEALTH IMPACTS OF TRAFFICKING

Trafficking adversely affects physical, social, mental, emotional, psychological, and spiritual health. Acute and chronic headaches are among the most frequently reported physical conditions experienced by victims of HT (Hemmings et al., 2016; Oram et al., 2016; Oram, Stöckl, Busza, Howard, & Zimmerman, 2012; Le, 2018). Fatigue and dizziness are also common (Hemmings et al., 2016; Oram et al., 2016; Zimmerman et al., 2011). Additional complaints include memory problems, acute or chronic pain (especially headaches, backaches, and abdominal pain), and sleep disturbances (Hemmings et al., 2016; Oram et al., 2012; Oram et al., 2016; Le, 2018; Zimmerman et al., 2011). Other physical signs include unexplained or repeated traumatic injuries, such as bruising, fractures, ligature marks, and/or cuts. Victims may experience frequent exposure to infectious diseases, including tuberculosis and vaccine-preventable illness (Richards, 2014). Because of preventive care neglect, victims may experience long-term dental or oral health problems resulting in dental pain (Oram et al., 2012; Le, 2018) from trauma or injuries to the mouth sustained during physical and sexual abuse (Zimmerman et al., 2011). Victims of CST often experience sexual and reproductive health problems from sexual violence and unsafe sex practices including urinary tract infections, pelvic inflammatory disease, and unplanned pregnancy (Hemmings et al., 2016; Zimmerman et al., 2011). Sexually transmitted infections, including hepatitis B or C and HIV, are among the most common sexual health issues reported (Cannon, Arcara, Graham, & Macy, 2018; Oram et al., 2016; Le, 2018; Zimmerman et al., 2011). Forced and unsafe abortions may occur (Richards, 2014). Similar to victims of CLT, those who experience CST may endure inhumane working and living conditions.

Victims of CLT work long hours with little rest and may be exposed to pesticides and other hazardous chemicals. Children are at risk for physical injury if they lack protective gear or operate machinery without proper training or oversight (Cannon et al., 2018; Ronda-Perez & Moen, 2017; Zimmerman et al., 2011). Victims of CLT may develop musculoskeletal issues from repetitive motions and limb injuries. Children may work in extreme weather conditions and develop skin infections from being exposed to poor sanitation and bacterial

hazards (Cannon et al., 2018) and injury (e.g., limb amputations). Child victims often live in overcrowded, unclean conditions where they are further exposed to communicable diseases (Zimmerman et al., 2011). Sexual abuse may occur during labor trafficking (Cannon et al., 2018).

CT victims experience repetitive traumatic events that result in cumulative psychological harm. The most common mental health conditions reported include anxiety, depression, post-traumatic stress disorder, and suicidal ideation (Hemmings et al., 2016; Oram et al., 2016; Le, 2018; Richards, 2014; Zimmerman et al., 2011). In addition, substance abuse or misuse may occur because of forced or coerced use of substances (Zimmerman et al., 2011).

PRESENTATION OF VICTIMS IN THE CLINICAL SETTING

It is estimated that 88% of victims access health care services sometime during their exploitation (Greenbaum et al., 2018; Reid et al., 2018). Since 2016, 14 states have enacted legislation addressing health professional education about HT (Atkinson, Curnin, & Hanson, 2016). Recent studies have demonstrated the inadequacy of identification and health care services of CT victims. The variability of each trafficking experience adds to the difficulty of recognizing victimization (Fedina, Williamson, & Perdue, 2019). HCPs are critical to identifying children at high risk for trafficking and offering timely, comprehensive, and multidisciplinary services.

Victims commonly present with a variety of behavioral clues that should raise CT suspicion. Often, illness or injury history is inconsistent with physical findings. The presence of a controlling accompanying adult who does not allow the child or adolescent to speak, or observation of overly submissive, withdrawn, or fearful behaviors should be concerning. Identification documents may be absent or "misplaced" (Shared Hope, 2019). Victims may be unaware of the current date or time and their current location or may be unable to provide a home address. Other warning signs include aggression, extreme fear, or withdrawal manifested by flat affect (Dignity Health, n.d.).

A variety of physical signs should alert the HCP to suspect HT. Note the discrepancy between stated age and observed age. Suspected victims who state their age to be over 18 years but appear to be younger should have age correlation with a physical examination and Tanner staging, although early-onset sexual abuse is associated with earlier pubertal onset (Noll et al., 2017). Physical signs of trafficking include evidence of physical or sexual violence, such as ligature marks, broken teeth or bones, and vaginal or rectal injury. Malnutrition or unmanaged chronic illness may be noted. Illegal substance abuse, especially when testing results positive for multiple drugs, should raise trafficking suspicion. Recurrent visits for urinary tract infections, sexually transmitted infections, pelvic inflammatory disorder, and partial or traumatic abortion are high-risk indicators (Shared Hope, 2019). Assess the entire body and document any tattoos because traffickers often brand their victims with permanent markings. In the United States, marking a youth under the age of 16 years with a tattoo is illegal in most states and should raise suspicion (National Conference of State Legislators, 2018). Commonly reported tattoos include using dollar signs, bar codes, or the words "daddy," "bottom" (designating a "bottom girl" or a victim who moved up in the victim hierarchy and may receive better treatment), or "___'s girl" (Fang, Coverdale, Nguyen, & Gordon, 2018; Napnap Partners, 2019).

IMPLEMENTING A TRAUMA-INFORMED AND CULTURALLY RESPONSIVE APPROACH

A trauma-informed approach minimizes triggers, stabilizes the patient, and de-escalates potentially volatile situations. Trauma response has significant impacts on psychological and physical outcomes, including long-term sequelae such as post-traumatic stress disorder (USDHHS, 2014). A trauma-informed framework encourages HCPs to adeptly recognize signs of trauma and its widespread impact while integrating trauma-related policies and procedures to help prevent retraumatization (USDHHS, 2014; Dignity Health, n.d.). Through this process, HCPs provide care that empowers survivors by considering their wishes, maximizing their input in care-related decisions, reassuring safety, and providing care with transparency and trustworthiness (Greenbaum et al., 2018; Dignity Health, n.d.). The trauma-informed approach assists HCPs in identifying subtle indicators of trauma while creating a safer space for self-disclosure of victimization (Greenbaum et al., 2018; Peck & Meadows-Oliver, 2019).

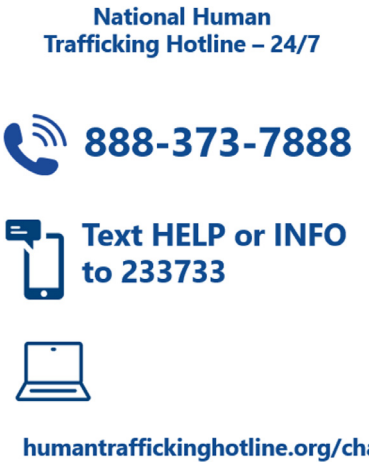
A primary tenet of trauma-informed care is developing trust. An initial step is to provide safety and privacy for the health care encounter, away from the accompanying person (Barnet et al., 2018). Be aware that a child may be a victim of familial CST or CLT, or the "friend" may be someone appointed by the trafficker to supervise and ensure victimization is not disclosed (Polaris, 2018; Sprang & Cole, 2018). Separate them via a required procedure that only the patient can attend, such as an x-ray or a urine test. Equally important is limiting the number of staff who are aware of the suspected trafficking situation to limit conversation and lessen the risk of the trafficker overhearing the conversation and leaving. Another aspect of establishing a trusting relationship and providing culturally responsive care is ensuring the patient can speak to HCPs in their native language. Three federal laws (The American with Disabilities Act, Title VI of the Civil Rights Act of 1964, and the Affordable Care Act) require HCPs or institutions who receive federal funds to provide qualified interpreters to patients with limited English proficiency and patients who are deaf or have impaired hearing, and explicitly bans the use of minor children or adult family members and friends as interpreters (USDHHS, 2014; USDS, 2019). People who accompany the suspected victim should never be translators. Never question potential victims about their immigration status.

Demonstrate respect for the child or adolescent by offering choices and control during the encounter. Ask patient permission before initiating a detailed history and physical. Throughout the encounter, ask, "How are you doing?" or "May I continue?" Use developmentally appropriate language and start with less invasive parts of the

examination by asking, "Are you comfortable with me listening to your lungs?" and then request permission to ask more probing questions and perform more intimate examinations (National Child Traumatic Stress Network [NCTSN], n.d.; Affordable Care Act, 2016).

Just as with other forms of trauma, many child victims, when questioned, are not willing to self-disclose as victims, and many do not recognize their victimization yet (NCTSN, n.d.; Polaris, 2018b). Some factors compelling nondisclosure include fear, distrust of authority, shame, hopelessness, and trauma bonds (Greenbaum et al., 2018). HCPs can provide support during the encounter (Table 2). Do not force, deceive, or coerce a patient to disclose with the intent to "save" or "rescue" them. Understand that survivors may express anger or be accusatory and/or belligerent as manifestations of survival behaviors. Do not be discouraged if a patient does not disclose victimization. It may take several visits for a child to feel safe enough to disclose their trafficking situation. Validate and normalize their feelings (NCTSN, n.d.; Affordable Care Act, 2016), and discreetly, verbally

FIGURE 1. National Human Trafficking Hotline. Source: National Human Trafficking Hotline, 2019.



(This figure appears in color online at www.jpedhc.org.)

TABLE 2. Health care provider response to CT victims in the clinical setting

Response	Action items
Evidence-Based	Practice within the scope of your education, license, certification and training Adhere to mandatory reporting laws in your state Seek high quality continuing education from reputable entities Provide appropriate care for presenting clinical concerns (i.e. injuries or illnesses) Advocate for use of scientifically-designed screening tools with evidence of reliability and validity Facilitate appropriate referral and connection to interprofessional holistic service entities
Trauma-Informed	**Safety**- Ensure emotional and physical safety for all involved parties in the clinical setting Avoid unintentional re-traumatization by using well-intentioned but ill-informed interview techniques Make every effort to provide privacy during clinician interaction with the individual, separate from individuals potentially posing threats (i.e. traffickers) **Choice-** Provide individuals with control and clear, appropriate messages about their rights and responsibilities Do not attempt to force the patient to self-disclose Know and adhere to federal and state laws as well as organizational policy governing mandatory reporting **Collaboration-** Share power in decision making and planning Collaborate with interprofessional disciplines **Trustworthiness-** Maintain respectful and professional boundaries Do not make promises you cannot keep **Empowerment-** Prioritize empowerment and skill building Do not "rescue" the patient Communicate messages of hope This is a safe place You are not alone This is not your fault You deserve to receive help
Culturally-Responsive	Identify your personal potential biases Use a professional interpreter or interpreter service(s) to provide linguistically appropriate services to individuals who speak a different language Recognize the differences between the cultures of law enforcement, the health care profession, trafficked individuals, and other interprofessional disciplines involved in care Advocate trafficking response teams that are inclusive and representative of diverse perspectives

Note. *CT, child trafficking.*
Source: Peck, 2019.

TABLE 3. Open-ended conversation approaches

Concern for labor trafficking	Concern for sex trafficking
What type of work do you do?	Do you ever feel pressure to do something you don't want to?
What are your work hours?	Have you been physically hurt?
How often do you get to see your family?	Did someone tell you what to say today?
Does someone prevent you from contacting them?	Has your family been threatened?
Can you get another job if you want?	Has anyone asked you to have sex with someone else?
Come you come and go as you please?	Have you ever felt you had to have sex to get what you need, such as food or to stay in where you live?
How many people live with you?	Has anyone asked you to dance at a gentleman's club or take your clothes off in front of someone?
Are you being paid?	
Do you have a safe place to go?	
Do you owe money to your employer?	
Do you have control over your money and ID/documents?	

**Note: Some questions overlap and may be appropriate for concern for both sex and labor trafficking. Principles of trauma-informed care should be implemented with any clinician-patient interaction. These may present a starting place for conversation to explore potential risk in the absence of a scientifically-designed screening tool with established validity and reliability.*
Source: National Human Trafficking Resource Center, 2019.

provide the information they may choose to act on in the future. This information may include providing them with the National Human Trafficking Hotline number (Figure 1). Avoid judgmental statements that may be abrupt or insensitive, such as, "Why didn't you ask for help?" or "How could this have happened?" Be open to unfamiliar narratives. Although there is currently no universal screening tool recommended for routine use, HCPs can use therapeutic communication to ask open-ended questions (Table 3).

RECOMMENDATIONS FOR CALLS TO ACTION

Pediatric HCPs play a pivotal role in raising CT awareness. Recommended calls to action are summarized in Table 4 with resources contained in Table 5. All pediatric HCPs

TABLE 4. Recommended calls to action

Evidence-Based, Trauma-Informed, Survivor-Informed, Culturally-Responsive

Entity	Action items
Individual HCPs	Seek evidence-based continuing education specific to HCPs
	Memorize the Human Trafficking Hotline phone and text numbers
	Learn how to be an effective advocate and clinician for victims presenting in the clinical setting
	Keep abreast of published scientific literature related to child trafficking
	Advocate for the implementation of a protocol within your institution
	Advocate for prevention of Adverse Childhood Events (ACEs)
	Educate children and families about risk factors for trafficking
	Volunteer with a local anti-trafficking advocacy group
	Serve on a city, state, or federal taskforce or committee
Health Systems/Clinical Environments	Establish an interprofessional workgroup to develop and implement an interprofessional protocol
	Designate an organizational taskforce to respond in the clinical setting
	Require annual training for ALL employees, not just clinical personnel
	Make trafficking awareness part of orientation or onboarding
	Work collaboratively with local/state/federal law enforcement task forces
	Develop and evaluate the use of order sets
	Take steps toward becoming a trauma-informed institution (5 primary principles include safety, transparency and trustworthiness, choice, collaboration and mutuality, empowerment- consider the Missouri Model as an exemplar)
	Consider scientific development of screening tools with evaluation for reliability and validity
	Create an evidence-based, trauma-informed and culturally-responsive organizational protocol
	Ensure mandatory reporting protocols follow state and federal law
	Implement and evaluate the use of trafficking-related ICD-10 CM codes
	Include trafficking survivors in interprofessional teams to promote survivor-informed practices
	Consider the potential impacts of vicarious trauma and ensure adequate support services are available and accessible
Academic Institutions	Implement evidence-based education in interprofessional health sciences curricula
	Support research agendas including social determinants of health, theory-based interventions and upstream prevention approaches with a public health paradigm
	Implement trafficking awareness training for ALL employees
	Establish policies and procedures to support employees and students who are identified as potential victims of trafficking

TABLE 5. Resources for individual HCPs, health care organizations, and academic institutions

Organization	Resource	Website
ACT, National Association of Pediatric Nurse Practitioners Partners for Vulnerable Youth	ACT Advocates Train the Trainer program for healthcare professionals and speaker's bureau	https://www.napnappartners.org/act-advocates-program
Dignity Health	Shared Learnings Manual	https://www.dignityhealth.org/hello-humankindness/human-trafficking
Dignity Health in partnership with HEAL Trafficking and Pacific Survivor Center	PEARR Tool (A Trauma-Informed Approach to Victim Assistance in Health Care Settings)	https://www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed/using-the-pearr-tool
HEAL Trafficking	Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings Recent Publications and Reports Webinars	https://healtrafficking.org/protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-health-care-settings/ https://healtrafficking.org/publications-and-reports/ https://healtrafficking.org/webinars/
Polaris	National Human Trafficking Hotline	https://humantraffickinghotline.org/
Shared Hope International	State Report Cards for Sex Trafficking Laws	https://sharedhope.org/what-we-do/bring-justice/reportcards/2018-reportcards/
U.S. Department of Health and Human Services; National Human Trafficking Training and Technical Assistance Center; Administration for Children and Families; Office on Trafficking in Persons; Office on Women's Health	SOAR to Health and Wellness Online Training Modules: Trauma-Informed Care; Culturally and Linguistically Appropriate Services; SOAR for: Behavioral Health, Public Health, Health Care, Social Services, School-Based Professionals	https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training/soar-online
U.S. Department of Homeland Security	Blue Campaign- A national public awareness campaign designed to educate the public, law enforcement and other industry partners to recognize and respond to human trafficking	https://www.dhs.gov/blue-campaign

Note. *ACT, Alliance for Children in Trafficking; HCPs, health care providers; HEAL, Health, Education, Advocacy, Linkage; PEARR, Privacy, Educate, Ask, Respect and Respond; SOAR, Stop, Observe, Act, Respond.*

should seek evidence-based, survivor- and trauma-informed, culturally responsive continuing education to inform their clinical practice. Questioning and examining children in a well-intentioned but poorly informed manner can cause further trauma, jeopardize subsequent criminal proceedings, and risk violating the limits of clinician licensure (Gordon et al., 2018). Pediatric HCPs should not conduct forensic interviews if not properly trained to do so.

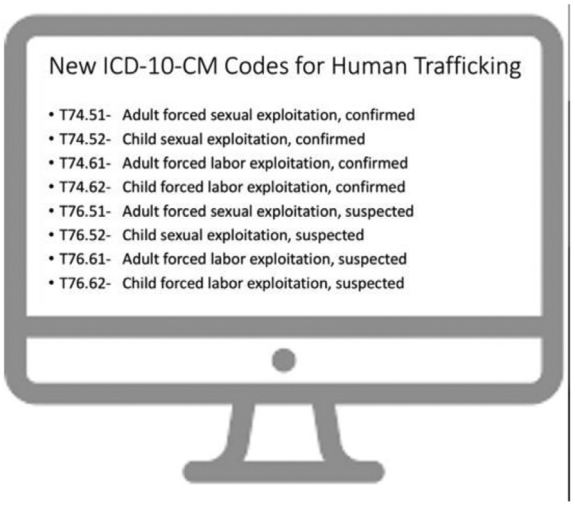
Pediatric HCPs should support evidence-based, scientifically rigorous approaches to the development and subsequent evaluation of CT preventive efforts. Use a holistic assessment approach and recognize that all body systems may be involved. A thorough review of symptoms and a comprehensive physical and mental health assessment should be performed to identify risk factors (Richards et al., 2014). Health care professionals should contribute to critical efforts to identify situations CLT in addition to situations of CST (Ronda-Perez & Moen, 2017). Victims of forced labor should not be underserved with preferential prevention and intervention efforts diverted or prioritized to vctims of CST.

In the broader context of health care organizations, pediatric HCPs should lead efforts to implement best practices through policies, protocols, and governance for children who experience and are at risk for trafficking. Health care organizations should ensure that trafficking awareness is included in the onboarding process for all new employees and in annual compliance training. Every health care delivery environment should develop and implement a clinical protocol with input from an interprofessional organizational coalition including clinicians, administrative leadership, staff support, institutional security personnel, ancillary care services, social service disciplines, child life specialists, sexual assault nurse examiners, and local and federal law enforcement (Dignity Health, n.d.). In particular, the collaboration between health care and law enforcement professions is an area needing further development to maximize resources and optimize patient outcomes. A clinical interprofessional protocol is critical to employ an evidence-based, trauma-informed, and culturally responsive approach. Protocols should address case management, patient referral, and care coordination. Of utmost critical importance, each protocol should address mandated reporting obligations for HCPs, which vary according to state law. Clinicians need clear direction on how to report suspected cases of child trafficking and the differences in reporting adult cases (Barnert et al., 2017). Reporting instructions should comply with federal and state law, including, but not limited to, protections for reporting confidential patient information and

avoiding violations of the Health Insurance Portability and Accountability Act. In addition, organizations should be aware of federal and state efforts and legal implications for trafficking victims including: criminalization of trafficking crimes, survivor protections in court, coordination between state and federal agencies, and business regulations (National Conference of State Legislatures, 2018). Organizations should ensure that employees know how to contact the National Human Trafficking Hotline (2019) and the appropriate guidelines for communication therein, considering state laws for mandatory reporting and boundaries for Health Insurance Portability and Accountability Act violations. Protocols should address discharge planning, patient safety counseling, and discreet provision of further resources for those who choose not to self-disclose victimization and who do not qualify for mandated reporting. Other considerations include safety considerations for victims, families, and staff; a procedure for handling care refusal or leaving against medical advice; and potential order sets for evaluation and treatment. HCPs must understand and abide by their education and mandated scope of practice to avoid unintentional revictimization, providing poor care, or potentially damaging criminal cases.

Although there is no diagnostic standard for trafficking, International Classification of Diseases, 10th Revision, Clinical Modification (i.e., ICD-10-CM) codes (Figure 2) were approved in October 2018, offering options for adult or child confirmed or suspected labor or sex trafficking. It is important for clinicians to use these codes to provide a better understanding of the scope of this problem (OTIP, 2018). When these codes are used in an electronic medical record, consider confidential use to protect victims from potential retribution for seeking health care. It is important to note that there is insufficient evidence to support universal adoption of a standardized screening tool for CST and CLT (Peck, 2019). Care should be taken to construct tools with a strong scientific approach and implement rigorous efforts to assess reliability and validity.

FIGURE 2. International Classification of Diseases, 10th Revision, Clinical Modification codes for trafficking. Source: Office on Trafficking in Persons, 2018.



Academic institutions should prioritize and support scholarly efforts to research clinician response to CT with emphasis on scientific inquiry inclusive of individual, relationship, community, and societal impacts on social determinants of health (i.e., a public health paradigm construct) and theory-based interventions. Care should be given to thoughtful construction of prevention and intervention efforts, with consideration and implementation of rigorous scientific studies with statistical outcomes measurement. Inclusion of child victimization should be examined scientifically, comparing unique experiences and holistic impacts of child vs. adult victims (Le, 2018).

CONCLUSIONS

Pediatric nurse practitioners and other pediatric HCPs are ideally positioned to lead efforts for trauma-informed, culturally responsive, and evidence-based care of children who have experienced or are at risk for experiencing trafficking (Peck, 2019). Adopting incremental and evidence-based clinical practice changes amplifies the impact of pediatric HCPs as effective leaders with a cohesive and collective response to child trafficking. By recognizing previously unidentified victims and employing upstream prevention approaches, pediatric HCPs can positively impact health outcomes for children.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at https://doi.org/10.1016/j.pedhc.2020.01.005.

REFERENCES

Affordable Care Act, 45 C.F.R. § 92.201. (2016). Retrieved from https://www.govinfo.gov/content/pkg/CFR-2016-title45-vol1/xml/CFR-2016-title45-vol1-part92.xml#seqnum92.201

Atkinson, H. G., Curnin, K. J., & Hanson, N. C. (2016). U.S. state laws addressing human trafficking: Education of and mandatory reporting by health care providers and other professionals. *Journal of Human Trafficking, 2*, 111–138.

Barnert, E., Iqbal, Z., Bruce, J., Anoshiravani, A., Kolhatkar, G., & Greenbaum, J. (2017). Commercial sexual exploitation and sex trafficking of children and adolescents: A narrative review. *Academic Pediatrics, 17*, 825–829.

Barron, C. E., Moore, J. L., Baird, G. L., & Goldberg, A. P. (2019). Domestic minor sex trafficking in the medical setting: A survey of the knowledge, discomfort, and training of pediatric attending physicians. *Journal of Human Trafficking, 5*, 13–24.

Cannon, A. C., Arcara, J., Graham, L. M., & Macy, R. J. (2018). Trafficking and health: A systematic review of research methods. *Trauma, Violence and Abuse, 19*, 159–175.

Centers for Disease Control and Prevention (CDC). (2019). About the CDC-Kaiser ACE study. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facestudy%2Fabout.html

Chisolm-Straker, M., Sze, J., Einbond, J., White, J., & Stoklosa, H. (2019). Screening for human trafficking among homeless young adults. *Children and Youth Services Review, 98*, 72–79.

Choi, K. R. (2015). Risk factors for domestic minor sex trafficking in the United States: A literature review. *Journal of Forensic Nursing, 11*, 66–76.

Dignity Health (n.d.). Taking a stand against human trafficking. Retrieved from https://www.dignityhealth.org/hello-humankindness/human-trafficking

Donahue, S., Schwien, M., & LaVallee, D. (2019). Educating emergency department staff on the identification and treatment of human trafficking victims. *Journal of Emergency Nursing, 45*, 16–23.

Fang, S., Coverdale, J., Nguyen, P., & Gordon, M. (2018). Tattoo recognition in screening for victims of human trafficking. *Journal of Nervous and Mental Disease, 206*, 824–827.

Fedina, L., Williamson, C., & Perdue, T. (2019). Risk factors for domestic child sex trafficking in the United States. *Journal of Interpersonal Violence, 34*, 2653–2673.

Fraley, H. E., Aronowitz, T., & Jones, E. J. (2018). School nurses' awareness and attitudes toward commercial sexual exploitation of children. *Advances in Nursing Science, 41*, 118–136.

Gordon, M., Fang, S., Coverdale, J., & Nguyen, P. (2018). Failure to identify a human trafficking victim. *American Journal of Psychiatry, 175*, 408–409.

Greenbaum, J., & Bodrick, N. (2017). Global human trafficking and child victimization. Policy statement. *American Academy of Pediatrics, 140*, e20173138.

Greenbaum, V. J., Dodd, M., & McCracken, C. (2018). A short screening tool to identify victims of child sex trafficking in the healthcare setting. *Pediatric Emergency Care, 34*, 33–37.

Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L. M., Stanley, N., … Oram, S. (2016). Responding to the health needs of survivors of human trafficking: A systematic review. *BMC Health Services Research, 16*, 320.

International Labour Organization. (2018). Forced labour, modern slavery and human trafficking. Retrieved from https://www.ilo.org/global/topics/forced-labour/lang—en/index.htm

Joint Commission. (2018). Identifying human trafficking victims. *Quick Safety*. Retrieved from https://www.jointcommission.org/assets/1/23/QS_41_Human_trafficking_6_12_18_FINAL1.PDF

Katsanis, S. H., Huang, E., Young, A., Grant, V., Warner, E., Larson, S., & Wagner, J. K. (2019). Caring for trafficked and unidentified patients in the EHR shadows: Shining a light by sharing the data. *PLoS One, 14*, e0213766.

Le, P. D. (2018). Human trafficking and health research: Progress and future directions. *Behavioral Medicine, 44*, 259–262.

Lutx, R. M. (2018). Human trafficking education for nurse practitioners: Integration into standard curriculum. *Nurse Education Today, 61*, 66–69.

NAPNAP Partners. (2019). Tattoos of human trafficking victims. Retrieved from https://www.napnappartners.org/tattoos-human-trafficking-victims

National Child Traumatic Stress Network (NCTSN). (n.d.). Understanding and addressing trauma and child sex trafficking. Policy Brief. Retrieved from https://www.nctsn.org/resources/understanding-and-addressing-trauma-and-child-sex-trafficking-policy-brief

National Conference of State Legislatures. (2018). Human trafficking overview. Retrieved from http://www.ncsl.org/research/civil-and-criminal-justice/human-trafficking.aspx

National Human Trafficking Hotline. (2019). National human trafficking hotline. Retrieved from https://humantraffickinghotline.org/

National Human Trafficking Resource Center. (2019). Comprehensive human trafficking assessment. Retrieved from https://humantraffickinghotline.org/resources/comprehensive-human-trafficking-assessment-tool

Niergarten, M. B. (2018). International child health: Identify, screen, treat and advocate for child victims of human trafficking. *Contemporary Pediatrics, 35*, 8–10.

Noll, J. G., Trickett, P. K., Long, J. D., Negriff, S., Susman, E. J., Shalev, I., … Putnam, F. W. (2017). Childhood sexual abuse and early timing of puberty. *Journal of Adolescent Health, 60*, 65–71.

Office on Trafficking in Persons (OTIP). (2018). CDC adds new human trafficking data collection fields for health care providers. Retrieved from https://www.acf.hhs.gov/otip/news/icd-10

Oram, S., Abas, M., Bick, D., Boyle, A., French, R., Jakobowitz, S., … Zimmerman, C. (2016). Human trafficking and health: A survey of male and female survivors in England. *American Journal of Public Health, 106*, 1073–1078.

Oram, S., Stöckl, H., Busza, J., Howard, L. M., & Zimmerman, C. (2012). Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: Systematic review. *PLoS Medicine, 9*, e1001224.

Owens, C., Dank, M., Breaux, H., Banuelos, I., Farrell, A., Pfeffer, R., … McDevitt, J. (2014). *Understanding the organization, operation, and victimization process of labor trafficking in the United States*. Washington, DC: Urban Institute. Retrieved from https://ncjrs.gov/pdffiles1/nij/grants/248461.pdf

Peck, J. L. (2019). Human trafficking of children: Nurse practitioner knowledge, beliefs, and experience supporting the development of a practice guideline: Part two. *Journal of Pediatric Health Care*. doi:10.1016/j.pedhc.2019.11.005

Peck, J. L., & Meadows-Oliver, M. (2019). Human trafficking of children. Nurse practitioner knowledge, beliefs, and experience supporting the development of a practice guideline: Part one. *Journal of Pediatric Health Care, 33*, 603–611.

Polaris. (2018a). 2018 U.S. National Human Trafficking Hotline Statistics. Retrieved from https://polarisproject.org/2018statistics

Polaris. (2018b). Healthcare providers play a crucial role in victim identification. Retrieved from https://polarisproject.org/blog/2016/11/03/healthcare-providers-play-crucial-role-victim-identification

Rajaram, S. S., & Tidball, S. (2018). Survivor's voices - Complex needs of sex trafficking survivors in the Midwest. *Behavioral Medicine, 44*, 189–198.

Recknor, F. H., & Chisolm-Straker, M. (2018). Human trafficking: It's not just a crime. *Journal of Family Strengths, 18*(1) Article 7.

Reid, J. A., Baglivio, M. T., Piquero, A. R., Greenwald, M. A., & Epps, N. (2018). No youth left behind to human trafficking: Exploring profiles of risk. *American Journal of Orthopsychiatry, 9*, 704–715.

Richards, T. A. (2014). Health implications of trafficking. *Nursing for Women's Health, 18*, 155–162.

Ronda-Perez, E., & Moen, B. E. (2017). Labour trafficking: Challenges and opportunities from an occupational health perspective. *PLoS Medicine, 14*, e1002440.

Scannell, M., MacDonald, A. E., Berger, A., & Boyer, N. (2018). Human trafficking: How nurses can make a difference. *Journal of Forensic Nursing, 14*, 117–121.

Shared Hope. (2019). Report trafficking. Retrieved from https://sharedhope.org/join-thecause/report-trafficking/

Sinha, R., Tashakor, E., & Pinto, C. (2019). Identifying victims of human trafficking in central Pennsylvania: A survey of health-care professionals and students. *Journal of Human Trafficking, 5*, 165–175.

Speck, P. M., Mitchell, S. A., Ekroos, R. A., Sanchez, R. V., & Messias, D. K. H. (2018). Policy brief on the nursing response to human trafficking. *Nursing Outlook, 66*, 407–411.

Sprang, G., & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence, 33*, 185–195.

Sweileh, W. M. (2018). Research trends on human trafficking: A bibliometric analysis using Scopus database. *Globalization and Health, 14*, 106.

Toney-Butler, T. J., Mittel, O. (2019). Human trafficking. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK430910/

US Department of Health and Human Services [USDHHS]. (2019). The role of healthcare providers in combating human trafficking

during disasters. Retrieved from https://www.phe.gov/Preparedness/planning/abc/Pages/human-trafficking.aspx

US Department of Health and Human Services [USDHHS]. (2014). Substance abuse and mental health services administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. Retrieved from https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.html

United States Department of State. (2019). United States Advisory Council on Human Trafficking: Annual Report 2019. Retrieved from https://www.state.gov/wp-content/uploads/2019/05/US-Advisory-Council-2019-Report.pdf

Viergever, R. F., West, H., Borland, R., & Zimmerman, C. (2015). Health care providers and human trafficking: What do they know, what do they need to know? Findings from the Middle East, the Caribbean, and Central America. *Frontiers in Public Health, 3*, 6.

Zimmerman, C., Hossain, M., & Watts, C. (2011). Human trafficking and health: A conceptual model to inform policy, intervention and research. *Social Science and Medicine, 73*, 327–335.