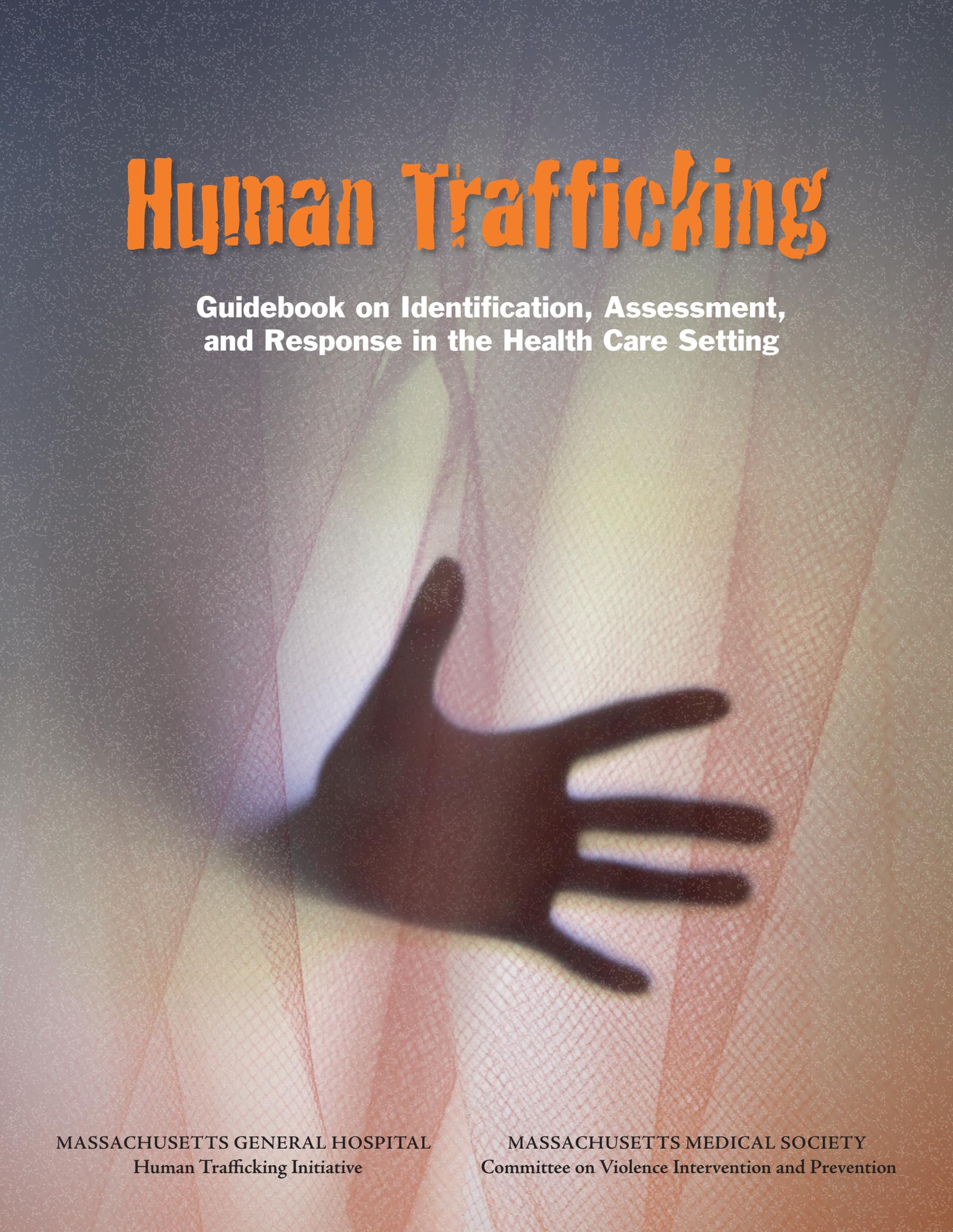


Human Trafficking

A hand is shown reaching out from behind a fine, orange-tinted mesh barrier. The hand is dark, and the fingers are slightly spread. The background is a gradient of dark blue to light orange, with the mesh creating a grid-like pattern over the hand.

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

MASSACHUSETTS GENERAL HOSPITAL
Human Trafficking Initiative

MASSACHUSETTS MEDICAL SOCIETY
Committee on Violence Intervention and Prevention

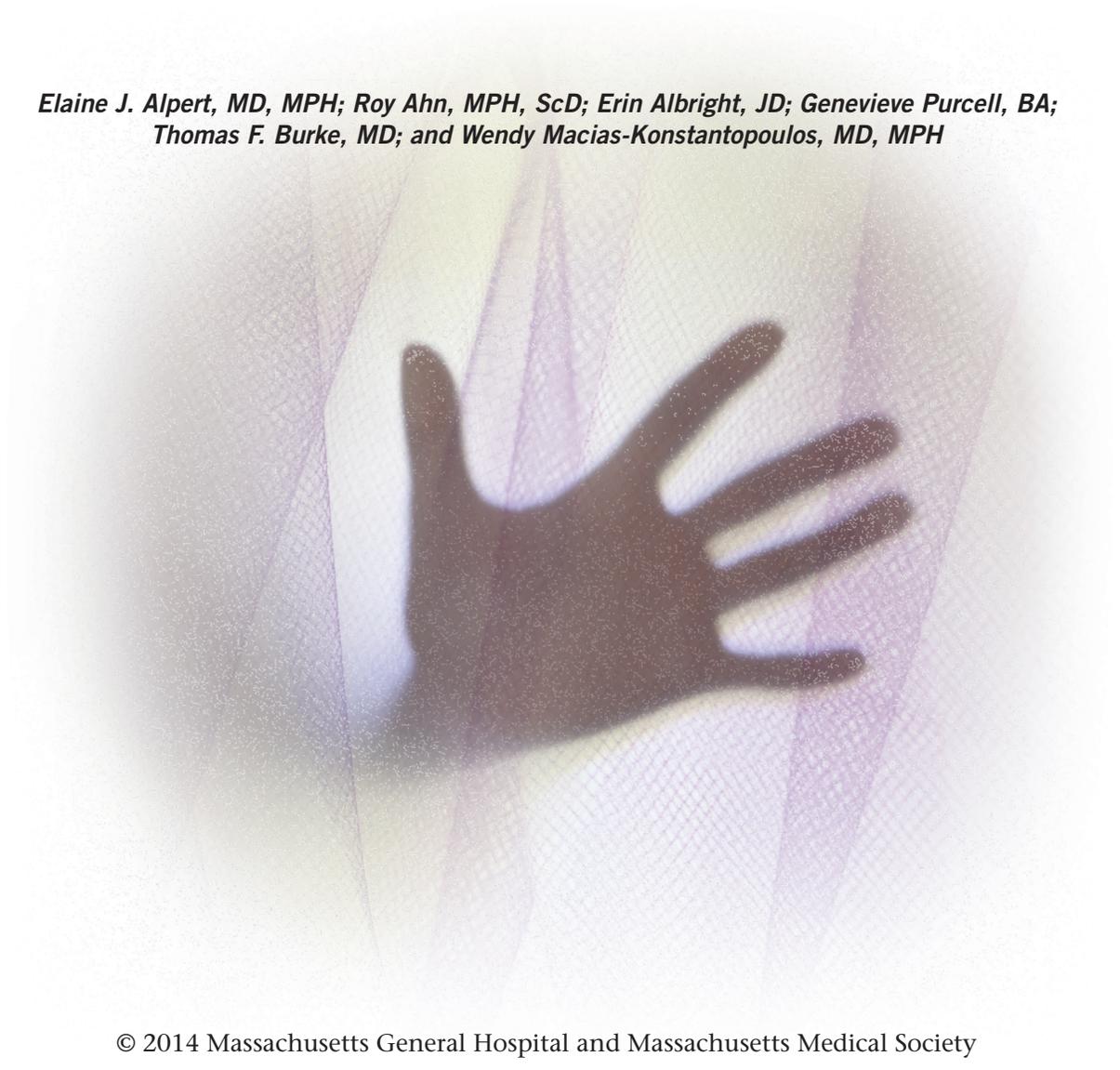
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Human Trafficking:

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

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Its contents should not be considered legal advice.

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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. As a health care issue, trafficking affects people of every age, gender, race, nationality, class, sexual orientation, religion, disability, and immigration status. The physical and psychological trauma caused by human trafficking is undeniably enormous; its impact on the health of our patients, communities, and society at-large is only just beginning to be determined.

The Massachusetts General Hospital (MGH) Human Trafficking Initiative and the Massachusetts Medical Society Committee on Violence Intervention and Prevention have worked in partnership to create the first 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 care professionals regarding identification, assessment, care, and follow-up.

The objectives of this guidebook are to educate health care providers about human trafficking, and to provide resources for patient referral and ongoing professional education. Achieving these objectives will support the larger goals of advancing both health care scholarship in the field, as well as the health care system's evolving contribution to global efforts directed at intervention, and ultimately, prevention of human trafficking.

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The MGH Human Trafficking Initiative would like to extend its most sincere gratitude to the past and present executive leadership of the MGH Department of Emergency Medicine, Alasdair K.T. Conn, MD (Chief Emeritus, Emergency Services); David F.M. Brown, MD (Chief, Department of Emergency Medicine); Robert Seger, MBA (Executive Director, Emergency Services and Emergency Preparedness); and the MGH Senior Vice President for Surgical and Anesthesia Services and Clinical Business Development, Ann L. Prestipino, MPH, for their unwavering support of our work over the years. We are grateful for your vision, your leadership, and your encouragement. The MGH Human Trafficking Initiative also gratefully acknowledges grant support from the private foundation Give Way to Freedom (Burlington, Vermont) during the preparation of this guidebook.

The MMS Committee on Violence Intervention and Prevention extends its gratitude to the Massachusetts Medical Society and its members and leadership. The Society has been a staunch supporter and advocate for violence prevention and cessation long before the establishment of the Committee in 1992. We particularly thank Ms. Corinne Broderick, MMS Executive Vice President, and Ms. Susan Webb, Director, MMS Department of Public Health and Education.

We also acknowledge and thank Mr. Chris Twichell, Senior Graphic Designer, Premedia and Publishing Services at the Massachusetts Medical Society, for taking it upon himself to read a near-final draft of this guidebook in order to design the cover and illustrations found throughout.

Finally, we are most indebted to the countless survivors of human trafficking whose very honest and personal accounts 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. We extend our most humble admiration and gratitude.

*The external peer reviewers were invited to review a near-final draft of the guidebook. Their involvement as reviewers should not be construed as their endorsement of the final format.

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Introduction

Human trafficking, one of the most egregious forms of intentional exploitation of vulnerable individuals for the personal gain of the exploiter, is now recognized as an emerging health care priority.^{1, 2, 3, 4} All health care providers, particularly those engaged in primary care, emergency care, reproductive health, mental health, occupational medicine, and pediatrics, are well-positioned to identify and assist trafficked individuals as well as those who may be at-risk but have not yet been actively exploited.⁵

Even though trafficked individuals' freedom, choice, and movements are often tightly controlled and may be hidden from public view, a surprising proportion of trafficking survivors report having accessed medical care services while under the control of their traffickers.^{6,7} Health care providers who are educated about the risk factors and clinical manifestations of human trafficking, and who can provide efficient and compassionate assistance to patients, have the potential to play a key role in addressing this age-old yet newly recognized problem.^{8,9,10}

The purpose of this guidebook is to provide clinicians with the following:

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

The topic of trafficking in persons generates strongly held, often ideologically based opinions, among lay people and experts alike. Productive dialogue and progress in terms of service provision and policy formulation can be difficult, particularly in regard to issues related to illegal labor, work within the commercial sex industry, and reproductive health needs of survivors. This guidebook acknowledges the strongly and, at times, fervently held opinions of valued colleagues and partners while maintaining an ideologically neutral, trauma-sensitive, strengths-based, and human rights-focused approach to care. In addition, it bears noting that difficulties in accruing 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 largely 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

Providing an accurate definition of a term is important for describing its “essential nature.”¹¹ Definitions are important for determining a problem’s scope, characteristics, and risk factors; for developing both research and action agendas; and to help anchor complex discussions.

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

1. United Nations Definition of Human Trafficking (the “Palermo Protocol”)

The United Nations (U.N.) defines human trafficking, also called “trafficking in persons,” as:

The recruitment, transportation, transfer, harboring 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 labor or services, slavery or practices similar to slavery, servitude or the removal of organs.¹²

2. The United States Trafficking Victims Protection Act

The Trafficking Victims Protection Act (TVPA) passed by the United States (U.S.) Congress in 2000, and reauthorized in 2003, 2005, 2008, and 2013, uses the term “severe forms of trafficking in persons” to describe human trafficking, which is defined as:

- The recruitment, harboring, transportation, provision, or obtaining of a person, through force, fraud, or coercion, for the purpose of a commercial sex act 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 subsection to involuntary servitude, peonage, debt bondage, or slavery^{13,14}

3. Commonwealth of Massachusetts Trafficking Definitions

The Commonwealth of Massachusetts’ definition of human trafficking distinguishes sex trafficking, labor trafficking, and organ trafficking as three separate, yet related, criminal acts. The Massachusetts definition of sex trafficking is broader than the Federal TVPA definition, in that the phrase “by any means” is used instead of “force, fraud, or coercion.” 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

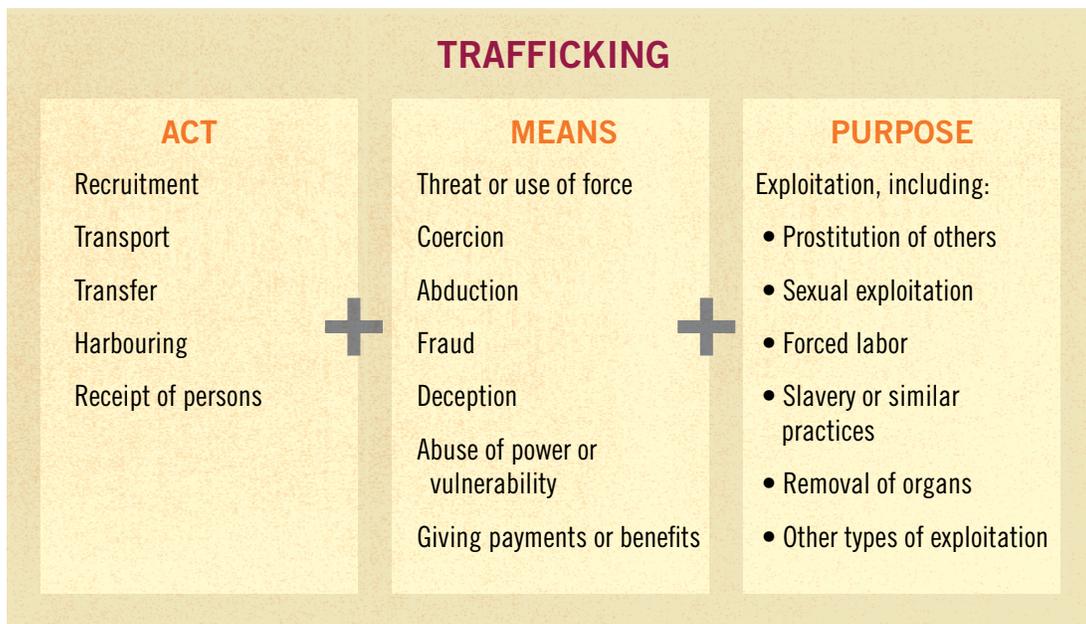
B. Elements Common to All Definitions

Each definition described incorporates three common and essential elements (the **Act**, the **Means**, and the **Purpose**), as described in Figure 1.

The term “**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 is in the case of victims of sex trafficking who are minors, who, by virtue of their age, are deemed by statute as not capable of providing consent to their own exploitation.^{12,13} 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 Common Elements of Human Trafficking — Act, Means, and Purpose



(Source: U.N. Office on Drugs and Crime, www.unodc.org/unodc/en/human-trafficking/what-is-human-trafficking.html)

C. Trafficking versus Smuggling

On its surface, human trafficking can be confused with the crime of human smuggling. Smuggling and trafficking, however, are separate and distinct phenomena.^{15,16} Smuggling is a discrete, voluntary transaction, the purpose of which is to transport an individual 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. Whereas smuggling always involves the crossing of international borders, human trafficking can occur both across borders as well as within a country — and even within a circumscribed 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, may become evident only after arriving at the agreed upon (or sometimes different) destination. Legal distinctions notwithstanding, however, smuggled and trafficked individuals alike may present to health care providers with similar health risks and comparable needs for treatment and services.⁵

D. Who Are the Victims and Where Do They Come From?

Human trafficking is a local issue as well as a global problem. As mentioned previously, victims can be trafficked across international borders, as well as within a country, from city to city or even within a single neighborhood. Victims of trafficking in the United States can be U.S. citizens or foreign nationals (both documented and undocumented).¹⁷ They can be adults, adolescents or children — as young as newborns. Females, males, and transgendered individuals alike can be victimized.

E. Types of Trafficking

The U.N., U.S., and Massachusetts definitions of trafficking underscore the varied and widespread nature of human trafficking. Individuals may be trafficked for purposes of commercial sexual exploitation; for labor in industries such as agriculture, mining, textiles, fisheries, restaurants, factory work, and construction; for domestic servitude in private homes; and even for the provision of organs or other vital tissues. Bonded labor (for example, to pay off an artificially inflated “debt” for transportation, training, housing, sustenance, or even “uniforms”) and trafficking in the context of forced criminal activity (for example, transporting illegal drugs or weapons) are additional forms of human trafficking. Children can be trafficked into all of the industries described above. They may also be exploited as child soldiers, members of begging and peddling rings, “mail-order brides,” or as part of illegal adoption processes.^{18,19}

1. Sex Trafficking

Individuals can be introduced into the commercial sex industry by female as well as male traffickers. Female traffickers may be known and respected in the victim's community, where they gain access with inflated or distorted offers of employment or education to unsuspecting victims and their families. Male traffickers may lure at-risk individuals by using a "boyfriend" approach in which seduction is used as a key tactic, a "daddy" approach in which the trafficker shows kindness to the individual and provides emotional affirmation, financial assistance and/or material goods, or a combination of these scenarios.

Additionally, children can be brokered in transactions that target destitute, chaotic, or abusive families; sold into servile marriages as "mail-order brides"; or made available for marriage arranged in return for a lump-sum payment. In some cases, individuals have been forcibly abducted and sold into the commercial sex trade.⁸

Victims of sex trafficking can become involved in a variety of enterprises, including street prostitution, brothel-based work, internet-based prostitution, pornography, or coerced employment in sexualized jobs as hostesses, exotic dancers, strippers, escorts, massage parlor workers, or as "companions" at truck stops.²⁰ Minors (both boys and girls) who have run away from home are often forced to engage in "survival sex," through which they trade sexual acts for shelter, food, drugs, or protection. Boys and individuals who identify as transgendered or transsexual are frequently targets of commercial sexual exploitation as well.^{21,22}

2. Labor Trafficking

The U.S. Department of Health and Human Services Office of Refugee Resettlement describes three types of exploitative practices linked to labor trafficking.²³

- *Bonded labor*, or "debt bondage" occurs when an individual's labor is demanded in order to repay a 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 unlawfully exorbitant debts that continue to accrue over time.
- *Forced labor* occurs when a person is forced to work against his/her own will under the threat of violence or other punishment. Typically, the person cannot come and go as he/she wishes, and extreme and sometimes violent forms of control can be 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, and domestic settings.

- *Child labor* trafficking is a particularly heinous form of coerced work, with features often described as akin to slavery. Forms of child labor that are considered trafficking include “bonded labor, camel jockeying[†], child domestic labor, commercial sexual exploitation and prostitution, drug couriering, and child soldiering [as well as] exploitative or slavery-like practices in the informal industrial sector.”²⁴ Children may be sent to live with other families ostensibly for education and a better life, only to be placed in situations of domestic servitude where they can be both physically and sexually exploited. This situation, for example, is not uncommon in Haiti, where it is estimated that 225,000 mostly female children live essentially without rights as “restaveks.”²⁵

Some labor trafficking victims may enter a country legally on work visas for specific industries or jobs (e.g., for seasonal employment in hotel, restaurant, or agricultural jobs) while others enter illegally. Recruitment of labor trafficking victims can look very much like the legal recruitment of workers for jobs in the formal or informal sector. Once recruitment and transportation to the destination has been achieved, however, traffickers use violence, threats, lies, and coercion to force people to work against their will.²⁶ In these situations, the forced labor might — or might not — be within the industry for which the individual was originally recruited.

3. Organ Trafficking

Like other forms of human trafficking, organ trafficking is a newly recognized emerging global health problem. While precise prevalence statistics are not available, cases of organ trafficking are thought to occur throughout the world. The United Nations notes that “the organs commonly transplanted include kidney, liver, heart, lung, and pancreas.”²⁷ Trafficking of corneas has also been reported in the lay press.

The U.N. Global Initiative to Fight Human Trafficking subdivides its definition of organ trafficking into three parts:²⁸

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.

[†] Camel racing is a popular sport in the Persian Gulf countries of the Middle East. Young children, including those trafficked from Bangladesh, Pakistan and Sudan, are often used preferentially as jockeys because they weigh less than adults. Not only are these children victims of labor trafficking, but they are also subjected to physical confinement, physical and sexual abuse, intentional nutritional deprivation (to keep their growth stunted and thus their weight low), emotional neglect, and extremely hazardous working conditions with the constant risk of fatality from trampling. The use of children for camel jockeying has been officially outlawed, though the practice of using children in the camel racing industry is still believed to occur. Please access <http://2001-2009.state.gov/g/tip/rls/fs/2005/50940.htm> for additional information about this practice.

The term “transplant tourism” has been coined to describe the phenomenon whereby wealthy recipients from developed countries travel to developing countries to receive an organ transplant.²⁹ Organs tend to move from donors living in resource-limited settings (“organ-exporting countries”) to recipients in developed nations (“organ-importing countries”).³⁰ Vulnerable individuals, usually financially unstable and often living in extreme poverty in a developing country, 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 inside the developed nation.³¹

F. Epidemiology

Despite garnering considerable attention in the academic literature as well as lay press, the incidence and prevalence of human trafficking is not known. Accurate estimates remain elusive due to the clandestine nature of the crime, victims’ fear of disclosure, stigma and shame, and corresponding challenges of data collection. Domestic trafficking, in particular, may be far more prevalent than previously thought.

Most of the available estimates come from border security, immigration, migration, or criminal justice sources, not from health sector research or community-based agencies that may interface more with domestic trafficking victims. Difficulty obtaining accurate surveillance data poses challenges in terms of advancing basic research, generating evidence-based practice, and anticipating personnel and capital requirements for sensitive yet cost-effective health care service delivery.

The International Labor Organization (ILO) estimates that there are nearly 21 million victims of forced labor worldwide.³² According to the 2014 *U.S. Department of State Trafficking in Persons Report*, there were 9,460 trafficking-related prosecutions, 5,776 convictions, and 44,758 victims identified globally in 2013.¹⁸

The Human Trafficking Reporting System (HTRS) accrues data from state and local law enforcement agency investigations of human trafficking allegations as reported to federally funded human trafficking task forces in the United States. The HTRS database includes 389 confirmed incidents of human trafficking from 2008–2010 involving 488 suspects and 527 victims (some incidents had multiple suspects and multiple victims). Of those confirmed incidents, 80% were classified as sex trafficking, 10% were labor trafficking, and the remaining 10% were undetermined. The vast majority of sex trafficking victims (83%) were U.S. citizens, whereas the majority of labor trafficking incidents involved exploitation of noncitizens. Of cases confirmed to be human trafficking, 64% involved the commercial sexual exploitation of a child (younger than age 18). Ninety four percent (94%) of confirmed sex trafficking victims of all ages were female.³³ It is important, however, to recognize that these data are reflective of cases reported *and* investigated, and they may or may not represent the true epidemiology of human trafficking in the United States.

Over the last decade, the U.S.-based National Human Trafficking Resource Center (NHTRC) has fielded calls from all fifty states and the District of Columbia.³⁴ These calls have ranged from “drop-a-dime”-style tips offered about potential trafficking situations to more formal requests for both training and general information about human trafficking. In Massachusetts alone, 971 calls that referenced 172 potential trafficking situations were recorded by the NHTRC Hotline between December 2007 and September 2013.³⁵

G. Trafficking Determinants

Although anyone can be at risk for victimization, the majority of trafficking victims are women and girls.¹⁸ People at highest risk of becoming trafficked include those who live in extreme poverty, have had minimal education, have a history of abuse or instability in their family of origin, or have some other vulnerability (for example, those who are disabled or who may belong to a marginalized or stigmatized gender, ethnic, or cultural group). Victims can be enticed by any number of false promises, including the prospect of being able to earn money that can be used to improve their own lives or help their families, the dream of becoming famous working in the “entertainment” industry, the lure of receiving a high quality education in a developed country, or the hope of finding true love and a secure future.⁸

In addition, a number of “push” and “pull” factors that influence people to leave their home or situation (push factors), or that attract people to a new location (pull factors) conspire to create circumstances that make individuals particularly susceptible to human trafficking.^{8,36} These factors, summarized in Table 1, can influence individuals at the individual, interpersonal (relationship), community, and societal levels of the Social Ecological Model (Figure 2).³⁷ Notably, poverty is a push factor in virtually every level of the social-ecological model, as economic adversity affects individuals, relationships, communities and society at-large.

Figure 2: The Social Ecological Model³⁷

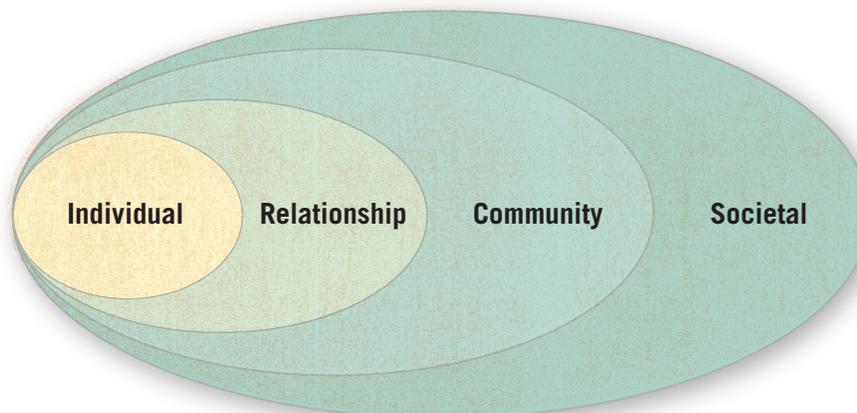


Table 1: Key Determinants for Human Trafficking^{5,8,38,39,40,41,42}

Social-Ecological Level	Push factors	Pull factors
Individual	<ul style="list-style-type: none"> • Young age (limited life experience) • History of abuse • Individual vulnerability • Deprivation (including poverty, hunger, housing instability) • Lack of education, illiteracy • Desire for material comforts • Poverty 	<ul style="list-style-type: none"> • The glamour and anonymity of city life • Hope for future love, fame, success
Interpersonal	<ul style="list-style-type: none"> • Physical and sexual abuse by family members or others during childhood and adolescence • Exposure to or witnessing violence in the home • Obligation/desire to help family • Sold or persuaded by family • Entrusting of children to “trusted” individuals • Peer influences • Desire to please “boyfriend” • Need to belong, desire for kinship • Poverty 	<ul style="list-style-type: none"> • Seduction by boyfriend • Misplaced trust in assurances and promises made by others • Deception, “bait and switch” of job promises
Community	<ul style="list-style-type: none"> • Lack of economic opportunity • Poor employment opportunities • Regional political conflict • Religious persecution • Corruption • Poverty 	<ul style="list-style-type: none"> • Consumer goods just out of reach • Promise of employment at destination
Society	<ul style="list-style-type: none"> • Political and civil unrest • Armed conflict • Gender inequality, especially systematic devaluation of women and children • Ethnic discrimination • Corruption • Lack of opportunity • Natural disasters • Environmental toxins (land and water) • Decreased crop yields • Climate change • Poverty 	<ul style="list-style-type: none"> • Globalization • Demand for labor in destination areas, particularly migrant labor in “3D” sites (dirty, dangerous, difficult) • Demand for commercial or transactional sex • Promise of lucrative career • Influence of TV, radio, Internet • Societal expectations of children and women to take care of family

H. The Perpetrators of Human Trafficking

1. Who Are the Traffickers?

Traffickers can be male or female, foreign nationals or U.S. citizens, members of organized crime networks, or individual operators.^{5,34} While some traffickers may be complete strangers, many others are known to — and trusted by — the victim as well as her/his family. Traffickers can be:

- Friends or acquaintances
- Family members
- Intimate partners
- Neighbors
- Community members
- Persons affiliated with civic or religious organizations
- Representatives of “employment” agencies
- Agents of industry, restaurant, or entertainment establishments
- Small business owners and managers
- Large factory 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

Traffickers utilize a variety of methods, often tailored to take advantage of the victim’s individual and cultural characteristics, for the purpose of exerting power and maintaining control. Tactics include but are not limited to physical violence (e.g., beating, branding, tattooing, cigarette burns, forced drug use, strangulation, sleep deprivation, starvation, and other forms of physical violence and even torture); sexual violence (e.g., rape, gang rape, rape with denigrating rituals, and coerced sexualized work such as exotic dancing, webcam pornography, and prostitution sometimes masquerading as massage services); intimidation (e.g., display beatings of others, threats with weapons); emotional violence (e.g., shame and humiliation, isolation, restricted

movement, threats of expulsion or deportation, and fostering uncertainty and confusion by alternating acts of violence with acts of seeming kindness); coercion and threats (e.g., threats of violence against family members, blackmail, and extortion); and economic coercion (e.g., confiscating all assets including personal belongings, money, and tickets for return transportation, and creating marked-up “charges” for minimal subsistence).^{8,43,44} Traffickers may also move victims frequently and confiscate their passports and other important identification documents, often under the guise of “keeping everything in a safe place.” These methods manipulate and control the movements of victims, thus restricting their abilities to form friendships or identify sources of potential help. Such tactics ensure that victims remain under the control of traffickers and their associates.

I. Barriers to Disclosure in the Health Setting

Although disclosure is a common prerequisite to active help seeking, the time periods immediately prior to and following disclosure are often emotionally difficult and potentially dangerous for the trafficking victim. 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 a proactive and often courageous act taken by the victimized individual.

Even when provided with a safe and supportive environment in the health care setting, some trafficked individuals do not disclose their situation — even when asked directly — because they may not fully understand the concept of coercive control, or even recognize that they are indeed trafficked. These 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 victims, regardless of whether they self-identify as being trafficked, may be so fearful of being harmed if they disclose, that they choose to remain in an unsafe, albeit relatively predictable environment. In some cases, the movements and actions of victims are monitored so closely (by cell phone or other GPS locators, by electronic ankle or wrist bracelets, or through direct observation by associates of the trafficker) that they elect not to disclose. Whether employed continuously or intermittently, strategies such as monitoring, tracking, and stalking are often used by traffickers to instill fear and deter attempts to obtain assistance. In such cases, victims may end up believing that their traffickers are able to predict or anticipate their next moves, or even know what they are thinking.⁴⁵

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. Others may engage in bringing in younger, less experienced victims into a trafficking ring in exchange for higher status or better treatment.

Some victims 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, represents the first, essential step toward safety. Even so, it is not uncommon for victims to make deliberate choices not only about *whether* to disclose, but also about *when, what, and to whom* to disclose. Just as is seen in intimate partner violence disclosure, some trafficked individuals may prefer disclosing to a provider of the same sex, ethnicity, or of a similar age, while others might make different choices. Some might also want to “test” the health care setting by making two or more visits before deciding if it would be safe or advantageous to disclose. These decisions, which on the surface seem to impede disclosure, can be important steps toward autonomous decision making, and are critical prerequisites for exiting exploitation and moving towards independence.

Numerous additional challenges impede the ability of survivors to disclose their victimization to health care providers. Victims may be reluctant to disclose to health care providers that they are trafficked due to:

- Fear of harm to themselves, coworkers, friends, or family members
- Fear of being released back to the trafficker
- Fear of being sent back to a prior abusive environment
- Prior unsuccessful attempts to leave or escape
- Feeling overwhelmed or frightened
- Young age
- Stigma and shame
- Uncertainty regarding geographic location
- Language barriers combined with lack of availability of a trusted professional interpreter
- Physical or mental illness or disability
- Cultural or religious prohibitions against speaking up
- Sexual orientation or lifestyle
- Inability to speak privately with the health care provider
- Unfamiliarity with the health care system
- Distrust of authority figures including those in health care
- Prior negative experiences (self or co-worker) following attempts at disclosure or help-seeking
- Lack of money to pay for medical care
- Lack of safe options post disclosure
- Fear of deportation
- Prior criminal record

In addition, some individuals who have managed to exit a trafficking situation may feel pressured to cooperate with law enforcement or participate in legal proceedings against their trafficker. This is often an issue for undocumented victims, who may be required by law to cooperate with law enforcement in order to access certain types of relief and benefits made available through the TVPA. Others 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 achieved safety and stability might prefer to leave their trafficking situation “in the past” and choose not to disclose because they no longer consider themselves to be “victims.”⁵ All of these factors may serve as barriers to disclosure in the health care setting.

Above all, it is important for health providers to consider the diverse experiences and reactions of survivors and demonstrate a consistently patient, empathetic, culturally aware, trauma-informed, and open-minded approach to patient care.



Health Effects of Human Trafficking

Health care providers may encounter victims of sex trafficking, labor trafficking, and organ trafficking in the course of primary, specialty, or emergency care of patients of all ages. The health effects of trafficking are both wide-ranging and largely dependent on the particular situations experienced by individual victims. The following summary is offered for general guidance and should not be considered exhaustive.^{1,5,7,8,10,41,46,47,48}

A. Physical Health

1. Physical Injury

Trafficking victims may suffer from a range of physical injuries, including:

- Intentional and accidental burns
- Branding, tattoos, and other purposeful and permanent stigmata of “ownership”
- Blunt force trauma
- Firearm and knife wounds
- Strangulation injuries
- Fractures
- Dental and oral cavity injuries
- Traumatic brain injuries
- Neuropathies and other effects of torture
- Scarring, especially from unattended prior injuries

Depending on the specific work setting and type of coercion, victims of labor trafficking may suffer from a variety of exposure, overuse, or misuse injuries, such as:

- Chronic back pain from repeated strain or overuse
- 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

2. Reproductive Health

In addition to physical injuries, sex-trafficking victims and sexually abused labor-trafficking victims can suffer from the physical and mental health effects of:

- Rape or gang rape

- Genital trauma
- Repeated unwanted pregnancy
- Forced abortion
- Complications from repeated or poorly performed abortions
- Sexually transmitted infections (e.g., chlamydia, gonorrhea, human papilloma virus, hepatitis B and C, and HIV)

Left untreated, trafficking victims are at risk for infertility, chronic pelvic pain, cervical cancer, liver failure, HIV-AIDS, and chronic disease states resulting from untreated sexually transmitted infections.

B. Developmental Health

Trafficked children and adolescents are at particular risk for physical, cognitive, and emotional developmental health consequences, including:

- Delayed physical and cognitive developmental milestones
- Stunting, vitamin deficiencies, and other consequences of chronic under-nutrition
- Impaired social skills
- Long-term effects of inadequate treatment of common childhood diseases

C. Comprehensive Health

In addition to the specific physical health problems listed, victimized individuals generally lack access to most forms of primary, preventive, anticipatory, and illness-focused medical care, including routine immunizations, vision and hearing screening, dental care, cancer screening, and diagnosis and treatment of common, episodic, or chronic illnesses. As a result, even in the absence of acute traumatic injuries, patients may present for — or *with* — chronic or neglected health conditions such as:

- Malnutrition
- Dental caries
- Headaches
- Fatigue
- Abdominal complaints
- Chronic pain syndromes
- Substance abuse
- Infectious diseases usually prevented through routine immunization
- Other infectious diseases such as tuberculosis, intestinal parasites, and hepatitis⁴⁹

D. Mental Health

As a result of the constant fear, psychological manipulation, and physical, sexual, and emotional abuse experienced while trafficked, victims may experience a range of mental health sequelae.⁴⁶ Trafficking victims characteristically describe feelings of intense stigma, shame, anxiety, and hopelessness.⁵⁰ Victims of human trafficking can suffer from pathologic fear, panic attacks, sleep disturbances, dissociative disorders, depression, and suicidal ideation.⁵¹ The effects of the cumulative trauma experienced by trafficking victims extend far beyond the time under their traffickers' control by disrupting coping mechanisms, undermining self-confidence, and inhibiting the ability to form healthy and trusting relationships with others.⁵² Some survivors exhibit complex trauma-like behavior that has features similar to those seen in torture survivors.⁴⁴ All of these effects can be long-term and can pose vexing challenges for survivors attempting to reintegrate into society, leaving them susceptible to re-victimization.

E. Legacies of Prior Child Physical Abuse, Sexual Abuse, and/or Neglect

Many trafficking survivors carry the additional burden of likely antecedent trauma — child neglect and/or maltreatment, physical and/or sexual abuse, witness to violence in the home or community, intimate partner violence, political or religious persecution, or other forms of trauma over the course of life. The resultant physical and mental health effects of these prior adverse life events, as well as undiagnosed or untreated preexisting medical and mental health disorders, should be taken into consideration when assessing the complex mental health needs of trafficked individuals.

F. Specific Health Effects Related to Organ Trafficking

1. Health Effects for the Organ Donor

As more foreign-born individuals are either trafficked into or seek asylum in the United States, health care providers may find themselves providing treatment to individuals who were forced or defrauded into organ removal. Victims of organ trafficking may experience physical or mental health sequelae of botched organ harvests; removal of more than the organ “agreed upon” including vital organs; post-operative complications such as hepatitis B or C, HIV, or other blood-borne infections if transfusion was needed or if inadequately sterilized implements were used; and even death.

2. Health Effects for the Organ Recipient

Transplantation of diseased organs and organs carrying blood-borne diseases may result in new diseases and infections among recipients of organs procured on the black market. The transplantation of improperly tested and harvested organs can have detrimental effects not only on the recipients of those organs, but also on the integrity of the entire system of organ transplantation.

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:

1. Utilize a trauma-informed, resilience-oriented, human rights-focused, and culturally sensitive approach to the care of **all** patients
2. Collaborate with and seek advice from colleagues within the health sector who have been engaged in anti-trafficking or other violence prevention work
3. 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
4. Play an active role in self-directed education and training about human trafficking

1. Trauma-Informed Care

As the U.S. Substance Abuse and Mental Health Administration 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.”⁵³ Because of the coercive, exploitative, and purposefully disempowering nature of human trafficking, routine and customary procedures inherent to ordinary medical practice — such as asking a patient to undress for an exam, performing a gynecological exam, or even engaging in mundane activities such as checking a blood pressure — can be perceived as threatening and extremely anxiety-provoking. As a result, interactions with health providers can become frightening, triggering experiences that evoke 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* (also known as trauma-sensitive or trauma-aware care). Trauma-informed care is a strengths-based framework that incorporates acknowledgement of the prevalence and impact of traumatic events into clinical practice, placing an emphasis on instilling in the patient a sense of safety, agency, and reclamation of control and autonomy over one’s life and decisions.^{5,54,55}

The trauma-informed care approach assumes that all patients seen in clinical settings may have experienced some degree of trauma in their lives, and acknowledges that these experiences can influence the way patients perceive and interact with health care providers and others. The goals of the trauma-informed approach are to:

1. Reduce re-traumatization;
2. Highlight survivor strengths and resilience;

3. Promote healing and recovery; and
4. Support the development of healthy short- and long-term coping mechanisms.

In addition to demonstrating respect, empathy, patience, and acceptance, the trauma-informed approach can help providers respond sensitively, appropriately and effectively to trauma survivors who may feel threatened by the prospect of medical evaluation or treatment. Similar to the use of routine 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 they adjust the way they care for all patients accordingly.

B. “Red Flag” Indicators in the Clinical Setting

Anti-trafficking experts have identified specific “red flag” indicators for human trafficking.⁵⁶ The presence of any of the red flags listed below should heighten a health provider’s suspicion of some form of human trafficking or other serious coercion:⁵⁷

- Delayed presentation for medical care
- Discrepancy between the stated history and the clinical presentation or observed pattern of injury
- Scripted, memorized, or mechanically recited history
- Stated age older than visual appearance
- Subordinate, hyper-vigilant, or fearful demeanor
- Inability to produce identification documents
- Documents in the possession of an accompanying party
- Reluctance or inability to speak on one’s own behalf
- 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 any kind of physical violence including torture

Specific red flag indicators of sex trafficking, or of labor trafficking with concomitant sexual exploitation/abuse, include:

- Recurrent sexually transmitted infections
- Multiple or frequent pregnancies
- Frequent or forced abortion
- Frequent relocation to avoid detection

Labor trafficking should be suspected in patients of any age who present with injuries or ailments that could be due to lack of proper protective gear, excessively long work hours, heavy labor with restricted access to food/drink, or physical abuse, for example:

- Occupational-type injuries without evidence of legitimate employment (e.g., overuse injuries, chemical exposures, exposure to extreme or adverse climate conditions, head injuries)
- Physical ailments (e.g., dehydration, malnutrition, chronic fatigue), especially when accompanied by vague references to being related to a work situation

Given that foreign-born nationals are more likely than U.S. citizens to be trafficked for the purpose of forced or bonded labor,³³ the above indicators are especially relevant to patients for whom English is not the primary language.

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

- Presentation to the health care setting with non-guardian or unrelated adults
- Access to material possessions that one would reasonably doubt the patient could afford
- Over-familiarity with sexual terms and practices
- Seemingly excessive number of sexual “partners”
- History of school truancy or recurrent episodes of running away
- Reluctance to talk about a particular tattoo
- Fearful attachment to a cell phone (often used for monitoring or tracking)⁵⁸

Pediatric-age red flags 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

Scholarship in the field of human trafficking identification and assessment is 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.^{59,60,61} 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.

There are no evidence-based recommendations to guide either initial or follow-up inquiry about human trafficking in the health care setting. Practice-based evidence, however, 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 as well as broader strategies for assessment, intervention, prevention, and policy formulation.

Because there is no evidence base to support universal inquiry about trafficking in the clinical setting, the recommendations for screening and inquiry offered in this guidebook pertain to those situations in which suspicion about trafficking or other commercial exploitation has been raised, particularly in the context of the “red flag” indicators noted previously.

2. Framing Inquiry in Context

Victims of trafficking rarely identify themselves in the clinical setting. Anecdotally, survivors of trauma 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.⁶² In fact, the recommendation of this guidebook is to make establishing a trusting, caring relationship the primary goal of the patient encounter. It is in this context that identification or disclosure is more likely to occur, and in a manner that may be far less re-traumatizing. Although not written specifically for health care providers, the Ohio Human Trafficking Task Force Human Trafficking Screening Tool offers general guidance for approaching inquiry about human trafficking.⁶³

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 after a trusting relationship has been established, and within a larger and more general conversation about coercion, abuse, and violence from a lifespan perspective.^{64,65} Although several visits may be needed to establish a relationship of trust with a victimized individual, just a few minutes may be needed to establish rapport with some patients, especially when trauma-informed care principles are employed 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.⁶⁵

3. Initial Questions

The items below are offered as suggestions; they should not be considered to be a verbatim checklist. Rather, health care providers should familiarize themselves with indicators and red flags relevant to their scope of practice, ask questions as appropriate, and follow up on responses and disclosures accordingly. The importance of first establishing rapport prior to taking a history is underscored, since many of these questions do not normally arise during the course of routine or ordinary medical evaluation. Sample questions, offered as examples, include:⁶⁶

- ✓ How many hours per day (or week) do you work? What kind of time off do you have?
- ✓ Are you paid for the work you do? How much? Are you getting paid the amount agreed upon?
- ✓ Can you come and go as you please during time off?
- ✓ Can you quit your job or situation if you want to?
- ✓ Have you been threatened with harm if you try to leave?
- ✓ Have you been physically or sexually harmed in any way by your employer or by an associate of your employer?
- ✓ Has anyone threatened or harmed your family?
- ✓ What are your working/living conditions like?
- ✓ Where do you live, sleep, and eat?
- ✓ Are there locks on the doors and windows where you work or sleep so you cannot get out?
- ✓ Do you have to ask permission to eat, sleep, or use the bathroom?
- ✓ Has your identification or documentation been taken away from you?
- ✓ 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?
- ✓ Are you scared of or frightened by people in your everyday life or work setting?
- ✓ Would you know how to seek help if you needed it?
- ✓ Are you afraid to get help?

Inquiry and assessment for human trafficking should be done in a private and confidential setting that supports the dignity and promotes the safety of potential victims. Health care providers should assure at-risk individuals that any information that is disclosed will be kept confidential to the extent possible, explaining any limits imposed by mandated reporter and other legal requirements.

In some cases, trafficking victims may be accompanied by their traffickers or by their traffickers' 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. These steps should be undertaken in an inconspicuous manner in order to assess for abuse and violence to the best extent possible. *For reasons of safety, inquiry about trafficking or about any other form of abuse should not be done unless privacy can be assured.*

Parallel to accepted practice in cases of sexual assault, intimate partner violence, and child maltreatment, health care providers should refrain from asking questions that primarily satisfy their own curiosity or that go beyond information that is required for treatment planning or for making a decision about notifying appropriate authorities if the situation falls under mandatory reporting requirements.

D. Performing the Physical Examination

1. Basic Principles of Physical Assessment

Relevant elements of the physical examination should be performed carefully and sensitively, guided by the clinical presentation and by information elicited during the history.

In cases involving sexual violence and other forms of trauma, forensic evaluation and evidence collection should be offered when appropriate (e.g., if the most recent sexual assault has occurred within 120 hours of presentation, and with the patient's consent or in conjunction with mandated reporter responsibilities). Forensic evaluation and evidence collection should be performed using a state-approved sexual assault evidence collection kit. The services of sexual assault/forensic nurse examiners, specifically trained in the proper methods of forensic evaluation and evidence collection, accompanied by trained medical advocates from a sexual assault crisis center for emotional and logistical support, should be sought when available.

2. 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
- Pregnant woman with any injury, particularly to the abdomen or breasts; vaginal bleeding; or decreased fetal movement
- Occupational injuries not linked clearly to legitimate employment

E. Documentation

Careful and accurate documentation in the medical record not only is essential for optimal patient care, but also can be a source of invaluable information should the patient seek legal redress. In some cases, accurate and legible documentation can potentially substitute for, or supplement, the clinician's personal testimony in court.

1. Documenting Oral Disclosure and Other Findings from the Patient Interview

The patient's medical history, along with any oral disclosures, should be documented in writing, in an unbiased manner, using direct, unaltered quotes from the patient, to the extent possible.

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. In terms of photography, the image should contain the patient's face and the injury or lesion measured with a ruler or other common object (such as a coin). A piece of paper with the date the photograph was taken should be included within the photographic image. Additional photographs can document close up views of each relevant injury or lesion. Follow-up photographs, taken serially over 7–10 days, can document progression or healing of ecchymoses and other signs of injury. A notation in the chart should be included indicating the identity of the photographer and also stating that the photos are both *accurate* and *unaltered*. Consent for photographic documentation should be obtained and noted prior to taking any photographs. Patients should be informed that they have a right to refuse photographic documentation altogether or to restrict photographic documentation to certain specific areas if they so choose.

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

F. The Role of Forensic Sexual Assault Nurse Examiners

Sexual assault nurse examiners (SANEs), also known as Forensic Nurse Examiners (FNEs), are critical team members in cases of suspected or disclosed sexual and physical violence, including human trafficking. SANEs and FNEs are specifically trained to take a detailed, unbiased, and compassionate history, collect forensic evidence, ensure that evidence collected is maintained in a useable fashion (maintaining the “chain of evidence”), and testify in legal proceedings as required. SANE programs have been shown to:^{67,68}

- Ensure optimal collection of forensic evidence
- Facilitate provision of post-assault medical 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

G. Guidelines When Language Translation Is Required

When language barriers are present, health care providers should refrain from allowing accompanying persons (e.g., friends, relatives including children, or others) to serve as interpreters, as these individuals might be the traffickers themselves, their associates, or might unintentionally compromise confidentiality. Even if they are not complicit in the trafficking, familiar, nonprofessional interpreters might compromise the patient’s safety by disclosing what they have heard 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. Instead, the services of objective, third-party professional translators should be sought.

Professional medical interpreters normally receive regular training about patient privacy and confidentiality, particularly in regard to highly sensitive issues such as abuse and violence. All interpreters should be screened for ties to the community and/or trafficker that may place a victim at increased risk. In addition, victims should be asked about their preference/comfort with using a local interpreter; clinicians should strive to respect the wishes and preferences of their patients.

Accessing professional translation services may be more difficult in remote health care settings or in areas with limited resources. Compromising the quality or safety of translation, however, may result in missed opportunities to intervene, and place victims in increased danger, especially if accompanying parties are used for translation. Even when there is a professional interpreter available in a small community, that interpreter’s ties to the local community may still pose a risk for victims. In such instances, or in the absence of appropriate professional interpreters, remote telephone interpretation services should be sought.

Meeting the Needs of Trafficked Individuals

A. Making the Decision to Disclose

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 survivor must make on an individual basis.

A host of individual, interpersonal, and institutional factors can inhibit or even preclude disclosure of human trafficking in the course of a given medical encounter, even when inquiry is done in a sensitive and compassionate manner. The clinician's goal should not be to "get a disclosure" from a patient suspected of being trafficked or otherwise abused. Instead, the health care provider should, in the process of delivering needed medical care, strive to create a climate in the health care setting that allows each and every patient to feel safe, secure, cared for, validated, and empowered to disclose if he or she so chooses. Disclosure might occur at a later date if the patient does not feel "ready" to disclose in the immediate clinical setting. Therefore, each individual clinical encounter should be viewed as a step on a pathway to safety for at-risk patients.

B. Health Care, Forensic, Safety, and Case Management Considerations

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 collaboration with law enforcement. Clinicians 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. Medical and Psychological 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, clinical situation, immediate needs, and stated priorities. A trauma-informed, 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 clinician can play an invaluable role in helping the patient assess his or her own personal risk, making an independent judgment about risk and communicating this opinion to the patient, initiating discussion about safety planning, and making 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 his or her own appraisal of both immediate and future safety needs. Since patients may minimize or deny the danger of their situations, the following indicators of escalating risk should be explored with the patient:

- An increase in the frequency or severity of threats or assaults
- Increasing or new threats of homicide or suicide by the trafficker if the patient discloses
- The presence or availability of a firearm or other lethal weapon
- New or increasingly violent behavior by the perpetrator

Although the clinician should be familiar with the general elements of safety planning, detailed safety planning and related case management 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 survivor to assess the patient's level of danger and the resources needed to flee (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 she/he remains in the current trafficking situation, regardless of the reason
- Resources and supports that may be needed if escape is being contemplated or desired
- Steps that can be put in place in case the patient decides to take further action at some point in the future

Again, detailed 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 follow-up with known and trained community-based resources.

3. Case Management

Effective case management should be tailored individually to each survivor's situation and to the patient's current and anticipated needs. Strategic planning should incorporate both immediate "exiting" considerations, as well as proactive, long-range anticipatory planning to maximize safety, independence, and self-determination for the foreseeable future.

Optimal case management incorporates elements of:

- Safety planning, including the articulation of and planning for immediate, intermediate, and long-term needs
- Housing, including immediate safe shelter as well as stable longer-term housing
- Resources for daily living, including daily necessities such as food, clothing and personal items
- Comprehensive medical care, including reproductive care and primary care
- Immediate financial support
- Employment assistance, including support for locating, interviewing, securing, and maintaining productive employment
- Life skills capacity building, including assistance in budgeting and social development
- Language assistance, including both translation assistance and English as a second language training
- Retrieval or reconstitution of personal documents
- Visa and immigration assistance
- Repatriation and reintegration if desired
- Basic education (a critical issue for rescued or escaped children)
- Community and family education, allowing for safe and successful reintegration or (repatriation and reintegration) to original settings

In the absence of personalized case management, 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. A private, safe space at the health care facility should be provided so that the patient can place these calls. 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 and in no way commits them to a particular course of action. Quite often, the same information needs to be provided more than once.

C. Elements of Comprehensive Health Care for Survivors of Human Trafficking

In addition to bearing medical and psychological burdens of the abuse they suffered prior to and while being trafficked, survivors also have the same comprehensive health care needs of non-exploited individuals. Health care services for human trafficking survivors, therefore, should include, as appropriate:

- **Primary care:** a strong, longitudinal relationship with a primary care-focused physician, nurse practitioner or physician assistant for both illness- and prevention-focused health care
- **Mental health care:** with a focus on complex trauma and of the appropriate duration, which may extend beyond the restrictions 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 screening:** screening and assessment for intimate partner and other forms of family and relationship-focused interpersonal violence
- **Substance abuse screening and treatment:** as indicated
- **Anticipatory guidance:** regarding growth and development, life skills, healthy social relationships, and parenting
- **Immunizations:** as indicated for age
- **Reproductive care:** including contraception and family planning services
- **Dental care:** with a focus on reversing signs of abuse and neglect, restoring oral health, and encouraging preventive dental care

All health care should be delivered in a trauma-informed, non-judgmental, and culturally competent manner.

1. When Follow-Up Cannot Be Assured

Some patients will be unwilling or unable to return for ongoing or follow-up care. For this reason, the clinician should strive to assure patients that they do not deserve to be abused or coerced, that they are not to blame in any way, 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 not required to — and in fact **may not** — report suspected instances of human trafficking that involve a competent adult victim, without the patient’s express consent. Accordingly, health care providers must refrain from involving law enforcement and/or social service providers (e.g., housing/shelter services, legal services, and case management) without first obtaining the explicit informed consent of the patient, or unless otherwise required under relevant law (e.g., mandatory reporting laws for disabled adults; elders; children of victimized adults whose safety and well-being may be compromised; injuries resulting from burns, firearms, or knives; or threats of imminent harm to oneself or another).

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 options for accessing 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.

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 (9 a.m.–5 p.m., weekdays), or by calling the Massachusetts DCF Child-At-Risk Hotline, (800) 792-5200 (evenings, weekends, holidays).⁶⁹ A report must be phoned in and then followed up 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 any 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, the DA referral will also be sent to the Support to End Exploitation Now (SEEN) Case Coordinator, who will coordinate an appropriate multidisciplinary team (MDT) response on behalf of the child within 48 hours of receiving the DA referral. Whenever possible, 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) 779-2145.

Using age- and developmental stage-appropriate language combined with a trauma-informed approach, health care providers should strive to engage minors with respect and patience — explaining the reasons for reporting, describing the process, validating patients’ fears and experiences, and highlighting their strength and resilience in such adverse circumstances. Such an approach not only is empowering to those who have been chronically deprived of agency and self-esteem, but also may help to engender trust and promote recovery. Child Protection Teams should be consulted in facilities where such teams are available to 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.

Box 1: Relevant Massachusetts Definitions^{70,71‡}**

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

1. is the victim of the crime of sexual servitude pursuant to section 50 of chapter 265 or is the victim 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:⁷² “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] the attending physician believes that a criminal act was involved.”
- MA GL c. 119 § 51A:⁷³ “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:
 - The alleged perpetrator made threats to kill the caretaker, child(ren) or him/herself and the caretaker fears for his or her own safety, or for the safety of his or her child(ren).
 - A child was physically injured in an incident in which the caretaker was the target.
 - The child was coerced to participate in or witness the abuse of a caretaker.
 - The 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

Health care providers are required to report suspected abuse of disabled adults under Massachusetts law, unless the disabled adult patient invokes doctor/patient privilege to maintain confidentiality of communications with the provider.⁷⁴ 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 (888) 822-0350 TTY for detailed guidance.⁷⁵

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

When the victim 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 outside of mandatory reporting requirements, health care providers should defer to the internal procedures of their health organization and act 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 survivors 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.



Legal and Immigration Issues

Domestic as well as international victims of human trafficking have specific legal rights under federal and state law. Accessing these rights is often hampered by fear or mistrust of law enforcement, judicial, and other authority figures, stemming from factors such as endemic complicity and corruption in the country or region of origin, 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 support and reluctant to disclose to or seek help from law enforcement, attorneys or service providers.

Fortunately, trafficking victims do not tend to perceive the health care system as particularly threatening or corrupt, thus affording health care providers 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 the patient may be a victim of human trafficking, with extra effort made to ensure that privacy and confidentiality, appropriate language assistance, and trauma-sensitive practices are utilized at all times.

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:**⁷⁶ “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. 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.
- **T-visa:**⁷⁷ Victims of severe trafficking in persons who meet eligibility criteria can apply for a T-visa. 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 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 to federal benefits to the same extent as refugees.

- **U-visa:**⁷⁸ 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. 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 eligibility criteria. This requirement can pose a substantial barrier for noncitizen victims who often associate law enforcement with the threat of deportation. Required cooperation with law enforcement can also, among other risks, add to any previous trauma experienced by the victim. 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 feel that a patient who is not a U.S. citizen or a legal permanent resident may be a victim of human trafficking, they should first assess the safety of the situation. When it is possible to speak with the victim alone, the health care provider should inform the person that they have legal rights and that support is available. Health care providers can then work together with an advocate or case manager, or they can contact a hotline resource for further assistance.

Working Collaboratively

Given the complex needs and challenges faced by trafficking victims as they transition to safety and recovery, response protocols need to be both comprehensive and coordinated across disciplines and systems. No single discipline or sector can successfully meet all the needs of survivors. In the immediate phase, trafficking victims may require basic needs such as food, clothing, housing/shelter, and physical protection. Over time, survivors of trafficking may benefit from accessing a wide range of services including legal services, long-term housing, life skills training, language and literacy education, employment training, medical care, substance abuse 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 for assisting 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 survivors of other forms of abuse and hardship (e.g., intimate partner violence, child maltreatment, elder abuse, sexual assault, and homelessness) to develop patient-centered, culturally appropriate, and trauma-informed services in the health care setting (see “Resources” on page 38). Finally, active partnerships across systems with local and regional anti-trafficking stakeholders should be actively pursued as a means of expanding current knowledge, benefiting from the advice of experts, and facilitating collaborative, proactive, and ultimately, effective and compassionate care.

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

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

Providers caring for traumatized patients may suffer from emotional exhaustion, compassion fatigue, depression, anxiety, and psychosocial isolation.^{79,80,81} In order to work effectively with patients who have experienced significant trauma, health care providers should strive to understand their own trauma triggers and employ self-care practices that will support and nurture their own physical, mental, and emotional well-being. Such practices may include meditation, self-reflection, debriefing, reflective writing, exercise-based methods of stress reduction (e.g., yoga), and peer check-ins. The importance of self-care cannot be overstated as this will reduce the likelihood of occupational burnout — a syndrome characterized by disengagement, depersonalization, a sense of low personal accomplishment, and decreased career satisfaction.⁸² Effective self-care can enable clinicians as well as support staff to continue to work with highly 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.

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 are victimized. Preparing for a more effective health sector response requires not only increased awareness about human trafficking among health care providers, but also training on how to identify and assist victims who present for medical care. It is vital that practicing health care providers, providers in-training, and health professional students become educated about victim identification, screening and assessment, trauma-informed care, and coordination with law enforcement and social service providers. Human trafficking should be integrated into the education and training of health professions students as well as graduates in advanced residency and fellowship training.⁸³ Continuing education about human trafficking could be offered to health care providers in practice, or even made a requirement for re-licensure. As an example of such an effort, the Florida Medical Association offers an online educational module on intimate partner violence — with a focus on human trafficking — that is required for physician re-licensure.⁸⁴ A recent systematic review identified 27 educational resources on trafficking — ranging from short, descriptive articles to freestanding online educational modules — specifically designed for health care audiences and, in some cases, offering continuing education credits.⁸⁵ Finally, academically based training initiatives (e.g., the Massachusetts General Hospital Human Trafficking Initiative, a collaborator 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, and elder abuse, health care providers can leverage their positions of leadership and respect within communities, hospital organizations, professional societies, and public policy circles to:

- Expand education and training opportunities for others
- Inform policy formulation when medical perspectives are relevant
- Advocate for improved human trafficking laws and practices
- Provide essential legal testimony when needed
- Join community and state-wide collaboratives, commissions, and other leadership-focused initiatives

D. Preventing Human Trafficking

The medical and public health community can take advantage of prevention opportunities at individual, interpersonal, community, and societal levels, using established frameworks such as the Social-Ecological Model³⁷ and the Spectrum of Prevention.⁸⁶ As in the parallel case of intimate partner violence, health professionals can collaborate effectively with advocates, social workers, law enforcement, and community stakeholders to address and prevent abuse utilizing a lifespan approach. Collaborative, prevention-focused approaches can examine and then systematically address the social determinants of trafficking from a prevention-focused policy perspective. By tackling determinants such as child abuse, gender inequality, unsafe migration, and interpersonal violence, medical professionals can contribute their expertise to help modify the very environments and settings that predispose vulnerable individuals to becoming trafficked.

Resources

Massachusetts-Specific

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: www.mass.gov/ago/about-the-attorney-generals-office/community-programs/anti-human-trafficking/human-trafficking-task-force

Addresses all aspects of human trafficking from a policy perspective.

My Life My Choice (Boston)

Website: www.fightingexploitation.org

Phone: (617) 699-4998

Offers survivor-led programs, peer mentoring, and advocacy for survivors of human trafficking.

SafeLink — Statewide Hotline

Website: www.casamyrna.org/index.php/what-we-do/safelink-hotline

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 of Victim Assistance

Website: www.mass.gov/mova

Advocacy and services for crime victims, including victims of human trafficking. Also provides for survivor-informed policy development, fund administration, training, and individual assistance.

Children’s Advocacy Center of Suffolk County — Support to End Exploitation Now (SEEN)

Website: www.suffolkcac.org/programs/seen

Phone: (617) 779-2146

SEEN Case Coordinator: (617) 779-2145

Coordinates activities of 35 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: <http://iine.us>

Provides and facilitates services for trafficking survivors with a focus on integration into the community.

National

Polaris Project: National Human Trafficking Resource Center Hotline

Website: www.polarisproject.org/resources/tools-for-service-providers-and-law-enforcement

Hotline: (888) 373-7888 or text BeFree (233733), 24/7

The hotline fields tips about potential trafficking situations, provides urgent and non-urgent referrals for services, and offers technical assistance and comprehensive anti-trafficking 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: www.justice.gov/actioncenter/crime.html#trafficking

Hotline: (888) 428-7581

Funded by the U.S. Department of Justice; direct call to federal law enforcement from 9 a.m. to 5 p.m. EST on weekdays.

National Center for Missing and Exploited Children (NCMEC)

Website: www.missingkids.com/home

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: www.missingkids.com/CyberTipline

To offer leads and tips regarding suspected crimes of sexual exploitation committed against children.

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