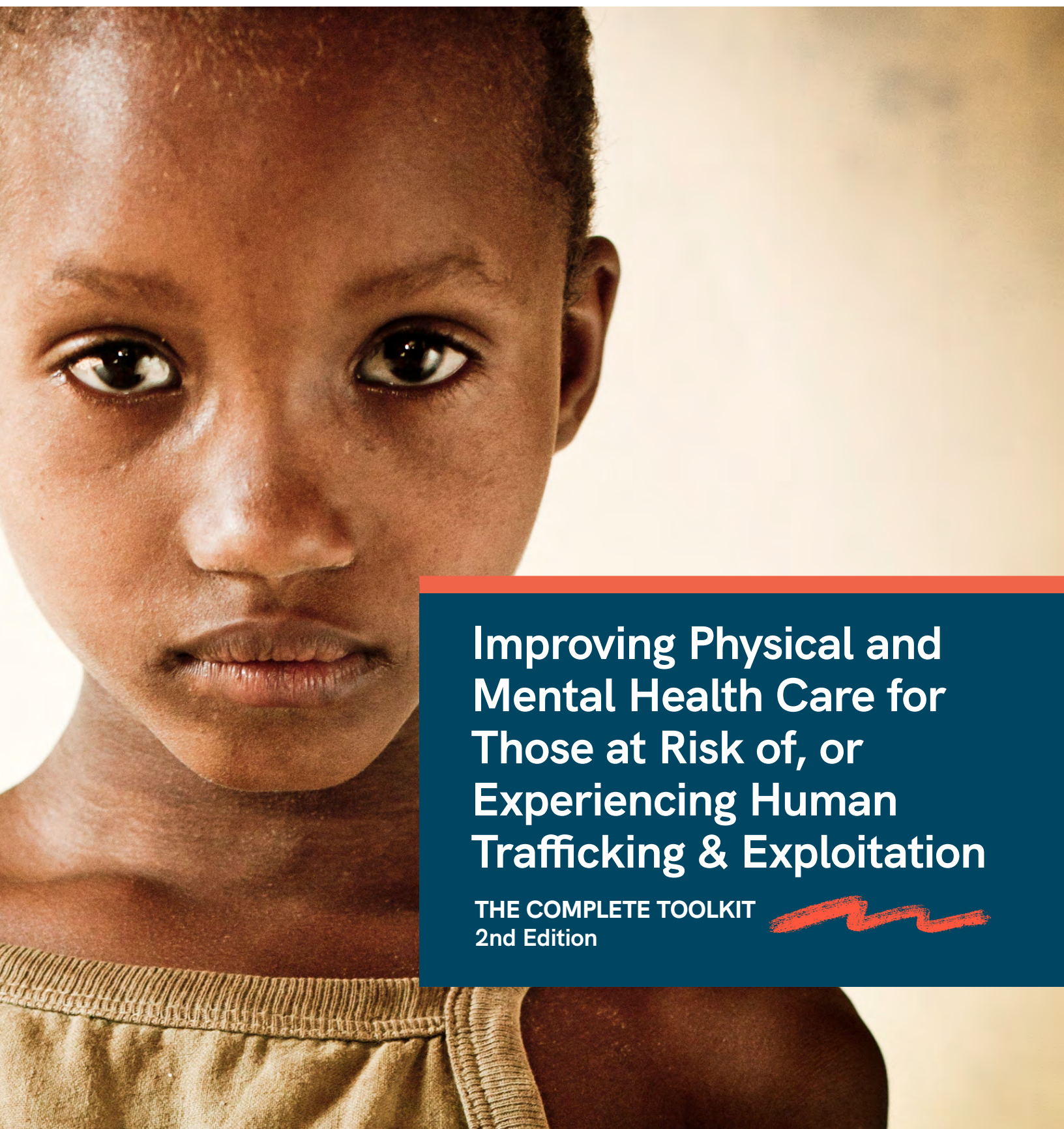




International Centre™
FOR MISSING & EXPLOITED CHILDREN



Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking & Exploitation

THE COMPLETE TOOLKIT
2nd Edition



Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking & Exploitation: **The Complete Toolkit**

2ND EDITION

AUTHORS:

JORDAN GREENBAUM, MD

International Centre for Missing and Exploited Children Alexandria, VA, USA
jgreenbaum@icmec.org

KAREN ALBRIGHT, PHD UNIVERSITY OF DENVER

University of Colorado, Anschutz Medical Campus Denver, CO, USA
karen.albright@du.edu

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Patricia A. Normandin, DNP, RN, CEN, CPN, CPEN, FAEN; Steven Frankel, MD; NAPNAP Partners Alliance for Children in Trafficking Leadership team: Brenda Cassidy, DNP, RN, CPNP-PC; Shenoa Rose Jamieson, CRNP, SANE-A, SANE-P; Jason Spees, MSN, MaOM, APRN, L.Ac., FNP-C; Dipl Ac & CH, Geraldine Hirsch Fitzgerald, RN, MSN, CPNP; Katelyn Brown, CRNP; Nancy S. Harper, MD; Corey Rood, MD; Ashley Garrett; Breanna Heisterkamp, BSN, RN, PHN, SANE-A, SANE-P; Joyce Lo, MD; Sr. Anne Victory, HM Cathy Miller RN, PhD, and Olivia Canter.

Foreword, 2nd Edition

The International Centre for Missing and Exploited Children (ICMEC) identifies gaps in the global community's ability to protect children from abduction, sexual abuse, and exploitation, and assembles the people, resources and tools needed to help fill those gaps.

In our work, we noted a scarcity of specialized health and mental health services available to those who have experienced labour and/or sex trafficking and exploitation, as well as substantial barriers to accessing care. With this in mind, ICMEC undertook a project to study specific barriers and potential strategies to improve access to, and quality of health services to individuals with a history of trafficking. This entailed a global literature review, a global qualitative study of human trafficking experts, and a roundtable of experts convening in Washington D.C. in 2018. The information gleaned from these sources led to the development of this toolkit, the first edition of which was published in 2018.

In 2022 we undertook a project to update the toolkit, incorporating evidence from new research and promising practices. The 2nd edition has been reviewed and edited by experts in the fields of human trafficking and child maltreatment. We truly appreciate the input and advice from these experts. We hope this 2nd edition will prove useful to health and mental health professionals, health systems administrators, public health and other government officials, and nongovernmental organization (NGO) staff who wish to assess and improve the health care of adults and children who experience labour and/or sex trafficking and exploitation.



Table of Contents

INTRODUCTION	1
HOW TO USE THIS TOOLKIT	2
SECTION I: OVERVIEW OF HUMAN TRAFFICKING & EXPLOITATION	3
Definition of Terms	4
Vulnerability Factors	6
Adverse Effects	7
Potential Indicators.....	8
Trauma-Informed Care	9
Health and Mental Health Services for Individuals Experiencing HT/E	
SECTION II: SERVICE ASSESSMENT TOOL	15
SECTION III: GUIDANCE	29
Policy and Practice, and Community Network	29
Privacy and Confidentiality	32
Staff Communication	33
Staff Professional Conduct	34
Interpreter Services	34
Children (<18 years old)	35
Patient/client Gender Roles, Gender Identity, and Sexual Orientation	37
Racial/Ethnic/Religious/Cultural Minorities and Migrant Individuals : Cultural Responsiveness ...	38
Mental Health Training/Supervision	39
Vicarious Trauma/Secondary Traumatic Stress	40
Available Health and Mental Health Services	41
SECTION IV: RESOURCES.....	45
Policy and Practice, and Community Network.....	46
Privacy and Confidentiality	50
Staff Communication	51
Staff Professional Conduct	51
Interpreter Services	52
Children (<18 years old)	52
Patient/client Gender Roles, Gender Identity, and Sexual Orientation	53
Racial/Ethnic/Religious/Cultural Minorities and Migrant Individuals : Cultural Responsiveness ...	55
Resources for Safety.....	56
Mental Health Training/Supervision	57
Vicarious Trauma/Secondary Traumatic Stress	58
Available Health and Mental Health Services	59
SECTION V: COMMUNITY DIRECTORY OF RESOURCES	63

Introduction

This toolkit is designed to assist health and mental health professionals, health administrators, government officials, shelter staff, and other care providers in assessing and improving health and mental health services available to children and adults who are at risk of, or who have experienced human trafficking and exploitation (HT/E). The kit may be used in the following ways:

- Administrators of a public or private hospital or clinic may use the toolkit to evaluate the health and mental health services provided in their own facility to individuals with a history of HT/E and those at risk of exploitation.
- Staff of a shelter may use it to assess their own facility's on-site health and mental health services.
- Staff of a community organization may use the toolkit to assess the services of the local hospital, clinic, or other health or mental health facility to which they send clients (part of their off-site 'referral network').
- Public health officials or other stakeholders may use the toolkit to evaluate the health and mental health services available in a given community to those at risk for or who have experienced HT/E. In this case, the evaluation is applied to a group of local organizations rather than a single site (e.g., to the human trafficking 'referral network'). For example, an evaluation of a patient/client may include visits to the local refugee health clinic, the public hospital, and a specific mental health clinic, all of which are members of the referral network.

The kit contains five sections: **(1) an overview of HT/E, (2) a service-assessment tool** for determining strengths and challenges in the health and/or mental health care delivery provided by one or more organizations, **(3) guidance for developing or improving health and mental health services** for individuals experiencing HT/E and those at risk of exploitation, **(4) publicly accessible resources** to assist in guidance implementation, and **(5) a template for a directory of key local and national service providers**. This directory will help facilitate access to comprehensive aftercare for patients/clients with a history of HT/E.

Because this toolkit is designed for global use, these materials need to be considered in the context of the legal, legislative, cultural, economic, and social environment of each institution/organization, as well as the local or national model of care used to address human trafficking. Opportunities for adaptation may vary for those working in low-vs. medium-vs high-resourced settings. Further, because improvement of health care delivery is an ongoing task, repeated assessments over time are suggested to support continued improvement efforts.

While utilizing the toolkit, it is important to remember that it is intended to focus exclusively on health care services for individuals who have experienced HT/E and those at risk for exploitation (adults/children/families, domestic/foreign origin, those exposed to current or past labour/sex trafficking/exploitation) and their children, rather than on all persons seeking health care in a given setting. While a wide variety of aftercare services are needed for those exposed to HT/E, this toolkit addresses only those directly applicable to health and mental health care.

How to use this toolkit:

The toolkit begins with a brief overview of labour and sex trafficking/exploitation and its health implications.

- This **OVERVIEW** is intended to **introduce the topic and clarify definitions**.
- The **SECOND SECTION** of the toolkit, the service-assessment tool, is **designed to help evaluate a target facility/organization** and identify opportunities for service improvement. This assessment ideally should be completed by multiple staff members, at multiple levels of responsibility in the target organization, as well as multiple external stakeholders in order to obtain diverse perspectives and a comprehensive assessment. For example, hospital physicians, advanced practice providers, psychologists, nurses, and administrators may participate in the assessment, as well as local shelter staff and/or law enforcement who refer clients to the hospital for care. It is extremely helpful to obtain input from patients/clients who have actually experienced HT/E, or their family members. You may have participants complete the assessment individually or as a group, but it is important to create an environment where candid opinions may be expressed.

The assessment tool asks you to answer several “Yes/No” questions about specific service domains at the target facility. You are then asked to use the information from these responses to rate on a scale of 1 to 5 the facility’s overall capacity and resources in the specific domain.

- The **THIRD SECTION** of the toolkit offers suggested **guidance to develop and/or improve the organization’s (or multiple organizations’) health and mental health services** for individuals who have experienced HT/E and those at risk. After completing the service-assessment and discussing results with your group, review this section and the next to obtain guidance and/or resources for each of the domains that you feel need improvement.
- The **FOURTH SECTION** offers a number of **publicly available resources** which you may find helpful when implementing the guidance.
- The **FIFTH SECTION** of the **toolkit is a template for a directory of key local and national service providers**. It may prove useful as your team conducts a community mapping exercise to identify key patient/client resources in the area.

If you are assessing a facility in your referral network and are unable to obtain cooperation from organization staff, it may be difficult to obtain information for some domains. However, in such cases you can use your own experiences as a consumer to evaluate, as well as the experiences of individuals with a history of HT/E and their families. For example, you may not know if hospital staff have been trained on trauma-informed care, but if they demonstrate an insensitive approach to your clients, you may infer a lack of such training.

SECTION I

Overview of Human Trafficking & Exploitation



Overview of Human Trafficking

Definition of Terms

Human trafficking

According to the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, 'trafficking in persons' involves the "Recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."¹

In the case of children (persons under 18 years of age), proof of specific means of exploitation (of the types described above) is not required. That is, one does not need to show force, fraud, or coercion of a child to prove trafficking has occurred. Further, when considering adults, consent becomes irrelevant when any of the means described above are used. For example, a woman who 'consents' to being recruited for commercial sex becomes a trafficked person if and when she is coerced into continuing to participate or forcefully prevented from leaving her situation.

It is important to note that the UN Protocol provides the international definition of human trafficking, but countries implementing the protocol create their own national definition of human trafficking, which may differ from the above. For example, U.S. law requires the 'means' (force/fraud/coercion) when defining child labour trafficking, whereas the UN protocol does not. In some countries, the case of a 15-year-old child who engages in a sexual encounter with an adult in exchange for food may be viewed as commercial sexual exploitation, whereas in other countries it may be considered sex trafficking. For these reasons, this toolkit addresses both human trafficking and exploitation.

Forced labour

According to the ILO Forced Labour Convention, 1930 (No. 29), 'forced labour' includes, "all work or service that is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily."² 'Forced labour of children' involves "work performed by a child under coercion applied by a third party (other than his or her parents) either to the child or to the child's parents, or work performed by a child as a direct consequence of his or her parent or parents being engaged in forced labour."³ 'Child labour' may be defined as any work that 'deprives children of their childhood, their potential and their dignity, and that is harmful to physical and mental development.'⁴ Forced labour can be found in a variety of settings and fields, including restaurants/bars, agriculture, logging, animal care, shepherding, fishing, factory work, service provision, door-to-door sales, meat processing, construction, mining, tourism, and domestic work. It may involve forced criminality (e.g., begging, drug sales, petty theft), selling trinkets or services on the street, providing child care (e.g., 'nanny') or involvement in armed conflict (e.g., child soldier).

Sexual exploitation

'Sexual exploitation' is defined by the UN as "any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another."⁵

Use of terms: survivor vs. victim

There is controversy concerning use of the terms 'victim' and 'survivor' to refer to individuals who have experienced HT/E. On the one hand, 'victim' is used in most national laws and international conventions. In addition, use of the legal designation, 'victim of trafficking' may be required for a designee to gain access to services in some countries or facilities. On the other hand, many people feel that this term implies a lack of agency on the part of the person who has experienced HT/E, and conveys a sense of weakness, which is avoided when using the term, 'survivor'. In addition, many persons do not

view themselves as victims. Throughout this toolkit we use person-first language whenever possible, and when ‘victim’ is used, it is used in its objective, legal sense as indicating a person who has been harmed as a result of some event or action or who has suffered because of someone else’s actions. It does not refer to how the person may feel or perceive themselves as a result of the event(s) and is not intended to be used to label that person.

Health Care Professional (HCP)

In this document, ‘health care professional’ refers to trained individuals providing either health or mental health services.

Privacy

Privacy is defined as a) ‘the quality or state of being apart from company or observation; b) freedom from unauthorized intrusion. In health care, privacy refers to the right of an individual to decide how their personal information is shared.

Confidentiality

Confidentiality refers to ‘the state of keeping or being kept secret or private.’ With respect to health care, confidentiality involves the obligation of professionals to keep information about a patient private. Such information may come from records or other communication.

Trauma

Per the U.S. Substance Abuse and Mental Health Services Administration, trauma results from, “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being⁶.

Vicarious traumatization (VT)

VT refers to the effects on professionals working with traumatized persons, including changes in their views of self, others and the world. It refers to the cognitive changes the professional experiences in response to learning about others’ trauma.

Trauma-informed care (TIC)

See below, [“Trauma-Informed Care” section.](#)

Rights-based, patient/client-centered care

Care that is based on basic human rights outlined in the Convention on the Rights of the Child⁷ (ex., right to voice, information, confidentiality, respect, dignity, etc.) and care that prioritizes the patient/client’s best interests in all decisions and actions involving that individual.

Sexual orientation

Sexual orientation describes a person’s enduring emotional, romantic, and/or sexual attraction to others, regardless of gender.

Gender identity

This term refers to one’s fundamental concept of oneself as female, male, neither or both. This self-concept may be the same or different from the biological sex they were assigned at birth.

Transgender

‘Transgender’ refers to those individuals whose assigned biological sex at birth does not match their gender identity as male or female. There may or may not be a desire for medical or surgical treatment to reassign gender. Transgender does not imply a specific sexual orientation.

Non-binary

Individuals who describe themselves as non-binary do not view their gender as either male or female.

Gender expression

This term refers to the way one expresses their gender identity; it does not imply a given gender identity or sexual orientation.

Vulnerability to Human Trafficking & Exploitation

HT/E may occur in any country, and within any ethnic, racial, religious, cultural, or socioeconomic group. It may involve persons of any gender or age. However, certain persons may be more vulnerable to HT/E because of characteristics and circumstances that involve themselves (individual factors), their immediate social group (relationship factors), their entire community or the society at large. Some of these factors are listed in Table 1, using a socio-ecological model to view the multiple levels of vulnerability^{8,9}.

TABLE 1:
VULNERABILITY FACTORS FOR HUMAN TRAFFICKING & EXPLOITATION, USING THE SOCIO-ECOLOGICAL MODEL ^{3, 9-18}

INDIVIDUAL FACTORS

- | | |
|---|--|
| <ul style="list-style-type: none"> • History of sexual violence; physical abuse/neglect • Homeless/runaway/throwaway status^A; street-based living situation • Lack of official documents (immigration, birth certificate, etc.) | <ul style="list-style-type: none"> • Member of marginalized group • Involvement with juvenile justice and/or child protection systems • Lack of knowledge of resources • Poverty |
|---|--|

RELATIONSHIP FACTORS

- | | |
|--|---|
| <ul style="list-style-type: none"> • Intimate partner and family violence • Abandonment; orphan status; divorce; single-parenthood • Family poverty/ Unemployment • Family dysfunction • Gender bias and discrimination • Parent/peers involved in sex work, sex trafficking or labour trafficking | <ul style="list-style-type: none"> • Gang affiliation • Intolerance of LGBTQ+ status^B • Forced migration • Family crisis, loss • Undiagnosed mental health issues |
|--|---|

COMMUNITY FACTORS

- | | |
|---|--|
| <ul style="list-style-type: none"> • Tolerance of sexual exploitation and gender-based violence • Lack of community resources (jobs, wealth, cohesiveness, family support) • High crime rate (esp. organized crime) • Active informal labour markets • Tourism/transient populations in area | <ul style="list-style-type: none"> • Lack of awareness regarding labour and sex trafficking • Adult sex work in area • Mass migration • Intolerance of LGBTQ+ status |
|---|--|

SOCIETAL FACTORS

- | | |
|---|---|
| <ul style="list-style-type: none"> • Cultural attitudes/beliefs (e.g., normalization of child labour; xenophobia; homophobia; systemic racism; ethnic bias/discrimination) • Gender roles & gender-based violence & discrimination • Natural disasters or prolonged drought • Conditions associated with climate change | <ul style="list-style-type: none"> • Political/societal upheaval, military conflict • Law enforcement/Political corruption • Lack of acknowledgment of child rights • Myths about HIV and sex with children • Limited knowledge of human trafficking |
|---|---|

A: Throwaway status: child told to leave home or told not to return home

B: LGBTQ+: Lesbian, gay, bisexual, transgender, queer, questioning and other

Adverse Effects of Human Trafficking & Exploitation

Numerous studies from around the globe demonstrate a plethora of adverse physical and mental health conditions associated with HT/E.¹⁹⁻³⁰ Vulnerabilities to these health complications vary with the type of HT/E, the individual involved, and the circumstances of exploitation, as well as other factors.

TABLE 2:
HEALTH CONDITIONS ASSOCIATED WITH HUMAN TRAFFICKING & EXPLOITATION

- | | |
|--|---|
| <ul style="list-style-type: none">• Physical injury (from work-related accidents, over-use, physical or sexual assault)• Chronic disease (as a consequence of work-related exposure, stress, inadequate treatment of pre-existing disease)• HIV and other sexually transmitted infections (STI)• Non-sexually transmitted infections such as tuberculosis, scabies, diarrheal diseases• Unplanned pregnancy and complications thereof• Substance misuse• Dental problems (injury, infection) | <ul style="list-style-type: none">• Chronic pain• Memory loss• Dizziness• Exhaustion• Malnutrition and dehydration• Post-traumatic stress disorder• Depression and suicidality• Anxiety disorders• Somatic symptoms (e.g., physical symptoms related to emotional distress)• Behavioral problems |
|--|---|



Potential Indicators of Human Trafficking & Exploitation

Individuals currently experiencing HT/E and those with a history of prior exploitation may or may not self-identify to a health or mental health professional (HCP). They may not disclose their HT/E due to feelings of guilt or shame, fear of harm to themselves or others, fear of deportation or arrest, distrust of others, or a lack of perception of themselves as being exploited³¹. However, when individuals access health or mental health services, there may be one or more potential indicators of HT/E that suggest risk. While most indicators are nonspecific and may be associated with situations not related to trafficking, their presence should cause an observer to take note and ask additional questions to assess for risk of HT/E (assuming it is safe to do so). It is important to keep in mind that individuals who are experiencing HT/E may not show any of these potential indicators.^{20,28}

TABLE 3:
POTENTIAL INDICATORS OF HUMAN TRAFFICKING & EXPLOITATION

INITIAL PRESENTATION	
PATIENT/CLIENT	PERSONAL HISTORY
<ul style="list-style-type: none"> • Appears depressed, fearful or very anxious • Does not have possession of their own identification documents • Is unfamiliar with city/town, cannot give address where they are staying • Has a companion who is: <ul style="list-style-type: none"> - Aggressive - Domineering - Insists on speaking for the patient/client; resistant to having a professional interpreter - Reluctant to answer questions - Eager for discharge - Does not want to leave patient/client alone with provider 	<ul style="list-style-type: none"> • History of gender-based violence, sexual, emotional or physical abuse, or neglect, intimate partner violence • Street-based living; history of running away from home or told to leave; or history of living in group home/orphanage • Prior involvement with social services (especially child services) or law enforcement • LGBTQ+^B status • Behavior problems and/or untreated mental health problems • >5 sex partners (adolescents) • Multiple prior STIs^C • History of pregnancy at young age; history of multiple induced abortions • Immigrant status
PHYSICAL EXAM	
<ul style="list-style-type: none"> • Flat affect; withdrawn, OR fearful, OR hostile • Evidence of dissociation, hypervigilance, triggered anxiety responses (signs of PTSD^A) • Advanced sexual knowledge, vocabulary, and behavior in relation to age and developmental stage (children) • Signs of malnutrition, dehydration • Signs/symptoms of exposure to extreme heat/cold • Signs of substance use/misuse 	<ul style="list-style-type: none"> • Evidence of trauma or infection to genitalia or anus, or internal reproductive organs • Patterned injuries or injuries in protected areas (neck, ears, torso, upper arms, thighs) • Injuries associated with lack of safety equipment/safety practices at work • Inappropriate clothing (e.g., inadequate protection from cold; inappropriate for age and developmental stage if individual is a child) • Suspected toxic exposure

A: PTSD: Post-traumatic stress disorder

B: LGBTQ+: Lesbian, gay, bisexual, transgender, questioning/queer, other sexual minority groups

C: STI: sexually transmitted infection

Trauma-Informed Care

Individuals with a history of HT/E have almost inevitably experienced multiple traumatic events during their period of exploitation, and many have experienced repeated and chronic trauma earlier in life. Trauma may be multi-generational, and historical. These traumatic experiences have a major impact on the way a person views themselves and the world around them, the way they behave in any given situation, and the way they interpret others' words and behaviors. Understanding the impact of trauma, and responding in a nonjudgmental, supportive manner form the basis of a trauma-informed approach to care.⁶

TABLE 4:
CONCEPTS OF A TRAUMA-INFORMED APPROACH^{6,29,30}

CONCEPT	ATTITUDES AND BEHAVIORS OF HEALTH CARE PROFESSIONAL (HCP)
SCREEN FOR TRAUMA (HT/E)	HCP is aware of vulnerability factors and potential indicators of HT/E and asks questions to assess the level of risk.
ENSURE SAFETY	HCP actively works to increase patient/client's physical comfort (meets with individual in a warm, private, quiet environment; addresses basic physical needs) and decrease stress and anxiety. HCP follows a protocol to maximize physical safety of staff; interviews patient/client outside the presence of those who accompany them to the health/mental health center.
DEMONSTRATE RESPECT	HCP explains the purpose of the visit and the reasons behind each step (for example, the reason for asking personal questions; the function of the physical exam or the purpose of the psychological assessment) and answers the patient/client's questions before seeking consent for each step. The provider seeks and accepts the individual's perspective and decisions ^A . They actively listen and remain nonjudgmental and open.
BUILD TRUST	HCP takes time to build rapport with the patient/client; demonstrates an interest in learning about who they are and their situation; avoids making assumptions. HCP demonstrates empathy and concern for the individual's well-being.
ENGAGE AND EMPOWER PATIENT/CLIENT	HCP actively encourages the patient/client's questions and opinions, facilitates a 2-way discussion, and asks the individual for their thoughts about their situation/condition and the best way to address it. The provider encourages the individual to make choices and take control whenever possible throughout the visit.
USE A STRENGTH-BASED APPROACH	HCP identifies and emphasizes the patient/client's strengths and resiliency and acknowledges that the individual is the expert on his/her/their life.

TABLE 4: CONT...

MAINTAIN TRANSPARENCY	Before asking personal questions, the HCP explains any limits of confidentiality in a way the patient/client understands. S/he explains what will happen during the visit and keeps the individual updated on activities occurring during the visit.
DEMONSTRATE SENSITIVITY TO DIVERSITY	The HCP is aware of, sensitive to, and respectful of differences that may exist between themselves and the patient/client (e.g., differences in culture, nationality, race, ethnicity, religion, gender, or sexual orientation). They actively seek to understand the individual's beliefs and perspectives as these pertain to their physical and mental health, their life, and their situation. The HCP accommodates the patient/client's preferences whenever these are safe for the person, possible and feasible.
MINIMIZE RE-TRAUMATIZATION	The HCP limits questions to those needed to perform their duties, assess safety, and promote the patient/client's well-being. They avoid questions that are irrelevant and that may trigger anxiety and distress. The HCP monitors the individual for verbal and nonverbal signs of emotional distress throughout the visit. They provide reassurance and support and have resources available to manage major psychological distress. They implement procedures to ensure that the patient/client does not have to repeat her/his/their information multiple times.
PROVIDE RESOURCES/ REFERRALS	HCP or designee creates and regularly updates a list of local, regional and national resources for the myriad needs of patients/clients who experience HT/E or are at risk for exploitation. Ideally, the HCP establishes relationships with community service agencies and uses a 'warm hand-off' ^B to a referral agency when possible.
ENSURE PRIVACY AND CONFIDENTIALITY	The HCP and the facility maintain strict protocols on documentation and release of information that respect the patient's/client's right to privacy and confidentiality. Staff receive training on maximizing patient privacy/confidentiality and are held accountable for maintaining high standards.

A: Respecting a patient's decision about evaluation and treatment assumes there are not life-threatening health issues that require emergent care, such as uncontrolled bleeding.

B: "Warm hand-off" refers to the HCP directly contacting the service agency to discuss and arrange the referral or assisting the patient/client with making contact while in the health facility.

Health and Mental Health Services for Individuals Experiencing HT/E

Individuals who have experienced HT/E or who are at risk of exploitation may have many immediate and long-term health and mental health needs. Most facilities are not able to provide all of the services listed in the two tables below, so may rely on making referrals to other organizations in the community. By establishing a community network, healthcare professionals and organizations may provide a holistic, collaborative multidisciplinary response to HT/E.

HEALTH SERVICES FOR INDIVIDUALS WHO HAVE EXPERIENCED HT/E

Initial medical evaluation that includes:

- Screening questions to assess for risk of HT/E if history is unknown (ideally use screen clinically validated for the patient population)
- Comprehensive history/physical examination to assess general health, presence of injury, untreated conditions, infections, etc.
- Assessment and treatment of traumatic injuries
- Laboratory testing for acute and chronic disease, malnutrition, vitamin deficiencies, toxins, other
- Emergent dental care
- Brief mental health screen (assess for suicidality, homicidality and other psychiatric emergencies)
- Screen for substance use/misuse
- Sexual assault forensic examination with forensic evidence collection, as indicated
- Testing for sexually transmitted infections (STI), HIV and other infections (TB)
- Treatment for STI's/HIV
- Pregnancy testing and emergency contraception
- Access to condoms
- Treatment of non-sexually transmitted infections (e.g., TB, scabies, malaria) and common chronic disease conditions

Ongoing general primary and preventive care (immunizations, developmental assessment (child), health and reproductive health education, preventative screening, screening for high-risk behavior, testing/treatment for HIV/STI, HIV PrEP, etc.)

- Family planning (e.g., contraception, termination of pregnancy)
- Women's health services
- Preventive and restorative dental services
- Prenatal, perinatal and postpartum care
- Specialty medical care (e.g., surgery, cardiology, physical therapy)
- Primary medical care for children of individuals who have experienced HT/E

POTENTIAL MENTAL HEALTH SERVICES FOR INDIVIDUALS WHO HAVE EXPERIENCED HT/E

- Comprehensive mental health assessment (including trauma-related symptoms and co-morbid diagnoses)
- Individual mental health therapy
- Group mental health therapy
- Family mental health counseling/therapy/education
- Peer support groups
- Psychotropic medications with prescriber oversight
- Traditional healing methods, rituals, cleansing ceremonies
- Expressive/Experiential therapy (e.g., art, dance, music, drama)
- Meditation, yoga, and/or mind-body therapy
- Psychoeducation (e.g., on trauma, emotion regulation, healthy relationships, stigma, grief and loss, etc.)
- Substance misuse treatment services
- Treatment for severe, chronic mental health issues unrelated to trauma
- Inpatient psychiatric treatment
- Case-management



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SECTION II

Service Assessment Tool



Each of the 12 service domains included in this assessment contains a table with a series of items addressing important aspects of the service. Please review each item and indicate whether or not it is present or whether it has been addressed at the facility being evaluated. Then consider the entirety of your answers to all of the items of the given service domain (e.g., all questions related to “Protocol and Community Network”) and provide a general score on the overall adequacy of the service (e.g., “Protocol and Community Network”: 1-very weak, 5-very strong).

1. POLICIES AND PRACTICES: PROTOCOL & COMMUNITY NETWORK ASSESSMENT

Have staff received training on:	YES	NO	N/A
HT/E (e.g., definitions, dynamics, risk factors, potential indicators of labour/sex trafficking)?			
Common immediate and long-term health and mental health needs of persons experiencing, or at risk for HT/E?			
Local, national, and international laws regarding HT/E, and the provision of health and mental health care to impacted individuals?			
Potential immigration assistance available to foreign-national individuals?			
Does the facility have a protocol to respond to cases of suspected HT/E?			
IF YES,			
Was the protocol developed in consultation with a multidisciplinary team, including individuals who have experienced HT/E?			
Does the protocol describe potential indicators of HT/E, and clearly delineate staff roles/responsibilities?			
Is the protocol periodically reviewed and updated?			
Are staff trained on the protocol and how to access it?			
Is there a system for monitoring staff adherence to the protocol?			
Does the facility have easily accessible, up-to- date lists of relevant external agencies that can provide social, legal, health, mental health, educational/ vocational, advocacy, housing, and immigration resources to patients/clients with concerns of HT/E?			

Based on your responses, how would you rate the organizational infrastructure in place to recognize and respond to suspected HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in “[Guidance on Protocols and Community Network](#)”

2. PRIVACY/CONFIDENTIALITY

ASSESSMENT

	YES	NO	N/A
Is there a policy in place to ensure patient/client privacy and confidentiality?			
Do staff demonstrate respect for patient/client privacy and confidentiality?			
Do staff demonstrate proficiency in differentiating the bounds of patient privacy vs. mandatory reporting?			
Is there a procedure for staff, patients/clients, and other stakeholders to safely lodge a complaint regarding breaches in privacy and confidentiality?			
Is there a policy and/or procedure for investigating and managing concerns of possible breaches in privacy and confidentiality?			

Based on your responses, how would you rate the overall strength of privacy and confidentiality policies and procedures at the facility? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Privacy and Confidentiality](#)"



3. STAFF COMMUNICATION

ASSESSMENT

	YES	NO	N/A
Are adequate resources in place to help patients/clients (including those who do not speak the dominant language) find their way from one place to another at the facility (e.g., signage, maps, information desks, directions)?			
Have staff received training on:			
Impact of trauma and the trauma-informed approach to care (see Overview section)?			
Human rights-based/client-centered approach to care (see Overview section)?			
Do staff members routinely:			
Use a trauma-informed, patient-centered, culturally responsive approach to patient/family interactions? (See Overview for description of trauma-informed approach.)			
Respect a patient/client's rights to information and transparency, informed consent, and the right to decline to answer questions or participate in other aspects of the visit?			
Communicate options to patients/clients regarding risks and benefits of testing, medications, and treatment in a way they can understand?			
Provide information about external services and referrals to patients/clients who may have experienced HT/E and those at risk?			
Encourage patients/clients to engage in shared decision-making?			
Provide information about patient/client rights and responsibilities?			
Discuss cost of care and payment options/policies with patients/clients, as applicable?			
When discussing the above with patients/clients, do staff members use language that is appropriate for differing levels of literacy, developmental abilities, and age?			
Do staff utilize professional interpreter services when patient/client language is different from the staff dominant language?			
Does the facility provide patients/clients with information about making complaints when they experience problems?			

Based on your responses, how would you rate the overall ability of staff at the facility to communicate necessary information to patients/clients who have experienced HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Staff Communication](#)"

4. STAFF PROFESSIONAL CONDUCT

ASSESSMENT

	YES	NO	N/A
Does the facility have a policy regarding appropriate and ethical behavior between staff and patients/clients/accompanying persons (e.g., addresses bias, discrimination, harassment; abuse; inclusion/exclusion)?			
Do staff consistently exhibit professional conduct when caring for patients/clients who have experienced HT/E?			
Does the facility have a system in place for staff, patients/clients and accompanying persons to safely notify leadership of concerns regarding staff behavior?			
Are there clear policies/procedures in place for addressing concerns of inappropriate and/or unethical staff behavior?			

Based on your responses, how would you rate the practices in place at the facility to prevent and address unprofessional behavior by staff toward patients/clients who have experienced HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Staff Professional Conduct](#)"

5. INTERPRETER RESOURCES

ASSESSMENT

	YES	NO	N/A
Is there an adequate number of interpreters and/or qualified bilingual staff (on-site or off-site)?			
If needed, are professional interpreters available 24 hours per day, every day?			
Is there an adequate range of languages covered by professional interpreters and staff?			
Do staff consistently use professional interpreters rather than relying on family members and patient companions?			
Are interpreters trained on <ul style="list-style-type: none"> • The impact of trauma, and the trauma-informed response? • Human trafficking and exploitation? • Cultural responsiveness? 			
Do interpreters consistently demonstrate respect for patient/client privacy and confidentiality?			
Are written materials for individuals with concerns of HT/E translated into foreign languages commonly encountered in this health / mental health setting?			

Based on your responses, how would you rate the facility's overall capacity to communicate with patients/clients who do not speak the dominant language? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Interpreter Resources](#)"

6. CHILDREN (UNDER 18 YEARS OF AGE)

ASSESSMENT

Do staff members demonstrate awareness of, and sensitivity to:	YES	NO	N/A
Special needs of children and adolescents, compared to adults?			
A child's right to voice their opinions and participate in care-planning as developmentally appropriate?			
Issues of child consent with/without involvement of the guardian as appropriate/required?			
The role of developmental stage on a child's behavior, ability to answer questions, participate in care-planning, etc.?			
Strategies for interacting with children of differing ages/developmental stages?			
Physical and genital exam techniques appropriate for children?			
Diagnostic test considerations specific for children?			
Potential laws on mandatory reporting of suspected HT/E and other laws and policies relevant to children (e.g., conducting an exam when a guardian is not available to provide consent)?			

Based on your responses, how would you rate overall staff competence in treating minors experiencing HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Children](#)"

7. PATIENT/CLIENT GENDER ROLES, GENDER IDENTITY, AND SEXUAL ORIENTATION

ASSESSMENT

	YES	NO	N/A
Have staff members received training on the intersectionality of HT/E and issues related to gender roles, gender identity, and sexual orientation?			
Do staff members demonstrate an awareness of, and sensitivity to:			
Gender bias/discrimination and gender- based violence?			
Issues of cultural stigmatization regarding loss of virginity, 'prostitution', giving birth to children out of wedlock, etc.?			
Males experiencing HT/E, and cultural stigmatization?			
LGBTQ+ individuals experiencing HT/E and cultural stigmatization?			
Unique needs of cisgender females vs cisgender males with a history of HT/E?			
Unique needs of LGBTQ+ individuals who have experienced HT/E, including potential challenges related to laws surrounding sexual minority status?			
When appropriate, do staff discuss sexual and reproductive health and rights with individuals with a history of HT/E?			

Based on your responses, how would you rate overall staff awareness and sensitivity regarding issues related to gender and sexual orientation of patients/clients experiencing HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Issues Related to Gender Roles, Gender Identity and Sexual Orientation](#)"

8. RACIAL/ETHNIC/RELIGIOUS/CULTURAL MINORITIES AND MIGRANT INDIVIDUALS: CULTURAL RESPONSIVENESS

ASSESSMENT

Have staff received training on:	YES	NO	N/A
Types of implicit/explicit bias and their impact on patient/client care?			
Systemic racism and other cultural beliefs/practices that marginalize certain groups in society?			
Common cultural beliefs and practices of their patient/client population regarding health and mental health, and issues related to HT/E?			
The unique needs of patients/clients who have experienced HT/E and who are of migrant or minority status?			
Do staff demonstrate cultural humility and responsiveness when working with patients/clients?			
Does the facility have access to additional support outside the organization to increase awareness of cultural differences regarding health and mental health care (e.g., access to leaders in the minority community, refugee organizations, etc.)?			
Do staff members demonstrate an understanding of the legal implications of notifying authorities of migrant individuals who have a history of HT/E?			

Based on your responses, how would you rate the overall staff sensitivity and responsiveness to the unique needs of migrant patients/clients and those of racial/ethnic/religious/cultural minority status who have experienced HT/E?

Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Racial/Ethnic/Religious/Political/Cultural Minorities and Migrant Individuals](#)"

9. SAFETY

ASSESSMENT

	YES	NO	N/A
Is there a policy in place to assess and ensure the physical safety of staff and patients/clients?			
Does the facility have adequate safety measures in the environment (e.g., buzzers, deadbolts, alarm systems)?			
Is there a private, safe place to talk with the patient/client, outside the presence of the person who accompanies them?			
Are there safe strategies for discretely providing information and resources to patients/clients who may be in danger?			
Are there rules about being alone with a patient/client?			

Based on your responses, how would you rate the facility's overall ability to safely manage cases of suspected HT/E?

Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Safety](#)"

10. MENTAL HEALTH STAFF TRAINING/SUPERVISION

ASSESSMENT

	YES	NO	N/A
Are there designated mental health staff available (e.g., those with formal training in providing mental health assessment and therapy)? This could include a counselor, social worker, psychologist, etc.			
IF YES,			
Have they received training that allows proficiency in the assessment and treatment of trauma and traumatic stress?			
Do they receive ongoing supervision by an expert clinician (e.g., through chart review, case consultation)?			
Do they incorporate culturally responsive approaches in treatment as appropriate?			
Does at least one staff member have an advanced degree signifying training in counseling or mental health (e.g., equivalent of Master's, doctorate)?			
Is mental health service integrated into other health services in a single location? • If "No", do providers have an easily accessible mechanism to refer patient/clients to other organizations for mental health services?			
Are resources available to treat co-existing disorders such as substance misuse and chronic mental health conditions?			

Based on your responses, how would you rate the overall effectiveness of the mental health staff in working with patients/clients who have experienced HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Mental Health Staff Training/Supervision](#)"

11. VICARIOUS TRAUMA/SECONDARY TRAUMATIC STRESS (VT/STS)

ASSESSMENT

	YES	NO	N/A
Are staff members trained on vicarious trauma and secondary traumatic stress (e.g., definitions, symptoms, possible indicators)?			
Does management monitor for signs of VT/STS and offer services to staff when they detect it?			
Is there debriefing available for staff who have undergone a traumatic patient/client encounter?			
Is there counseling to support staff experiencing vicarious trauma?			

Based on your responses, how would you rate the overall effectiveness of the mental health staff in working with patients/clients who have experienced HT/E? Rating: _____

1	2	3	4	5	N/A
VERY WEAK	SOMEWHAT WEAK	MODERATE	SOMEWHAT STRONG	VERY STRONG	(DON'T KNOW)

Additional Guidance can be found in "[Guidance on Vicarious Trauma \(VT\) and Secondary Traumatic Stress \(STS\)](#)"

12. AVAILABLE HEALTH AND MENTAL HEALTH SERVICES

When assessing the quality of health and mental health care for patients/clients who have experienced HT/E or who are at risk for exploitation, it is useful to consider the Availability/Accessibility/Acceptability/Quality framework (**AAAQ**) developed by the World Health Organization. This framework addresses the provision of health care from a human rights perspective:

- **Availability:** (extent facility(ies) have resources and services to meet patient/client needs).
- **Accessibility:** (e.g., how easily patient/client can reach locale, the affordability of services, whether there is access to services by all individuals, without discrimination/exclusion)
- **Acceptability:** (the extent to which an individual is comfortable with the service provider and vice versa),
- **Quality:** (providers possess necessary skills; supplies are adequate; facility(ies) is safe and sanitary, etc.)

Use a scale of 1-3 to rate your own facility as well as each of the organizations in your health care referral network according to their compliance with the AAAQ framework (1=Poor compliance with AAAQ framework; 2=Moderate compliance with AAAQ; 3=excellent compliance with AAAQ). For example, if your facility does not provide dental services and you must refer patients/clients to a dental clinic that is 120 km. away, that does not provide language interpretation, and that charges high fees for foreign national patients/clients, you would give a score of '1' for that dental clinic.

N/A	1	2	3
SERVICE NOT AVAILABLE	POOR COMPLIANCE WITH AAAQ	MODERATE COMPLIANCE WITH AAAQ	EXCELLENT COMPLIANCE WITH AAAQ
LIST OF FACILITIES PROVIDING HEALTH AND MENTAL HEALTH SERVICES			
AAAQ SCORE (N/A, 1-3)			
1. (Your facility)			
2.			
3.			
4.			
5.			

Additional Guidance can be found in "[Guidance on Services Available](#)"

SECTION III

Guidance



Guidance

Developing & Improving Health Care Services for Persons Experiencing HT/E and Those at Risk for Exploitation

Based on the outcome of the self-assessment, the following guidance should be considered when working to improve a facility's health care service delivery to patients/clients with a history of HT/E. The domains discussed below reflect the order and organization of the assessment tool to support convenient reference. Staff and stakeholders will need to decide which actions are feasible and desirable for the organization and its partners. Efforts should be viewed as a work in progress, with improvements to be accomplished over time. Staff may want to focus on one or a few domains during any given period.

For specific resources to assist with implementation of the guidance, [please see Section IV: Resources](#). The categories of resources mirror the organization of the assessment tool and guidance sections.

1. GUIDANCE ON PROTOCOLS AND COMMUNITY NETWORK

In order to adequately meet critical health care needs, staff must be trained to understand the nature and dynamics of labour and sex trafficking/exploitation, to recognize individuals experiencing HT/E and those at risk, and to deliver trauma-informed, human rights-based, culturally responsive, client-centered care. Training may be administered in person or electronically (e.g., webinar or self-paced online modules). ALL staff with the potential to interact with patients/clients with a history of HT/E should receive training although the level and depth of training may differ according to staff role. The following suggestions are helpful to keep in mind:

ALL STAFF SHOULD RECEIVE TRAINING ON

- Definitions, dynamics, risk factors and potential indicators of labor and sex trafficking/exploitation. If specific HT/E screens are used, staff should receive training on appropriate administration and interpretation.
- The reporting processes dictated by national law, national referral mechanisms, and child protection systems.
- Privacy and confidentiality policies and practices (See "Guidance on Privacy and Confidentiality")
- Issues related to Special Populations (please see guidance for "Children," "Gender Identity and Sexual Orientation," and "Racial/Ethnic/Religious/Cultural Minorities and Migrant Individuals")
- Training on the HT/E protocol (see below)
- Trauma-informed, human rights-based and client-centered approach to care. Direct service providers will need additional, advanced training on these strategies. (See "Guidance on Staff Communication" and the section dedicated to trauma-informed care).

Ideally training should be repeated annually and supplemented by continuing support and supervision by leaders and qualified staff.

The facility should implement strategies to monitor and evaluate staff training.

When at all possible training should include the input of an individual with a history of HT/E, as a presenter, and/or as a consultant in the development of training materials. The individual should be paid for their work.

PROTOCOL

To improve the facility's ability to identify and serve patients/clients who have experienced HT/E, and those at risk for exploitation, it is helpful to have a protocol in place. This formal set of guidelines is best developed by engaging a multidisciplinary protocol development committee to include individuals with lived experience of HT/E, or caregivers of these patients/clients; administrators; clinicians; frontline staff; and representatives from outside agencies. The following actions may support effective development and implementation. The resource list associated with this section includes toolkits for protocol development and an online module providing guidance in the creation of a HT/E protocol.

- Identify someone in the facility to serve as a ‘champion’ to encourage protocol development, implementation, and compliance. There always should be at least one person driving the initiative forward and maintaining momentum.
- Obtain support for the protocol from top administrators of the facility/department.
- Establish a staff contact for answering legal questions and troubleshooting protocol issues.
- Ensure that the protocol is easily accessible to staff; create short lists containing specific information (e.g., common potential indicators of trafficking; a list of community contacts for services). Flow diagrams (algorithms) should be included and easy-to-read.
- Design a strategy for monitoring adherence to the protocol and evaluating protocol efficacy. This may entail periodic review of health/mental health charts, staff surveys, patient/client or caregiver surveys or observation of staff practice.
- Establish a method of obtaining ongoing input and feedback from staff and from patients/clients and families (ex., anonymous comment box; staff and patient/client surveys, surveys of key external stakeholders). Shelters may also survey their clients about the quality of care received at the referral network facility.
- Ensure regular, periodic review and updating of the protocol and associated training curricula.
- Regularly update the list of community referral agencies and their contact information.
- Ensure that staff understand their mandatory reporting responsibilities (who to call and under what circumstances), as well as the consequences of reporting.
- Develop a plan for sustainability of the facility’s human trafficking response. Consider staff turnover and the transition of staff to different roles (including the protocol ‘champion’).

The level of detail of the protocol may vary and in some cases, it may be feasible to adapt an existing protocol on a related issue (e.g., sexual violence) by integrating key HT/E components into the content.

A comprehensive HT/E protocol designed for facilities serving the general population, such as a hospital, medical or mental health clinic, may include the following:

- Definitions of all types of human trafficking and relevant laws.
- Risk factors for sex and labour trafficking.
- Potential indicators of human trafficking (during period of exploitation and afterwards).
- Common adverse health effects of labour and sex trafficking (physical, sexual, mental health, behavioral).
- Trauma-informed, rights-based and client-centered approach to patient/client care
- Questions to ask to assess risk of trafficking (may include formal screening using a validated or evidence-informed, culturally responsive tool and/or universal education about HT/E which allows vulnerable patients/clients the option of reaching out for assistance).
- Trauma-informed physical exam, diagnostic evaluation and treatment options (for a health facility).
- Guidelines to address potential safety issues (e.g., trafficker present at facility; patient/client feeling psychologically or physically unsafe).
- Legal and mandatory reporting requirements relevant to the country/region/organization and contact information for police and child protection services.
- Potential community referrals for services for patients/clients experiencing HT/E and those at risk (based on mapping of available community resources).
- Guidance on appropriate documentation in health/mental health records to maximize privacy and confidentiality and respect patient/client wishes when possible, while complying with legal and organizational requirements.
- Guidance on addressing confidentiality issues when communicating with the media or external agencies.
- For those facilities providing ongoing primary health or mental health care for patients/clients with a history of HT/E, consider incorporating into the protocol specific measures to accommodate the unique needs of this population (for example, flexibility in scheduling appointments; see “Health Services” guidance).

Some organizations (e.g., a shelter), may provide on-site mental health assessment/treatment but refer patients/clients off-site for health care.

FOR THESE ORGANIZATIONS THE PROTOCOL MAY INCLUDE A VARIETY OF SERVICES PROVIDED BY THE ORGANIZATION, BUT SHOULD SPECIFICALLY ADDRESS:

- Common adverse health effects of HT/E (physical, sexual, mental health, behavioral).
- A trauma-informed, rights-based and client-centered approach to care.
- Procedures for obtaining the initial health evaluation and ongoing health care (who accompanies client to health facility, when and where evaluation occurs; what evaluation entails; procedures for information-sharing with health institution; processes for obtaining medications and follow-up, etc.).
- Procedures for conducting the initial mental health assessment and subsequent treatment (as appropriate) (e.g., who conducts the assessment, what assessment tools are used; when assessment occurs, procedures for responding to crises such as acute suicidality and homicidality, etc.).

Please see [“General Resources”](#) and [“Resources for Protocols”](#)

GUIDANCE FOR COMMUNITY NETWORK

When establishing a protocol for HT/E, it is important to involve relevant agencies and organizations in the community. No individual or single organization can provide all of the necessary services to individuals who have experienced HT/E. It is critical to embrace a multidisciplinary, collaborative approach to serving this vulnerable population, and their families. This requires detailed knowledge of local service providers from state and civil society, including their availability, and the scope and quality of their services. These providers and organizations form the community referral network. Patients/clients with a history of HT/E may be overwhelmed with their situation so to ensure their needs are met, referrals to partner agencies need to be managed carefully. It is preferable if a provider personally contacts the referral agency on behalf of the patient/client to set up an appointment (assuming permission has been granted by the patient/client as appropriate) OR provides support while the individual contacts the referral agency from the facility. The following guidance may prove helpful:

- Conduct a mapping of community service providers; regularly review this list, evaluate agency/organization services and update the list. Feedback from patients/clients who received the services is extremely helpful in determining which organizations should remain on the list.
- Actively build and maintain relationships with community service providers when possible (meet with state agency and NGO representatives; invite them to staff meetings, visit the agencies and NGO's, provide cross-training opportunities).
- For service organizations, clarify services available, hours of operation, and eligibility criteria including legal status, age, gender, nationality, etc. Gather written information about these organizations and make it available to staff and to patients/clients and families.
- Consider how an individual with a history of HT/E and their family might experience the community services (consider the organizations' services from the perspective of the patient/client and family).
- Establish a strategy to determine if the patient/client followed up with the referral.
- Establish a process with each agency for making reports/referrals. Processes should be consistent with current legislation, national referral mechanisms and child protection systems.
- Investigate ways of combining resources to help individuals with a history of HT/E secure transportation to appointments and obtain childcare.
- Establish a case manager or patient/client navigator to be in charge of assisting the individual and their family in accessing services; the case manager is part of a comprehensive, multidisciplinary, multi-organization case management system for HT/E.
- Establish memoranda of understanding (MOUs) with outside agencies to address confidentiality, information-sharing, referral processes, etc.

Please see [“General Resources”](#) and [“Resources for Community Network”](#)

2. GUIDANCE ON PRIVACY AND CONFIDENTIALITY

Privacy and confidentiality are essential to the safety and well-being of individuals who have experienced HT/E and need to be maintained at all levels of interaction with patients/clients, as well as with staff and others, consistent with relevant laws and policies. No one should access the health/mental health record if such access is not required for the staff member to perform their roles and responsibilities.

INCLUSION OF SENSITIVE INFORMATION IN HEALTH RECORDS IS IMPORTANT FOR SEVERAL REASONS:

- Helps to ensure continuity and optimization of the individual's care over time, especially when multiple clinicians are involved
- Assists providers in obtaining relevant resources for the patient/client.
- May help keep the patient/client (as well as staff and visitors) safe in the hospital or clinic if there are concerns that the trafficker may come to the facility.
- Helps HCPs to recognize the prevalence of HT/E, which can help decrease bias and stigmatization, especially among disenfranchised populations (e.g., transgender).
- May be useful for a criminal investigation.

HOWEVER, THERE ARE IMPORTANT CONCERNS REGARDING INCLUSION OF SENSITIVE INFORMATION IN THE RECORDS OF PATIENTS/CLIENTS WITH A HISTORY OF HT/E INCLUDING:

- A proxy (typically the guardian, if patient/client is a child) or trafficker may obtain access to the information and may harm the individual. For example, a trafficker may blackmail, threaten or otherwise manipulate the patient/client.
- Staff reading sensitive information may exhibit bias/discrimination in their treatment of the patient/client.
- An individual may feel shame or other negative emotions regarding the sensitive information.
- The possibility that documented sensitive information will be used against a patient/client in a legal proceeding (e.g., child custody hearing, criminal case, immigration proceeding.)
- Information may be used by the

Providers need to document complete and accurate information necessary to support health/mental health decision-making and treatment, while considering and respecting the patient/client's desires and preferences related to the way in which sensitive information is documented. In some situations, legal and administrative policies or the professional judgment of the practitioner may dictate decisions.

Patients/clients need counseling on how their health/mental health information is documented, protected, handled, maintained, and accessed. They need information about who may have access to the records. And, within the confines of laws and policies, they need to be empowered to participate in making decisions about documentation. The depth and detail of conversations with individuals about documentation will necessarily vary, based on their developmental stage, cognitive abilities and emotional state, as well as the clinical context.

THE FOLLOWING ACTIONS MAY BE HELPFUL:

- Identify all situations in which staff members, or non-staff individuals may access the patient/client records (e.g., discharge paperwork viewed by others; insurance payor; clinic/hospital administrative staff; clinical staff involved with the patient/client over time, etc.)
- Identify and implement strategies for limiting access whenever feasible and reasonable. For example, eliminate mention of diagnoses in the discharge paperwork.
- Provide training and guidance to staff regarding:
 - How to initiate conversations with patients/clients and/or trusted caregivers regarding documentation of sensitive information and able to work collaboratively with them to determine

appropriate information to include in the record. Sensitive information may be partially protected by using abbreviations not commonly known to non- health/mental health professionals, or by using language that is more general than specific, yet still communicates necessary information to other clinicians providing care to the patient/client.

- Privacy and confidentiality policies and procedures, including the strategies implemented at the facility to maximize privacy and confidentiality (for example, sections of the record with restricted access).
- The limits of confidentiality related to mandatory reporting of suspected crimes. This should include guidance on how to provide this information to patients/clients before asking sensitive questions and how to maintain transparency when reporting is required. Staff should be trained to respect an individual's decision NOT to report suspected HT/E if mandatory reporting is not required.
- Trainings should be required and periodically repeated.
- Ensure that staff have access to knowledgeable supervisors who can advise on documentation questions.
- Have evaluation and monitoring strategies in place to ensure
 - High quality of training
 - Adherence by staff with privacy/confidentiality measures.

Please see [“General Resources”](#) and [“Resources for Privacy and Confidentiality”](#)

3. GUIDANCE ON STAFF COMMUNICATION

Individuals who have experienced HT/E, like all patients/clients, benefit from effective communication by HCPs and other staff.

THE FOLLOWING SUGGESTIONS MAY IMPROVE THE ORGANIZATION'S ABILITY TO COMMUNICATE CLEARLY WITH PATIENTS/CLIENTS:

- Ensure that all written materials and signage are translated into languages relevant to the patient/client population, and tailored to differing ages and stages of development, as well as to various levels of literacy.
- Increase the signage in the facility and/or implement creative ways of delineating commonly used routes through the facility. Utilize universal communication strategies such as icons and symbols.
- Develop a written list of patient/client rights and post them so that they are easily visible in waiting and exam rooms.
- Place placards with hotline information prominently in staff areas, as well as exam and waiting rooms.
- Ensure that staff routinely explain each step of the health/mental health visit and the reason behind it to the patient/client and trusted caregiver and make clear that patient/client participation is voluntary (with exceptions related to safety, emergency care, mandatory reporting, etc.). Staff should routinely ask individuals if they have any questions about the visit.
- Require staff training on rights- based, trauma-informed care, resilience, and strength-based approaches to care, since these emphasize open communication, transparency, and shared decision-making. Include in the training, guidance on appropriate strategies for questioning patients/clients of varying age and cognitive capacity, including use of open-ended questions, non-leading questions, etc.
- Use multiple approaches to explaining procedures, tests, and treatments (e.g., verbal, written, video) and use plain language understandable to individuals with limited education.
- Educate staff on the cost of tests and treatments so that they can communicate this to patients/clients and families.
- Ensure patients/clients and families are provided information about safe procedures for providing feedback and making confidential complaints about care.
- Ensure adequate availability of professional interpreters for languages commonly encountered

in the patient/client population, either on-site or via videoconferencing. (Please also see section on “Interpreters”.)

- Conduct a community mapping exercise to identify existing services for patients/clients with concerns of HT/E. Make these resources available to patients/clients and families. When possible, the HCP should contact the referral source while the patient/client is still at the facility or assist the patient/client in making the call).
- Explore using social media, text, instant- messaging and email as methods of communication with patients/clients and families, as long as safety and confidentiality can be ensured.

Please see “[General Resources](#)” and “[Resources for Staff Communication](#)”

4. GUIDANCE ON STAFF PROFESSIONAL CONDUCT

A common and significant barrier to accessing high-quality health and mental health care involves facility staff exhibiting bias and discrimination toward patients/clients who have experienced HT/E. Hostility and censure violate basic human rights and discourage persons from seeking critically needed care. It is imperative that facilities serving individuals with a history of HT/E develop and enforce guidelines for staff to ensure humane treatment, with a zero-tolerance policy regarding bias/discrimination.

DEVELOP A POLICY THAT:

- Requires staff to report unprofessional conduct
- Outlines the proper procedure for reporting, and consequences for misconduct
- Includes provisions to ensure the privacy and safety of the person reporting the conduct
- Ensures fair treatment of all involved

Develop a staff code of conduct and require each staff member to read and sign off on it annually.

Provide regularly scheduled staff training on cultural responsiveness, systemic racism, implicit/explicit bias, the organization’s code of conduct and the whistle-blower policy.

Ensure that a system is in place for staff/patients/clients/family/external stakeholders to provide feedback and call attention to concerns related to problematic staff behavior.

Please see “[General Resources](#)” and “[Resources for Staff Professional Conduct](#)”

5. GUIDANCE ON INTERPRETER RESOURCES

If providers and staff do not understand the language or dialect a patient speaks, their ability to meet his/her/their health care needs is severely diminished. The utilization of professional interpreters will help to facilitate understanding and communication between staff and patients/clients within the health care setting. However, depending on circumstances it may also inhibit a patient/client from disclosing sensitive information due to cultural norms, gender preferences or concern of confidentiality breaches.

THE FOLLOWING ACTIONS MAY BE HELPFUL:

- If on-site professional interpreters are not available, consider using phone or videoconference interpreter services when feasible. Do not use family/friends/companions as interpreters. Make every effort to accommodate the patient/client’s desire regarding the gender of the interpreter.
- In the absence of professionals able to translate written materials, consider utilizing online translation apps (NOTE: To ensure accuracy, back- translation is advised).
- Translate signage in your facility into multiple languages, as is relevant to your patient/client population. Realize that some individuals may be illiterate. Ensure that interpreters understand the literacy levels of patients/clients.

- Take into account dialectical differences in language when hiring interpreters.
- Provide training to interpreters on human trafficking, the trauma-informed approach to care, the intersection between culture and HT/E, confidentiality, and privacy.
- Provide training to interpreters on developmental considerations relevant to interpreting for children.
- Prior to the patient interview, meet with the interpreter to discuss the possibility of sensitive questions being asked, the need for an open, nonjudgmental approach, and the importance of confidentiality. Ensure that the interpreter does not know the patient/client or their family and is not from the same small community.
- If the interpreter feels comfortable and is able, ask them to alert the HCP if interpreter notes culturally specific signs that a patient/client may be experiencing distress (some of these signs may be subtle to a person from a different culture). The interpreter may or may not be able to assist in this way.
- Consult interpreters for information about the patient/client's culture, especially regarding beliefs/practices related to HT/E.
- Provide debriefings and/or emotional support for interpreters to alleviate vicarious trauma. See also the section titled, "Vicarious Trauma."

Please see "[General Resources](#)" and "[Resources for Interpreter Resources](#)"

SPECIAL PATIENT/CLIENT POPULATIONS

While human trafficking occurs in all populations, health and mental health services may not be available to all groups or may need to be obtained from a variety of organizations/agencies. For example, some facilities may not provide pediatric care. When assessing a facility's services, it is important to consider the special circumstances of individual groups.

6. GUIDANCE ON CHILDREN

Individuals under the age of 18 years have unique needs related to their age, their role within the family and community, their legal, immigration and social status, their stages of social, emotional, cognitive, and physical development, and other factors.

Differences in pre-pubertal vs. pubertal stages of development have implications for the health care response to trafficking (e.g., interview techniques, examination techniques, diagnostic evaluation and treatment strategies). Developmental differences must be considered in determining appropriate mental health assessment and treatment strategies, as well.

THE FOLLOWING ACTIONS MAY IMPROVE CARE TO CHILDREN WHO HAVE EXPERIENCED HT/E.

- The facility should ensure that all communication, including written materials, are developmentally appropriate (e.g., may involve visual representations).
- Health and mental health staff should receive training to include:
 - Basic child rights (per the U.N. Convention on the Rights of the Child), particularly the child's right to information, to voice their opinions, and to contribute to decision-making appropriate to developmental stage and consonant with national child protection systems.
 - Knowledge that the parent or guardian of a child could be
 - A trafficker, or someone complicit in the child's exploitation who knowingly works against the child's best interests
 - Experiencing HT/E themselves, with or without exploitation of the child. That is, multiple family members may be subjected to HT/E.
 - Knowledge that per the U.N. Palermo protocol, child trafficking does not require the presence of force/fraud/coercion, though national laws may vary regarding this requirement.
 - Risk factors for human trafficking that are particularly relevant to children (lack of life experience, immature brain with limited ability for insight, abstract and critical thinking, easily manipulated, accustomed to obeying adults, etc.).

- Information on the relevant laws and policies surrounding consent to examine and treat a minor in the absence of the guardian, mandatory reporting laws, state procedures for child protection, etc.
 - Developmental differences in a child's behavior, reactions to trauma, ability to answer questions and to participate in care-planning, etc.. Familiarity with developmental changes in a child's ability to describe their experiences, and the associated implications for questioning a child.
 - Strategies for interacting with children of differing ages/developmental stages (building rapport, explaining procedures, asking questions in nonleading manner, encouraging participation in health care visit, etc.).
 - Physical and genital/forensic exam techniques (health professionals)
 - Diagnostic test considerations specific to children.
 - Medical and developmental conditions common among malnourished or otherwise deprived children.
 - Health impact of labour and sexual exploitation on the developing body
 - How to conduct a basic developmental assessment.
- When at all possible, the HCP should speak with the child outside the presence of the caregiver/companion at some point during the visit. Sensitive questions should be avoided in the absence of privacy.
 - For medical examinations,
 - A staff chaperone should be present. Ideally, this person has skills in assisting children/youth during anxiety-producing medical procedures or other potentially stressful experiences.
 - If possible, the patient/client's desire for a specific gender, race/ethnicity of the HCP and chaperone should be accommodated.
 - The HCP should closely monitor the child for signs of emotional distress during the history, examination, diagnostic testing and completion of sexual assault evidence kits, responding with support and reassurance.
 - At the end of the examination, the HCP should explain any findings and ask the patient/client if they have any questions about their body, their health or about the medical visit, itself.
 - Regardless of patient/client age and the legal age of consent, a pediatric patient/client should be allowed to decline some or all of the components of the history-taking, examination, diagnostic testing and treatment processes (except in conditions in which the child's health may suffer). This respect for choice should be made clear to the patient/client. Every effort should be made to minimize patient/client distress and maximize the child's sense of control. This is important, even when caregivers give consent for a procedure. The child's best interest should drive all care decisions.
 - The limits of confidentiality (including mandatory reporting requirements) should be explained to a child (as developmentally appropriate) before commencing any discussion of sensitive issues, such as risk of HT/E. If a mandated report is ultimately required, the patient/client should be told about this before the call is made so that the individual may express their opinion and appropriate safety measures may be taken. While a report may be mandated, it is still important for the individual to feel that they have been allowed to express their concerns and desires.
 - The goal of the health/mental health professional is to identify potential risks for HT/E and provide potential resources. The goal is not to obtain a definitive disclosure of HT/E. Often, a child does not perceive their situation as exploitative or is not ready to disclose what is happening to them. It may cause unnecessary distress to pressure a child to disclose. Instead, identifying risk, assessing needs and providing options for resources can empower a child and communicate that help is available.
 - Ask the child/youth for their opinions, ideas, and concerns. Encourage open discussion and shared decision-making. Recognize that the patient/client is an expert on their own lives.
 - Create a child-friendly physical environment for pediatric patients/clients of varying ages (e.g., address interests of young children and adolescents).

Please see "[General Resources](#)" and "[Resources for Children](#)"

7. GUIDANCE ON ISSUES RELATED TO GENDER ROLES, GENDER IDENTITY AND SEXUAL ORIENTATION

In many societies, gender roles for males and females, as well as attitudes towards those identifying as lesbian/gay/bisexual/transgender/queer/questioning/other (LGBTQ+) contribute to risk for HT/E. In addition, they may have a profound impact on the quality and accessibility of services for those experiencing HT/E. It is important for staff to be educated about the potential negative impact of cultural beliefs, biases/ discrimination, and stigma surrounding gender roles, gender identity and sexual orientation, and maintain a nonjudgmental, open, attitude when working with all patients/clients experiencing HT.

- Develop and implement staff training on the following topics:
 - Gender-based violence and discrimination; the ways in which cultural beliefs and gender bias increase the risk of HT/E of women and girls;
 - Vulnerabilities of males to labour and sex trafficking/exploitation; how gender roles and cultural attitudes influence disclosure of HT/E, the family and community response to HT/E, and societal stigma regarding male vulnerability;
 - Sexual behavior during HT/E does not predict sexual orientation;
 - Understand that one cannot assume risk factors, and trafficking experiences are the same for males vs females vs trans individuals, or for those experiencing labour vs sex trafficking;
 - Terms related to gender identity and sexual orientation ([See glossary in Overview](#));
 - Stigma associated with sexual minority status and potential legal realities placing individuals at risk of harm;
 - Increased vulnerability of LGBTQ+ individuals to HT/E related to their increased risk of homelessness, violence, involvement in commercial sex, self-harm, and other adversity relative to their cisgender, heterosexual peers;
 - Unique aftercare needs of LGBTQ+ individuals who have experienced HT/E;
 - Trauma-informed, rights-based strategies for interacting with individuals who identify as LGBTQ +.(for example, universal use of gender-neutral language, respect of patient/client's feelings about discussing sexuality issues, use of a nonjudgmental approach which avoids making assumptions);
 - Cultural responsiveness around gender identity, sexual orientation, sexuality and reproductive issues;
- Implement strategies to monitor the training of staff, and the application by staff of learned material to their practice.
- Periodically review and update training materials.
- Offer culturally and developmentally appropriate anticipatory guidance to patients/clients regarding:
 - Reproductive issues (menstruation, STI's, HIV, condom negotiation, contraception, pregnancy)
 - Harm reduction strategies
 - Diet and hygiene
 - Preventive primary care
 - Male physiologic sexual response (for example, it is common for males to develop a penile erection during an assault and this in no way implies 'consent')
 - (For trans patients/clients): Risks/benefits/options for hormone and surgical treatment
- Identify at least one provider who has experience serving LGBTQ+ patients/clients and working with gender and sexuality issues.
- Ensure that the décor of the surroundings (waiting room, offices) is welcoming to individuals of all genders and sexual orientations.
- Have inclusive signage to acknowledge nonbinary patients/clients.

- Make patient/client forms gender-neutral; use pronouns preferred by patient/client in records
- Try to ensure adequate representation of genders among staff so patients/clients are able to choose the gender of their provider.

Please see [“General Resources”](#) and [“Resources for Issues Related to Gender Roles, Gender Identity and Sexual Orientation”](#)

8. GUIDANCE ON RACIAL/ETHNIC/RELIGIOUS/POLITICAL/CULTURAL MINORITIES AND MIGRANT INDIVIDUALS

Individuals with a history of HT/E often experience marginalization, discrimination and bias not only related to their involvement in exploitation (e.g., ‘prostitution’; forced criminality), but also to their cultural, racial, ethnic, political, or religious status. These harmful attitudes and actions may be expressed by members of the dominant culture, or by those within the culture of the patient/client. Additional marginalization may arise from cultural biases related to gender, sexual orientation, age, geographic location, disability, and other factors. It is critical for staff to be aware of the types and manifestations of bias and discrimination common within their own culture and within those of their patients/clients. Staff need to continuously work to identify and manage their own explicit biases and seek to uncover and address their implicit ones. The organization needs to implement a zero-tolerance policy for bias and discrimination of any form and support appropriate bystander intervention when it occurs in the facility. (Please also see section on [Professional Conduct](#).) Providers and staff who demonstrate the ability to understand and communicate with people across a range of cultures and experiences will be best able to care effectively for patients/clients with a history of HT/E.

- Provide regular, repeated staff training on cultural issues, including but not limited to:
 - General principles of cultural humility and responsiveness, explicit/implicit biases, systemic forms of racism and other types of discrimination (especially those encountered in the health/mental health setting).
 - Cultural attitudes and beliefs, as well as religious/faith-based practices and values held by patients/clients and families regarding health; health care; and mental health services.
 - Cultural meanings of LGBTQ+ terms in the relevant languages, and cultural attitudes toward LGBTQ+ individuals common within the cultures of patients/clients.
 - Skills that enable staff to understand their patient’s/client’s cultural beliefs and practices regarding health and mental health care using a nonjudgmental approach. For example, asking the patient/client open-ended questions regarding how they view their symptoms, and what they think would be appropriate treatment. Or how they view the medications, and other treatments being proposed by staff. This cultural information is useful to the provider as they work with the patient/client to devise a care plan.
 - Social determinants of health that may be impacting a patient/client with a history of HT/E, and one or more factors associated with marginalization.
 - Laws addressing the health care delivery pathway (e.g., access to care) for foreign and undocumented individuals with concerns of HT/E, and the associated costs of care.
 - Resources available to foreign-national patients/clients seeking immigration assistance
- Implement strategies to monitor staff training, and the application by staff of learned material to their practice.
- Periodically review and update training materials.
- Create an atmosphere where staff feel comfortable asking questions about culture, an atmosphere that creates understanding and tolerance while minimizing misperceptions and stereotypes. Identify particular staff who are specifically designated as ‘safe’ for staff to approach with questions.
- Provide staff with resources that summarize key points of cultures and subcultures that are relevant to the patient/client population (e.g., methods of communication; beliefs about HCP/patient relationship).
- Monitor for bias/discrimination and enforce a zero-tolerance policy.

- Ensure a safe system is in place for staff/patients/clients/visitors to provide feedback and call attention to concerns related to discrimination and bias.
- Ensure a system is in place to address breaches of conduct by staff.
- Ensure that patient/client forms and written resources are translated into the languages most commonly encountered at the facility, taking into account that individuals with a history of HT/E may be illiterate in their own language.
- Design easy-to-understand, culturally appropriate information sheets that address culturally sensitive issues that may be difficult for patients/clients who have experienced HT/E to discuss.
- Address signage in the facility, with non-text directions or translated signage appropriate for the patient/client populations most commonly encountered at the facility.
- Consider altering the physical environment to make it more culturally sensitive (e.g., cultural artwork, magazines in varied languages, culturally relevant toys for children; bilingual restroom signs).
- Anticipate interpretation needs and have a plan in place to engage the services of a professional interpreter. Do not allow the companion of a patient/client to interpret for the HCP since this may be unsafe and may not guarantee accuracy in interpretation (exceptions may exist wherein the facility has specified arrangements with a service agency such that the agency brings a qualified and trusted interpreter with the trafficked person). Ensure that the interpreter is not from the same village/immediate area as the trafficked patient/client as this may inhibit the latter and make it difficult to build trust.
- Identify agencies and organizations in the community that provide services to migrants regardless of documentation status, including organizations offering specialized services for individuals who have experienced HT/E and other crimes. Interpretation, legal services, immigration assistance, housing, communication with family in the home country, and language classes are important needs that require assistance for persons who have been trafficked from another country.
- Provide staff with resources for patients/clients with disabilities.
- Hire bicultural/bilingual staff consistent with the organization's patient/client population.

Please see [“General Resources”](#) and [“Resources for Racial/Ethnic/Religious/Political/Cultural Minorities and Migrant Individuals”](#)

9. GUIDANCE ON SAFETY

It is critically important to consider the physical and psychological safety of individuals who have experienced HT/E, other patients/clients and staff. A trafficker may or may not accompany a patient/client to the facility, but regardless, the latter may have very real fears of retaliation by the trafficker.

- Be aware of and responsive to anxiety and fears of staff and of patients/clients and take steps to address them.
- Ensure the facility has a private room for consultation (e.g., exam room, staff office). The room should be warm, comfortable, ‘patient/client-friendly’; should have a door that closes, and walls that prevent people from easily overhearing conversations.
- Educate staff to
 - Avoid screening for HT/E or asking sensitive questions in the presence of a patient/client’s companion (even if a family member). Ensure that at least a portion of the visit is conducted outside the presence of accompanying persons. Be aware that traffickers may attempt to monitor patient/client interactions with HCPs through use of electronic devices (e.g., phones).
 - Take time to build rapport with patient/client before asking sensitive questions. It may require multiple visits before a patient/client feels safe enough to discuss their exploitative circumstances.
 - Practice a trauma-informed, client-centered, culturally responsive approach to patient/client interactions (see [Overview section on Trauma-informed care](#))
 - If a physical exam is needed, allow patient/client to have a trusted person in the room if desired (provided staff do not have concerns that the companion is involved in trafficking).
 - Discuss documentation of sensitive information and explore patient/client’s concerns and opinions; ensure every effort is made to accommodate the individual’s wishes while adhering to policies/laws and ensuring safety and optimal continuity of patient/client care. (See resources in [“Privacy and Confidentiality”](#))

- Identify ways to provide patients/clients with concerns of HT/E with resource information in a discreet manner that does not place them in danger.
- Evaluate the clinical environment and identify potentially unsafe situations. Take steps to maximize safety of staff and patients/clients. For example, install locks on doors between the waiting room and service rooms; install alarm buttons in each room, etc.
- Create specific protocols to handle crisis situations (e.g., potential violence).
- Train staff on de-escalation techniques to be used when patients/clients or visitors become agitated.
- Ensure all staff are aware of safety procedures, and periodically practice 'crisis responses'.
- Develop a fact sheet for 'staying safe' to be posted in the facility.
- Ensure staff know how to call for help when needed (e.g., how to contact police or a security guard). If security personnel are on site, make them aware when there are concerns of possible HT/E involving a patient/client so they can increase security as indicated.
- There are a variety of resources to help ensure physical safety, although many are not feasible in all settings. They include:
 - Real-time location systems (that track staff location), with silent alarms that notify nearby staff when person is in distress.
 - Card swipes
 - Flagging potentially violent patients/clients/visitors
 - Locked areas
 - Security cameras
 - Security personnel
 - Panic buttons
 - A method for calling police
 - A code word to signal a dangerous situation

Please see [“General Resources”](#) and [“Resources for Safety”](#)

10. GUIDANCE ON MENTAL HEALTH STAFF TRAINING/SUPERVISION

In many, if not most, areas of the world, there is a scarcity of individuals trained to provide mental health care to those who have experienced HT/E or who are at risk of exploitation.

Increasingly, efforts are being made to identify appropriate strategies to enable non-professionals to deliver services that improve the emotional well-being of patients/clients with a history of HT/E in a way that acknowledges the impact of trauma. These services may take many forms, depending on the cultural practices and individual needs of patients/clients. “Western” methods of treatment (e.g., ‘talk therapies’) should not be assumed to be appropriate for all individuals. Guidance to improve the quality of mental health care to this vulnerable population include the following:

- Ensure annual staff training on human trafficking, trauma, and the basic trauma-informed approach to patient/client care. Input on the training curricula should be sought from those with lived experience of HT/E.
- Ensure specific training on assessing and responding to suicidality and homicidality.
- Supplement training of those delivering mental health services of any type with continuing education, as well as ongoing support and supervision by qualified persons. This need not be ‘on-site’ supervision but may employ teleconferencing and online mentoring with experts located elsewhere in the country, region or across the globe.
- Join a national or international network that allows access to mental health resources on human trafficking and trauma, and to various treatment strategies.

- Build relationships with universities or colleges that have programs in psychology, counseling, social work, or other treatment approaches (e.g., dance- movement therapy; art therapy) to collaborate and share resources.
- Implement strategies to monitor staff training and the application by staff of learned material into their practice. Training materials need to be reviewed and updated regularly. Provide regular evaluation of and feedback to staff (via observation, survey, test, etc.).
- Vicarious trauma and secondary traumatic stress are common among mental health professionals treating traumatized persons. Implement strategies for provider self-care. See guidance under [“Vicarious Trauma/Secondary Traumatic Stress.”](#)
- Build relationships with respected traditional healers, village/community elders, and others who are influential in the healing process within cultures embraced by the patient/client population. Encourage information sharing and cross-learning.
- Build relationships with local NGOs that provide suitable mental health services to individuals with a history of HT/E.
- Implement or make available a variety of culturally appropriate strategies to support a holistic approach to mental health and well-being (e.g., expressive therapy, meditation, yoga, Western ‘talk’ therapies; group and individual counseling, peer support).

Please see [“General Resources”](#) and [“Resources for Mental Health Staff Training/Supervision”](#)

11. GUIDANCE ON VICARIOUS TRAUMA (VT) AND SECONDARY TRAUMATIC STRESS (STS)

Providers and staff working with patients/clients with a history of HT/E may experience vicarious trauma (VT) and/or secondary traumatic stress (STS) from hearing about traumatic events and witnessing the pain, fear, and terror associated with those events. The following actions may help prevent and address VT/STS:

- Provide staff training on VT/STS to raise awareness of these issues (e.g., psychoeducation on symptoms and signs of VT/STS) and encourage staff to adopt self-care and stress management strategies; create self-care plans).
- Encourage organizational attitudes that allow staff to talk about VT/STS.
- Provide support mechanisms for staff (e.g., initiate specific discussions of VT/STS at staff meetings; ensure that supervisors understand VT/STS; incorporate flexibility around productivity requirements; consider establishing peer support groups; make mental health services and online support easily accessible to staff; consider mindfulness activities, art/recreation programs or alternative medicine programs).
- Educate families of staff about VT/STS so they understand and are able to be supportive.

Please see [“General Resources”](#) and [“Resources for Vicarious Trauma and Secondary Traumatic Stress”](#)

12. SERVICES AVAILABLE

Guidance on Health Services for Trafficked & Exploited Patients/Clients

The health needs of patients/clients who have experienced HT/E will vary individually and over time. Most facilities do not provide all of the services that may be needed, so it is important to have the ability to refer individuals to other facilities in the community or within a large city. Persons experiencing HT/E may face significant barriers accessing high-quality health services due to factors within the locus of control of the health facility. Using the WHO’s Availability/Accessibility/Acceptability/Quality framework (AAAQ), organizations may improve care to patients/clients.

TO IMPROVE AVAILABILITY AND ACCESSIBILITY,

- Map community and national health resources so all staff members know where services may be obtained, and how to refer patients/clients to these organizations (see directory). Resources should include health and mental health services not available at the facility being evaluated.

- Determine whether or not your community/jurisdiction requires forensic examinations to be conducted at a specific facility, such as a government hospital.
- Identify which community facilities offer immediate/emergency care for patients/clients who are experiencing HT/E (e.g., an initial evaluation), which facilities offer ongoing care, and which offer both.
- Identify which facilities offer services to individuals who have experienced HT/E but who are not formally (officially) identified as trafficked. Policies or regulations may impact the ability of these patients/clients to obtain care (or impact the cost of care).
- Develop outreach efforts in the local community (e.g., mobile clinics) in order to improve access to the facility being evaluated.
- Be aware of common times of day/night in which trafficked patients/clients who experience HT/E are likely to seek care.
- Consider one or more of the following options to increase access to care:
 - Utilize an on-call service system, in which staff are on call and able to come in from home, in order to respond to demand during times when the organization is closed.
 - Extend normal business hours.
 - Partner with other organizations to offer extended hours and/or 24/7 on-call coverage.
 - Offer walk-in services
 - Be aware that the need to be at work and make money is a common barrier to care and take measures to address/alleviate long wait times within the organization accordingly (for example, prioritize patients/clients with concerns of HT/E during triage).
- Discuss with community stakeholders and/or funders feasible ways to support patient/client transportation and expanded business hours.
- Identify any medications that are not available (especially in children's doses) or medications that are not culturally acceptable. Determine if there are other agencies/facilities in the community that carry the needed medications, or if there are alternative, effective medications available. Be sensitive to the cost of medications and contraception (affordability). Explore options for providing low-cost or no-cost treatment, such as crime reparations funding, philanthropy or grant funds.
- Investigate possible funders who could cover the costs of medications and/or contraception.

EFFORTS TO IMPROVE ACCEPTABILITY AND QUALITY INCLUDE:

- Much of the guidance in this toolkit addresses acceptability and quality issues. Additional suggestions include the following:
- If possible, ensure that each shift includes at least one clinician who is specially trained to manage patients/clients with a history of HT/E.
- Consider use of a screening tool to identify patients/clients at risk for HT/E. Such a tool should be developed with scientific vigor and clinically validated for the relevant patient/client population.
- Identify a validated brief mental health screen designed to identify patients/clients who may be suicidal/homicidal and/or in need of emergency treatment for other reasons (e.g., psychosis). These individuals may need immediate, specialized psychiatric care.
- Design simple, written materials appropriate for individuals with low health literacy levels. Topics include:
 - Medications, including explanations of the risks, benefits, and cost.
 - Basic hygiene,
 - Preventive health,
 - Sleep and diet recommendations and
 - Guidance on reproductive health, and contraception options.
 - These will need to be translated to languages common among patients/clients with a history of HT/E who attend the facility, and staff will need to be able to summarize the content of materials when patients/clients are illiterate. The latter may require interpreters.

ADDITIONAL GUIDANCE:

If the facility provides ongoing primary care, incorporate strategies to accommodate the unique needs of patients/clients with a history of HT/E, including:

- Flexibility in scheduling and rescheduling (e.g., accommodate cancellations and No Shows as much as possible)
- Periodic re-assessment of changing health care needs
- Flexibility in requiring identification documents
- Free services or sliding scale fees
- Need for childcare, access to transportation
- Consideration of myriad stressors for patients/clients (e.g., housing, job, immigration status, legal issues, stigma, and discrimination)
- Need for a holistic approach to care that includes community multidisciplinary service providers
- Consider how the facility may ensure ongoing health care if/when an immigrant patient/client is re-patriated. Are there NGOs in the home country that can ensure health needs are met? How can healthcare staff in the target facility communicate the ongoing health needs of the patient/client to the next health care provider (maintaining confidentiality and privacy as appropriate)? Doing so likely will require a protocol and designated person(s) assigned the task of organizing follow up care (case management).
- Consider the health and mental health needs of the children of individuals with a history of HT/E (primary care, immunizations, developmental assessments, nutritional assessments, psychoeducation on trauma).

Please see [“General Resources”](#) and [“Resources for Health Services for Trafficked/Exploited Patients”](#)

GUIDANCE ON MENTAL HEALTH SERVICES

Mental health services, those designed to address the psychological and emotional well-being of individuals, may encompass a wide range of strategies. The variety of services offered at a facility or within a referral network depends on resources available, prevailing cultural norms of the community, as well as cultural beliefs and practices of patients/clients who experience HT/E. Combinations of treatment strategies may be employed and appropriate strategies may shift over time as patients/clients move through the recovery phase.

When developing or improving mental health services for those who have experienced HT/E, keep in mind the following:

- Avoid assuming that all patients/clients who have experienced HT/E (or all of those within a specific cultural/ethnic/religious group) will respond positively to the same treatment strategies. There are important individual and group variations to consider.
- Over time, the most effective methods of facilitating the emotional well-being of a given individual may change. For example, initially a patient/client may be quite hesitant to participate in group therapy, but over time and as trust is built, they may find this type of interaction very helpful.
- Cultural issues of stigma surrounding mental health symptoms, mental health therapy and surrounding human trafficking in general (especially sex trafficking) need to be addressed with patients/clients and their families.
- Cultural, social, environmental, and other factors influence a patient/client’s desire and ability to engage in mental health services. Providers need to consider and address relevant barriers faced by individuals in seeking care and actively engaging in treatment.
- Treatment type and modality must be culturally appropriate, and responsive to the needs of the individual. For example, some patients/clients may benefit by integrating traditional practices (e.g.,

storytelling; mythology; healing ceremonies) and cultural beliefs into Western 'talk therapies.'

- Mental health services are best provided as an integrated component of a holistic treatment approach that addresses social, health, legal, immigration, economic and housing issues faced by those who have experienced HT/E.
- Treatment for trauma-related symptoms may need to be delayed until other, more pressing issues are addressed, such as housing stability, substance abuse and/or severe mental health disorders. Until these are addressed or stabilized, the patient/client may be unable to truly participate in trauma-focused treatment.
- Psychoeducation regarding the common effects of trauma, and the ways individuals often manage their stress may be very helpful to patients/clients and their families, as may discussion of potential triggers of anxiety, and strategies patients/clients may use to regulate their emotions. Education about common methods used by traffickers to manipulate and control individuals may be helpful when discussing a patient/client's self-blame, feelings of guilt or shame. Such information may relieve some of the anxiety individuals experience about their own feelings and behavior and may allow those close to them to empathize with what the patient/client is experiencing. Helping family and community members understand their own feelings and reactions to the patient/client's experiences may be helpful.

Please see "[General Resources](#)" and "[Resources for Mental Health Services](#)"



SECTION IV

Resources



GENERAL RESOURCES (APPLICABLE TO ALL ASSESSMENT DOMAINS):

This section begins with a list of general resources that are relevant to most, if not all, service domains addressed in the assessment. Virtually all of the listed resources are publicly available. Many of the resources here are available at the ICMEC Health Portal: <https://www.icmec.org/healthportal-resources/topic/research-and-resources-child-sexual-abuse-exploitation-and-trafficking/>, where there is a large collection of guidelines, protocols, research and other resources for health and mental health professionals.

Multiple online training modules on human trafficking; trauma-informed, person-centered care are available at this link: <https://www.icmec.org/healthportal-resources/topic/e-learning/>.

Most modules are free of charge; course certification is offered. Courses are appropriate for health and mental health care professionals and support staff.

- Top 10 Tips for Effective Communication with Children/Youth, available at <https://cdn.icmec.org/wp-content/uploads/2022/02/Effective-Communication-Top-10-tips.pdf>.
- SOAR to Health and Wellness training on Human Trafficking: <https://nhhtac.acf.hhs.gov/soar>
- HEAL Trafficking, & Hope for Justice. (2015). HEAL Trafficking and Hope for Justice's Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings. Available at <https://healtrafficking.org/2017/06/new-heal-trafficking-and-hope-for-justices-protocol-toolkit-for-developing-a-response-to-victims-of-human-trafficking-in-health-care-settings/>.
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- National Child Traumatic Stress Network. Many resources regarding LGBTQ youth and trauma. Available at <https://www.nctsn.org/what-is-child-trauma/populations-at-risk/lgbtq-youth>.

RESOURCES FOR PROTOCOLS

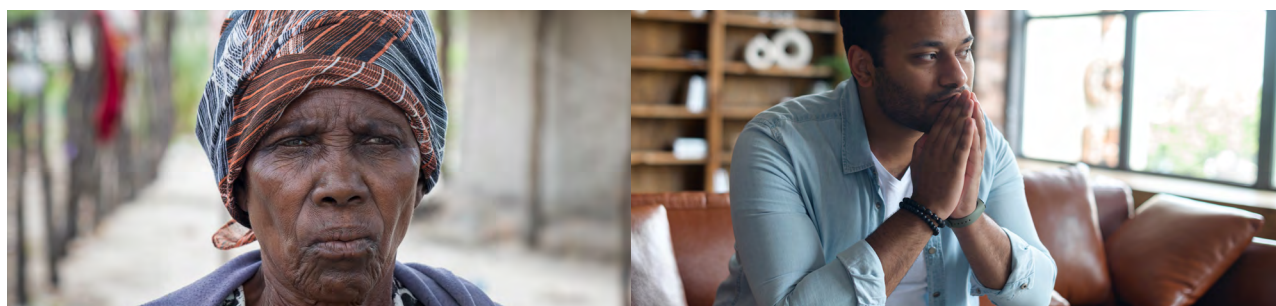
Please also see “[General Resources](#)” section

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1. RESOURCES FOR COMMUNITY NETWORK

Please also see resources under “[Protocols](#)”

- Schwarz, C. Unruh, E., Cronin, K., Evans-Simpson, S., Britton, H., & Ramaswamy, M. (2016). Human Trafficking Identification and Service Provision in the Medical and Social Service Sectors Health Hum Rights, 18(1), 181–192. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5070690/>; accessed on 3/2/22.
- SOAR to Health and Wellness, Multidisciplinary Treatment and Referral Team: https://nhttac.acf.hhs.gov/soar/eguide/resources/Building_a_Referral_Network
- Wisconsin Anti-Human Trafficking Task Force (2017). Guidelines for an Effective Coordinated Community Response to Sex Trafficking of Youth. Available at <https://dcf.wisconsin.gov/files/aht/pdf/ahttf/effective-community-response.pdf>; accessed on 3/2/22.
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2. RESOURCES FOR PRIVACY AND CONFIDENTIALITY

Please also see “[General Resources](#)” section

- Greenbaum, J., McClure, R. C., Stare, S., Barnes, W., Castles, C. E., Culliton, E. R., & et al. (2021). Documenting ICD codes and other sensitive information in electronic health records: Guidelines for healthcare professionals who encounter patients with a history of human trafficking or other forms of violence. Available at <https://www.icmec.org/healthportal-resources/topic/research-and-resources-child-sexual-abuse-exploitation-and-trafficking/guidelines-protocols-for-child-sexual-abuse-exploitation-trafficking/>; accessed on 2/22/22.
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3. RESOURCES FOR COMMUNICATION

Please also see “[General Resources](#)” section

- Top 10 Tips for Effective Communication with Children/Youth, available at <https://cdn.icmec.org/wp-content/uploads/2022/02/Effective-Communication-Top-10-tips.pdf>; accessed on 2/23/22.
- National Committee for Quality Assurance. (2016). A practical guide to implementing the national CLAS standards: For racial, ethnic and linguistic minorities, people with disabilities and sexual and gender minorities. Available at <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf> ; accessed on Nov 29, 2020.
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4. RESOURCES FOR STAFF PROFESSIONAL CONDUCT

Please also see “[General Resources](#)” section

- Humphrey, H. J., Levinson, D., Nivet, M. A., & Schoenbaum, S. C. (2020). Addressing harmful bias and eliminating discrimination in health professions learning environments: An urgent challenge. *Academic Medicine*, 95, 51-53.
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5. RESOURCES FOR INTERPRETER SERVICES

Please also see “[General Resources](#)” section

- Human Trafficking Task Force e-Guide, Interpreters. Available at <https://www.ovcttac.gov/taskforce-guide/eguide/3-operating-a-task-force/34-addressing-common-operational-challenges/interpreters/>; accessed on 3/4/22.

6. RESOURCES FOR CHILDREN

Please also see “[General Resources](#)” section

- National Association of Pediatric Nurse Practitioners (NAPNAP) resources: <https://www.napnappartners.org/provider-public-resources> <https://www.napnap.org/human-trafficking-prevention/> <https://ce.napnap.org/3-parrt>
- VanGraafeiland, B., Chiocca, E., Perks, D., Dietzman, H., Horner, H. (2022). Overview of Recognition and Prevention of Child Sex Trafficking in the Primary Care Setting: A Primer for Nurse Practitioners. *The Journal for Nurse Practitioners*, 18, 285-288. <https://doi.org/10.1016/j.nurpra.2021.12.010> Forkey, H., Szilagyi, M., Kelly, E. T., & Duffee, J. (2021). Trauma-Informed Care. *Pediatrics*, 148(2), e2021052580. doi:10.1542/peds.2021-052580
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- Top 10 Tips for Effective Communication with Children/Youth, available at <https://cdn.icmec.org/wp-content/uploads/2022/02/Effective-Communication-Top-10-tips.pdf>; accessed on 2/23/22
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- National Human Trafficking Training and Technical Assistance Center, US Department of Health and Human Services, O.T.I.P., US Department of Health and Human Services, S. C. G., HEAL Trafficking, International Centre for Missing and Exploited Children, & National Association of Pediatric Nurse Practitioners. (2021). Core competencies for human trafficking response in health care and behavioral health systems. Available at <https://nhhtac.acf.hhs.gov/resource/report-core-competencies-human-trafficking-response-health-care-and-behavioral-health>; accessed on Mar 6, 2021.
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- National Committee for Quality Assurance. (2016). A practical guide to implementing the national CLAS standards: For racial, ethnic and linguistic minorities, people with disabilities and sexual and gender minorities. Available at <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf> ; accessed on Nov 29, 2020.
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7. RESOURCES FOR ISSUES RELATED TO GENDER ROLES, GENDER IDENTITY AND SEXUAL ORIENTATION

Please also see “[General Resources](#)” section

- Free coursera ‘e’ courses: International Women’s Health and Human Rights: Introduction to sex work and sex trafficking. Available at <https://www.coursera.org/lecture/womens-health-human-rights/introduction-to-sex-work-and-sex-trafficking-iyNTI>; accessed on 3/6/22.
- Confronting Gender Based Violence: Global Lessons for Health care Workers. Available at <https://www.coursera.org/learn/gender-based-violence>; accessed on 3/6/22.
- UNODC, E4J University Module Series: Integrity and Ethics, Module 9: Gender Dimensions of Ethics: Ethics of Care and Feminism. Available at <https://www.unodc.org/e4j/en/integrity-ethics/module-9/index.html> ; accessed on 3/6/22.
- National Human Trafficking Training and Technical Assistance Center, US Department of Health and Human Services, O.T.I.P., US Department of Health and Human Services, S. C. G., HEAL Trafficking,

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- National Child Traumatic Stress Network. Many resources regarding LGBTQ youth and trauma. Available at <https://www.nctsn.org/what-is-child-trauma/populations-at-risk/lgbtq-youth>; accessed on 2/24/22.
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- ECPAT USA. And Boys Too: An ECPAT-USA discussion paper about the lack of recognition of the

commercial sexual exploitation of boys in the United States. 2013 Available at <https://d1qkyo3pi1c9bx.cloudfront.net/00028B1B-B0DB-4FCD-A991-219527535DAB/1b1293ef-1524-4f2c-b148-91db11379d11.pdf>; Accessed on 3/6/22.

- Supporting the reintegration of trafficked persons: A guidebook for the Greater Mekong Sub-Region (2017): Available at <https://nexushumantrafficking.files.wordpress.com/2017/04/final-reintegration-guidebook-gms.pdf>; accessed on 3/6/22 .

8. RESOURCES FOR RACIAL/ETHNIC/RELIGIOUS/POLITICAL/CULTURAL MINORITIES AND MIGRANT INDIVIDUALS

Please also see “[General Resources](#)” section

- WHO’s contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Health and freedom from discrimination. Health & Human Rights Publication Series, Issue No 2. Available at http://apps.who.int/iris/bitstream/handle/10665/66891/WHO_SDE_HDE_HHR_01.2.pdf?sequence=1.
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9. RESOURCES FOR SAFETY

Please also see "[General Resources](#)" section

- Guidelines for preventing workplace violence: For healthcare and social service workers. Available at <https://www.osha.gov/sites/default/files/publications/osh3148.pdf>; accessed on 3/3/22.
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10. RESOURCES FOR MENTAL HEALTH STAFF TRAINING/SUPERVISION

Please also see “[General Resources](#)” section

- National Human Trafficking Training and Technical Assistance Center, US Department of Health and Human Services, OTIP US Department of Health and Human Services, S. C. G., HEAL Trafficking, International Centre for Missing and Exploited Children, & National Association of Pediatric Nurse Practitioners. (2021). Core competencies for human trafficking response in health care and behavioral health systems. Available at <https://nhttac.acf.hhs.gov/resource/report-core-competencies-human-trafficking-response-health-care-and-behavioral-health>; accessed on Mar 6, 2021.
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See also, “[Protocols](#)” section for additional guidance. Please also see “[General Resources](#)” section.

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Please also see “[General Resources](#)” section

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SECTION V

Community Directory of Resources



PROFESSIONAL INTERPRETERS

	LANGUAGE	NAME OF INTERPRETER/SERVICE	CONTACT INFORMATION
LIST MOST COMMON LANGUAGES ENCOUNTERED			

ANTI-TRAFFICKING SERVICE ORGANIZATIONS

	NAME OF ORGANIZATION/ SERVICE	CONTACT INFORMATION	HOURS OF OPERATION
TYPE OF ORGANIZATION/ SERVICE			

LOCAL SERVICE ORGANIZATIONS			

NATIONAL ANTI-TRAFFICKING ORGANIZATIONS			

HOTLINES

TYPE OF ORGANIZATION/SERVICE	NAME OF ORGANIZATION/SERVICE	CONTACT INFORMATION	HOURS OF OPERATION
ANTI-TRAFFICKING HOTLINE			
SUICIDE HOTLINE			
CHILD HOTLINE			
FAMILY VIOLENCE			
MISSING PERSONS			

SHELTERS/HOUSING

TYPE OF ORGANIZATION/SERVICE	NAME OF ORGANIZATION/SERVICE	CONTACT INFORMATION	LENGTH OF STAY PERMITTED
CHILDREN'S SHELTER			
SHELTER FOR ADULTS WITH A HISTORY OF HT/E			
OTHER ADULT SHELTER (E.G., DOMESTIC VIOLENCE; HOMELESS)			
SHELTER FOR MALES			
SHELTER FOR TRANSGENDER YOUTH/ ADULTS			
MIGRANT AND REFUGEE SHELTER			
FOOD ORGANIZATIONS			

HEALTH AND MENTAL HEALTH SERVICES

TYPE OF ORGANIZATION/SERVICE	NAME OF ORGANIZATION/ SERVICE	CONTACT INFORMATION	HOURS OF OPERATION
LOCAL HOSPITAL			
CHILDREN'S HOSPITAL			
TRAUMA CENTER			
HT/E HEALTH CLINIC			
MIGRANT/REFUGEE CLINIC			
PEDIATRICS CLINIC			
REPRODUCTIVE HEALTH CLINIC AND OUTREACH SERVICES			
TERMINATION OF PREGNANCY SERVICES (WHERE LEGALIZED)			
FREE HEALTH CLINIC			
SUBSTANCE ABUSE TREATMENT CENTER (DRUGS, ALCOHOL)			
MOBILE CLINIC, OUTREACH SERVICES			
OBSTETRICS AND GYNECOLOGY			
PSYCHIATRIC HOSPITAL			
CLINIC WITH TRAUMA-FOCUSED MENTAL HEALTH SERVICES			
GENERAL MENTAL HEALTH CLINIC			
PEDIATRIC MENTAL HEALTH CLINIC			
THERAPISTS, COUNSELORS, PSYCHOLOGISTS			
TRADITIONAL HEALERS			

RELATED SERVICE ORGANIZATIONS

TYPE OF ORGANIZATION/SERVICE	NAME OF ORGANIZATION/ SERVICE	CONTACT INFORMATION	HOURS OF OPERATION
MIGRANT/REFUGEE ORGANIZATIONS			
FAMILY VIOLENCE ORGANIZATIONS			
LGBTQ+ ORGANIZATIONS			
VULNERABLE CHILDREN ORGANIZATIONS			
RIGHTS ORGANIZATIONS (E.G., CHILD, WOMEN, LABOUR, HUMAN RIGHTS)			

LEGAL AND IMMIGRATION SERVICES

TYPE OF ORGANIZATION/SERVICE	NAME OF ORGANIZATION/ SERVICE	CONTACT INFORMATION	HOURS OF OPERATION
LEGAL AID ORGANIZATIONS			
IMMIGRATION LAWYERS			
MIGRANT/REFUGEE ORGANIZATIONS			

EMBASSY AND CONSULAR OFFICES

TYPE OF ORGANIZATION/SERVICE	NAME OF ORGANIZATION/ SERVICE	CONTACT INFORMATION	HOURS OF OPERATION
EMBASSY/CONSULAR OFFICES FOR MOST COMMON POPULATIONS OF TRAFFICKED PERSONS			

INTERNATIONAL ORGANIZATIONS

TYPE OF ORGANIZATION/SERVICE	WEBSITE	CONTACT INFORMATION	
UNICEF	https://www.unicef.org/		
INTERNATIONAL LABOUR ORGANIZATION	https://www.ilo.org/		
UNITED NATIONS OFFICE ON DRUGS AND CRIME	https://www.unodc.org/		
UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS	https://www.ohchr.org/EN/pages/home.aspx		
UN REFUGEE AGENCY (UNHCR)	http://www.unhcr.org/en-us/		
WORLD HEALTH ORGANIZATION	www.who.int/		
SAVE THE CHILDREN	https://www.savethechildren.net/		
OTHER INTERNATIONAL AGENCIES			



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