Child Labor and Sex Trafficking

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EDUCATION GAPS

To recognize and appropriately respond to trafficked children and those at risk for exploitation, pediatricians need basic knowledge of the dynamics and health impact of human trafficking and familiarity with the rights-based, trauma-informed approach to care.

OBJECTIVES *After completing this article, readers should be able to:*

1. Recognize risk factors and potential indicators of child labor or sex trafficking.
2. Screen for risk of exploitation and provide universal education and resources.
3. Apply trauma-informed, rights-based strategies when working with vulnerable patients.
4. Work with trafficked patients to determine future safety and health needs.

ABSTRACT

Regardless of their practice setting or subspecialty, pediatricians are likely to encounter children who have experienced sex or labor trafficking or who are at risk for exploitation. Only 24.1% of health professionals in one study reported receiving previous training on human trafficking; after a brief presentation on the topic, 39.6% indicated that they knew or suspected they had cared for a trafficked person in the past 3 months. Trafficked and exploited children can present with myriad physical or mental health conditions; most have experienced repeated, significant trauma; and few are likely to spontaneously disclose their exploitative situation. As a result, clinicians face challenges in recognizing and appropriately responding to potential human trafficking. Knowledge of common risk factors and potential indicators of exploitation can assist the pediatrician in recognizing affected and at-risk youth. However, health professionals report that existing training tends to focus on general information about trafficking, with relatively little time spent discussing the specifics of the trauma-informed approach to patient interactions. Given the critical importance of building patient trust, empowering patients to

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ABBREVIATIONS

ATD	antithyroid drug
COVID-19	coronavirus disease 2019
CSEC	commercial sexual exploitation of children
EHR	electronic health record
LGBTQ+	lesbian/gay/bisexual/transgender/queer/questioning/other
SSCST	Short Screen for Child Sex Trafficking
STI	sexually transmitted infection

share their concerns, and engaging them in their own care and safety planning, this article focuses on the practical aspects of working with trafficked and exploited children. A brief overview of human trafficking is followed by an extensive discussion of rights-based, culturally sensitive, trauma-informed strategies for interacting with vulnerable patients.

DEFINITIONS AND EPIDEMIOLOGY

Increasingly, views of human trafficking are expanding beyond a focus on the legal implications to an understanding of severe exploitation as a public health crisis. (1)(2)(3) Such a viewpoint emphasizes the health effect on individuals, families, communities, and societies and stresses the importance of human trafficking prevention using rigorous scientific methods to build a strong evidence base. (4) A public health approach to human exploitation includes an important role for the pediatrician.

Child trafficking occurs when a person engages a child (<18 years of age) in a sex act involving an exchange for something of perceived value (sex trafficking) or compels a minor to perform forced labor. (5)(6) Although elements of force, fraud, or coercion are necessary to demonstrate child labor trafficking, none of these means are required to consider a child a victim of sex trafficking. A term closely related to child sex trafficking is *commercial sexual exploitation of children (CSEC)*, which describes the involvement of a minor in any kind of sexual act in exchange for something of perceived value or for the financial benefit of another. (7) Examples of child trafficking are given in Table 1. References to these examples of Daraja, Kya, and Les appear throughout the article to illustrate certain points. Definitions of terms related to child labor and forced labor are available elsewhere. (8)(9)

The prevalence of child trafficking and CSEC is difficult to determine due to underrecognition and underreporting, differences in definitions of key terms, variations in state statutes, and lack of a centralized database. (10)(11)(12)(130) The International Labour Organization estimated that 4.5 million children around the world were subjected to forced labor in 2016, approximately 1 million of whom experienced CSEC. (14) In a nationally representative sample of US adolescents and young adults, 4.9% reported ever exchanging sex for money or drugs. (15) Children in the United States can be exploited in prostitution or in the production of child sexual abuse materials (formerly called child pornography). (16) They might be induced to work in commercial sex venues such as strip clubs or bars and restaurants where sex is sold (eg, cantinas). (17) Commonly identified sectors involving forced child labor include construction, domestic work, food services, the hospitality industry, health and beauty, agriculture and animal husbandry, door-to-door sales, begging and peddling, and illicit activities such as petty theft and drug sales. (8)(18)(19)(20)(21)(22)

There is reason to believe that human trafficking and exploitation could be increasing during the coronavirus disease 2019 (COVID-19) pandemic. (23)(24)(25) Measures undertaken to mitigate the spread of the virus, including school and business closures, lockdowns, and travel restrictions, have led to increased isolation of at-risk persons, loss of income (especially for those working in low-paying jobs and in the informal economy or sector), decreased access of at-risk children to those who can identify and report exploitation, and decreased services to victims and vulnerable populations. (23)(26)(27)(28) Anxiety and stress related to the pandemic can increase the risk of trafficking by exacerbating mental health issues in parents and children, exposing children to increased violence in the home, and increasing unsupervised online screen time. (29)(30)

Risk factors for child trafficking and CSEC can be identified at the individual, relationship, community, and societal levels, as is demonstrated in the Figure. (31) Among Daraja's risk factors for child labor are familial poverty, limited education, her unaccompanied minor status, and, very likely, xenophobia by her employer. Les' vulnerability to sex trafficking lies with his history of sexual abuse, family dysfunction, and recent parental unemployment, and Kya is at increased risk for child labor and sex trafficking owing to her runaway status, gang affiliation, lack of community support in her neighborhood, and the pervasive presence of community violence.

Gender roles and expectations for boys to be strong, independent, and invulnerable can help explain a marked underrecognition of boys as targets of sexual exploitation and trafficking. (32)(33)(34)(35) In light of these cultural expectations, boys might be particularly reluctant to acknowledge their victimization (to themselves or others), and professionals might fail to consider the possibility and thus miss possible indicators. (36)(37) The tendency to overlook boys as potential victims of sexual exploitation can be fueled in part by existing human trafficking reports that cite females as the dominant gender within populations of

Table 1. Examples of Child Trafficking and Exploitation

TRAFFICKING TYPE	EXAMPLE	MEANS USED (F/F/C)
Labor	Daraja, a 16-year-old Nigerian girl, is sent to the United States by her uncle to work as a part-time housekeeper for a wealthy family. He promises her she will be able to attend school and send money home to her family. When she arrives, her employer confiscates her passport and visa; she is made to work 12–14 hours/day and not allowed to attend school or leave the home. She is told that if she tries to leave, her employer will have her deported. She receives no payment for her services.	Fraud, coercion
Sex	Les is a 9-year-old white boy whose father has sexually abused him for 2 years. The father recently lost his job during the pandemic and has begun inviting "friends" to the home to have sex with Les. In addition, he has Les perform sex acts in front of a webcam, at the direction of online "buyers." If Les refuses, he is beaten and threatened with abandonment.	None is needed per law, but force and coercion are present
Sex and labor	Kya is a 14-year-old African American female with a history of sexual and physical abuse who has run away from home several times. She begins spending time with local gang members who tell her that if she wants to "be" with them she must sell sex at a nearby motel. They also have her sell drugs to the sex buyers. She is very uncomfortable doing these things but fears physical violence and harm to her family if she refuses.	Coercion

F/F/C=force/fraud/coercion.

trafficked persons (13) and by a narrow focus of the general public on the sexual exploitation of girls. However, in a study of sex trafficking among homeless and runaway youth receiving services in 3 American cities, 31% of those reporting exploitation were male. A 10-city study of homeless youth receiving services from Covenant House demonstrated rates of 11%, 9%, and 16% for cisgender males (those who identify as male and were assigned male sex at birth) experiencing sex, labor, or any type of trafficking, respectively. (21) In a prevalence study of CSEC in New York City, 53.5% of the estimated 3,946 youth involved in exploitation were boys. (10)

Youth belonging to gender and/or sexual minority groups are at increased risk for homelessness (38)(39) and commercial sexual exploitation. (40) Research indicates that relative to their heterosexual, cis-gender peers, lesbian/gay/bisexual/transgender/queer/questioning/other (LGBTQ+) persons are more likely to experience substance use/misuse, violence at the hands of peers, and sexual or physical abuse; they are also more likely to run away from home and participate in transactional sex. (41)(42) Widespread homophobia and transphobia marginalize groups of youth, alienate them from family and peers, limit employment opportunities, and condone violence and discrimination. (43)

Although numerous risk factors for child trafficking have been identified, (44) it is important to remember that some exploited children have no obvious risk factors and may seem to be living "normal" lives in stable homes and supportive communities. Trafficking may occur across socioeconomic, ethnic, racial, cultural, and religious groups and involve all genders and sexual orientations.

DYNAMICS OF HUMAN TRAFFICKING

In many cases, trafficking involves a third party, over and above the trafficked individual and the "buyer." (45) Sometimes multiple individuals are involved in organizing and managing a trafficking organization; these groups can be highly sophisticated in their methods of recruitment, transportation, manipulation, and control of victims. (57) Traffickers can be family members (58) or other relatives, (59) intimate partners, (45)(59) peers, (60) employers (59) or strangers.

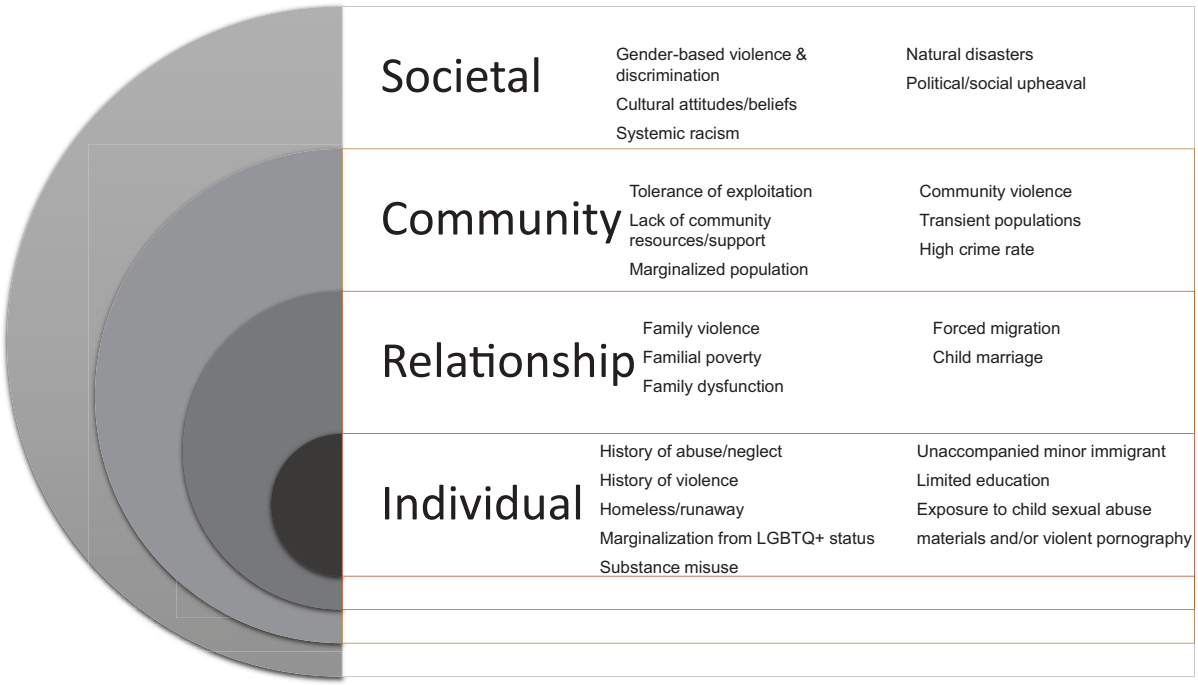


Figure. Risk factors for child trafficking and exploitation. (21)(43)(46)(47)(48)(49)(50)(51)(552)(53)(54)(55)(56) LGBTQ+=lesbian/gay/bisexual/transgender/queer/questioning/other.

They can be male or female. (13)(61) Some are respected community members. Often traffickers are from the same country as the trafficked person, but sometimes they are based in the destination country. (13)

Recruitment techniques vary (18)(56)(59)(62) but often involve false promises of romance or a "better life," fraudulent job opportunities, exciting career options, or offers of financial assistance that entrap vulnerable persons so that debts cannot be repaid (debt bondage). There might be offers of "free" assistance for a youth needing help, with the subsequent demand of "repayment." Some youth are "recruited" through use of violence and abduction. Control over a trafficked or exploited child can be maintained through psychological manipulation, apparent fulfillment of a child's need for attention and love, fear, shame, guilt, threats, blackmail, deception, and/or force. (59)(60) Many exploited persons do not recognize their situation as exploitative owing to the intense manipulation characterizing the relationship with their trafficker, lack of familiarity with a new culture and local laws, intentional misinformation from a trafficker, or an acceptance of cultural views condoning inequality and discrimination. (52)(63) This can lead children to remain in exploitative circumstances for days to years and to return to a trafficking situation multiple times before successfully extricating themselves from harmful conditions. (60)

HEALTH IMPACT AND CLINICAL PRESENTATION

Numerous studies in the United States and abroad consistently demonstrate significant adverse medical and mental health conditions related to labor and sex trafficking, including increased risk of sexually transmitted infections (STIs), human immunodeficiency virus/AIDS, unwanted pregnancy and pregnancy-related complications, work-related accidental injury, physical or sexual assault, weight loss, chronic pain, poorly managed chronic health conditions, posttraumatic stress disorder and complex posttraumatic stress disorder, depression with suicidality, substance use/misuse, anxiety disorders, behavioral problems (eg, hostility, aggression) and others. (54)(64)(65)(66)(67)(68)(69)(70)(71)(72) In a study of adolescents who experienced trafficking, 47% were found to have an STI at the time of identification, and 32% reported a history of pregnancy. (73) Depending on the occupational sector, labor-trafficked persons can be subjected to temperature extremes, noxious fumes/dust, toxic chemicals, and flying debris. (9)(63)(74) Any of these conditions can prompt an exploited child to seek health or mental health care.

Studies in the United States suggest that many trafficked youth and adults seek medical or mental healthcare close to and during the period of their exploitation. In a study of adolescent/young adult trafficked persons, 82.5% were seen at the local children's hospital within the year before identification. (75) In another study of sex-

trafficked adolescent girls, 42.9% had received health-care in the 2 months before identification. (76) Care can be sought in virtually any health-care setting. In a study of adolescent and adult females receiving services after human trafficking, 63% went to a hospital or emergency department, 57% attended an outpatient clinic, 30% visited Planned Parenthood, and 23% were treated by their primary care physicians. (77)

There is no "typical" presentation for a trafficked or exploited child. These children might seek care alone or with peers (perhaps all requesting STI testing); they can present with a parent (who may or may not actually fulfill that definition), another relative, or an acquaintance. They might be accompanied by a work site manager or employer. Care can be sought in virtually any health-care setting. (77) Again referring to the examples in Table 1, Daraja might be taken to an emergency department by her employer for treatment of an accidental injury; Les might be brought to his pediatrician by his mother for nightmares, loss of appetite, and vague stomach pain related to traumatic stress; and Kya might seek termination of a pregnancy at a Planned Parenthood clinic, arriving with an older male who claims to be an uncle.

Recent systematic literature reviews have identified numerous barriers faced by trafficked and at-risk persons when seeking health-care (Table 2), (78)(79) including challenges in accessing health-care systems, disclosing information related to exploitation, and obtaining needed services. (80)(81)(82) Daraja's employer might be reluctant to bring her for medical care and does so only when health issues are extreme. Daraja might fear arrest and deportation if she reveals her situation to health-care staff. She might be unaware of her legal rights, and her clinician might be unfamiliar with relevant labor laws and opportunities for assistance when labor exploitation is suspected. Kya might anticipate discrimination by health-care staff, who might view her as a "troubled youth," a "runaway," a "fast" child (quick to engage in sexual activities) who identifies with gangs and "gets herself into trouble." If she presents to a clinic or hospital she might be reluctant to disclose any personal information. Should staff harbor the views that Kya fears, their biases might prevent them from considering exploitation, asking appropriate questions, and offering critical services

Of note, many barriers to care fall under the control of health professionals and health-care organizations. (78) Importantly, many staff lack training on human trafficking and trauma-informed strategies for care. (1)(83)(84) When a provider engages in trauma-informed care the provider acknowledges the impact of trauma on a patient, family, and community; considers this impact when working with patients; and recognizes and responds appropriately to the signs of trauma, making every effort to avoid repeated traumatization. (85) Previous studies indicate that 62% to 89% of health-care professionals surveyed reported no previous training on trafficking. (1)(84)(87) In a recent study of health professionals, 75.9% reported no history of training, and of those who had attended training, the topic of trauma-informed care was the least often covered (21.4% frequency). (1)

Lack of knowledge of screening tools and potential trafficking indicators, as well as discomfort with broaching sensitive topics, can lead a provider to avoid discussion of exploitation and focus only on the medical condition at hand rather than on issues contributing to its presence. In turn, many health-care facilities lack protocols that guide clinicians to identify high-risk patients, assess for needs, and offer services. (87) There might be no organized approach to identifying relevant community services and connecting youth to these organizations. This lack of multidisciplinary collaboration makes it

Table 2. Health-care Barriers for Trafficked Persons (77)(78)(79)(80)(90)(91)(92)

LEVEL OF PATIENT	LEVEL OF PROVIDER	LEVEL OF HEALTH SYSTEM
Fear to seek care or disclose information (concerns of trafficker retribution, confidentiality breach, arrest, deportation, unwanted diagnosis, etc)	Discomfort with topic of human trafficking; lack of training	Lack of protocols for recognizing/ responding to suspected exploitation
Concern about being judged, stigmatized by staff	Lack of knowledge of community resources for trafficked and at-risk patients	Lack of services (eg, mental health, interpreter)
Distrust of authority	Fear of bringing harm to patient	Long wait times, restricted hours
Shame regarding exploitation	Bias/discrimination	Inadequate time for individual patient care
Feels needs are minimized	Fear of compromising patient confidentiality	Lack of organized system for making community referrals
Cultural and language barriers	Lack of trauma-informed approach	
Strong sense of self-reliance		
Lack of recognition of exploitation		
Prevented by trafficker from accessing care		

extremely difficult to initiate a holistic response that addresses the myriad needs of trafficked children. When adequate resources are not offered, exploited patients lose a critical opportunity for assistance.

Fortunately, resources exist to address many of the barriers to care involving providers and health-care facilities. (86)(93)(94) HEAL Trafficking, a network of professionals interested in addressing human trafficking through a public health lens, offers a compendium of online human trafficking training curricula for health professionals (https://healtrafficking.org/resources/compendium-of-educational-and-training-resources-for-health-professionals/), and the Office on Trafficking in Persons offers online and on-site training in its SOAR to Health and Wellness initiative (https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training). Toolkits to assist health administrators and providers in creating protocols and guidelines for human trafficking are available, (95)(96)(97) as are online health portals with screening tools and libraries of resources. (98)(99) Hansen et al developed an interactive, 75-minute online child sex trafficking training module for health professionals and medical students. (100) In a 3-month posttraining survey, 89% of students and 94% of providers reported that the curriculum had influenced their practice moderately or a great deal. 100) These and other online resources and training opportunities can be especially helpful during conditions such as the COVID-19 pandemic, when professional conferences might be canceled or postponed.

Given patient constraints on disclosure, such as potential shame, distrust, fear, feelings of guilt, and lack of perception of exploitation, it falls on the clinician to identify potential red flags for child trafficking. Although none are pathognomonic for exploitation and trafficked patients can present with no obvious indicators, there are several conditions that can alert health professionals to the possibility of exploitation. (101)(102) If Daraja is brought to the emergency department by her employer/trafficker, that person may well try to dominate the conversation with medical staff, answer questions directed at Daraja, and resist leaving her alone in the room with health professionals. (88)(103) That person might seem to know very little about her or not even speak her language. She, in turn, might appear intimidated, anxious, or fearful. If Kya's gang-involved traffickers decided to bring her to another city where gang affiliates rotate exploited youth, she can end up in an emergency department for care and not be able to tell staff what city she is in or where she is staying. She might give false information about her age or her relationship with her companion, or she might provide inconsistent explanations for her injuries. It might be that the provider becomes concerned about possible exploitation due to the nature of the patient's chief complaint. (73) Kya might present for STI testing and report a history of chlamydia, Les might be brought in for care after an acute sexual assault, and Daraja might have chronic pain from overuse injuries. Other trafficked children might present for behavioral health issues (especially suicidality), complications of substance use, or work-related injuries. (104)(105)(106) Heavy use of alcohol and/or drugs can serve as a risk factor for exploitation, but substance use can also begin or increase during the period of trafficking. This can be due to a trafficker or buyer encouraging or coercing consumption, (17) or it can be a result of the child self-medicating as a method of coping with extreme stress in his or her environment. (107) Traffickers might use drugs to manipulate and control exploited children. (45) In addition, drugs such as amphetamines or cocaine can assist a child in working long hours with little sleep. Regardless of the underlying causes, multidrug use (73) and substance misuse are common. (104) Other potential indicators of trafficking can be identified on physical examination and are listed in Table 3.

Limited child trafficking screening tools designed for the health-care setting are available. (73)(108)(109) The Short Screen for Child Sex Trafficking (SSCST) is a 6-item tool assessing risk of commercial sexual exploitation that has been validated for 11- to 17.99-year-old adolescents seeking care in pediatric emergency departments, teen clinics, and child advocacy centers (the latter provide services for maltreated children). (111)(112) The SSCST

Table 3. Potential Indicators of Trafficking/Exploitation Noted on Physical Examination (110)

Evidence of malnutrition
Untreated chronic disease or injury
Signs suspicious for assault (eg, acute or healed injuries in protected areas of the body such as the neck, torso, genitalia, and medial thighs)
Tattoos of gang insignia, street names, or sexual innuendo
Foreign body in vagina (not tampon)
Sad, flat, withdrawn affect
Hostile or suspicious attitude
Extreme anxiety

questions are listed in Table 4. The SSCST has not been validated in the LGBTQ+ population or with foreign national children and does not screen for risk of labor trafficking. If a patient answers affirmatively to 2 or more questions regarding risk factors for sexual exploitation, they are identified as being at risk for trafficking. Follow-up open-ended questions are needed to further assess risk and determine patient needs as well as the need for mandatory reporting. Importantly, the tool screens for risk of exploitation rather than querying whether a patient actually meets the criteria to fulfill the federal definition of child trafficking. This helps to limit retraumatization. Although a child might feel very reluctant to disclose exploitation, per se, or might not be cognizant of it, he or she might feel less anxious when asked questions about reproductive health, substance use, and other high-risk behaviors because such questions are not unusual in the medical setting. It is important to keep in mind that the clinician does not need to be certain that trafficking has occurred to determine what services might be indicated and whether a mandatory report is appropriate. As with other forms of child maltreatment, mandatory reporting requires that the reporter have a reasonable degree of certainty that the crime has occurred. A clear disclosure of exploitation/trafficking is not required, and extended probing with sensitive questions to achieve a disclosure can traumatize the patient.

Another short screening tool is available for young adults, although it has not yet been validated in a healthcare setting. The Quick Youth Indicators of Trafficking (Table 5) screens for labor and sex trafficking among homeless young adults receiving services. (113) A single positive answer to any of the 4 questions indicates that the

Table 4. Short Screen for Child Sex Trafficking (73)(111)(112)

Suggested introduction: "Hello. We often ask teens some questions to find out a little more about what is going on in their lives. It helps us understand more about how we might be able to offer help. Some of the questions are sensitive and may make you feel uncomfortable so it is important to know that *you do not have to answer the questions if you don't want to.* If you decide to answer them, it will help us with your evaluation. Answers to some of the questions may be included in your general medical record. I am generally able to keep what you tell me private (or confidential). There are two exceptions to this. The first is if you tell me there is a threat to your safety or the safety of someone else. The second is if we are required by law to share information in our medical record. Do you understand these exceptions? If not, please ask us and we are happy to explain."
Give the child the questionnaire, or ask the questions outside the presence of the person(s) accompanying the child if at all possible.
Screening questions:
Have you ever broken any bones, had any cuts that required stitches, or been knocked unconscious?[a] ___No ___ Yes
Some kids have a hard time living at home and feel that they need to run away. Have you ever run away from home? __ No ___ Yes
Kids often use drugs or drink alcohol, and different kids use different drugs. Have you used drugs or alcohol in the last 12 months? __ No ___ Yes
Sometimes kids have been involved with the police. Maybe for running away, for breaking curfew, for shoplifting. There can be lots of different reasons. Have you ever had any problems with the police? __ No ___ Yes
If you have had sex before, how many sexual partners have you had? __ 0 partners __ 1–5 partners __6–10 partners __ >10 partners
Have you ever had a sexually transmitted disease (STD), like herpes or gonorrhea or chlamydia or trichomonas? __ No ___ Yes

[a]Data from a recent study suggest that altering question 1 improved specificity by nearly 10%, whereas sensitivity remained stable. The altered form of the question is: "Have you ever been knocked unconscious?" (ie, eliminate mention of fractures and cuts). (112)

Scoring the questionnaire:

Question 5 is considered positive if the child reports more than 5 sexual partners.

Positive answers to 2 or more questions is considered a positive screen (eg, high risk). *However, further information will be needed to determine whether a child is actually being trafficked.* Additional information can be obtained by the provider or by a designated staff member with trauma training. The provider should keep in mind that the ultimate goal is not to obtain a disclosure of trafficking but to determine the level of risk and relevant patient needs so that appropriate resources can be offered based on the information available. Additional information about risk might be available from other sources (patient record, other staff).

Sample follow-up questions to help assess level of risk:

Follow up on any screening question that was answered in the affirmative. When possible, use open-ended questions, such as, "Do you feel comfortable telling me about it?"

Has a boyfriend, a girlfriend, or anyone else ever asked you to do something sexual with ***another*** person (including oral sex, vaginal sex, or anal sex with someone else)? __ No __ Yes

Do you feel comfortable telling me about it? _____

Has anyone ever asked you to do some sexual act in public, like dance at a bar or a strip club? __ No __ Yes

Do you feel comfortable telling me about it? _____

Sometimes kids are in a position where they really need food, clothing, a place to stay, or they want to buy something for themselves or someone else but they do not have money so they have to exchange sex for what they need. Have you ever been faced with a situation like that? __ No __ Yes

Do you feel comfortable telling me about it? _____

Has anyone ever asked you to pose in a sexy way for a photo or a video? __ No __ Yes

Do you feel comfortable telling me about it? _____

person is at risk for trafficking, and a follow-up assessment is indicated.

As a supplement to screening (ideally) or as a standalone measure, clinicians can choose to offer universal education and resources to their patients. (101) This strategy involves providing every patient with a brief (~5-minute) summary of key information regarding healthy relationships, the impact of violence on health, the concept of exploitation, and some key community and national resources. (114) It has been used successfully in women experiencing intimate partner violence and reproductive coercion. (115) Typically, the provider uses a small brochure to summarize the information and offers 1 to 2 copies to the patient for use themselves or to give to someone they know. The advantage to this strategy is that the provider is not asking sensitive questions of the patient and the individual does not need to discuss any risk factors or uncomfortable situations in their lives. Instead, they receive information they can use at any time. (114) Although it does not allow the practitioner to identify individual, specific risk factors that can inform recommendations for referrals, it does provide each patient with general information that can be quite helpful. Universal education and resources can also be used when a validated screening tool is not available for a given population.

Whether a pediatrician decides to use a specific screening tool, universal education/resources, or both strategies, preparation is important. One should not screen for exploitation if one has no resources to offer patients affected by trafficking or those at risk. Therefore, a community mapping exercise might be needed to identify existing organizations and agencies providing care to trafficked persons and those at risk. These include not only antitrafficking organizations but also groups that provide services addressing the myriad vulnerabilities that are associated with exploitation, such as homeless shelters, substance misuse programs, free or low-cost mental health clinics, and support for marginalized LGBTQ+ youth. A periodically updated resource list of these organizations is helpful. So, too, is having a working relationship with staff at the organizations so that the pediatrician is aware of the type and quality of services provided and can make direct phone referrals to agencies from the office or clinic (a warm handoff). (116)

Other factors to consider when contemplating adoption of screening and/or universal education initiatives are the need for privacy and the ability to separate patient from companion, (110)(117) as well as the need for basic staff training on use of the tools. Decisions about who to screen can be driven by the time and resources available in the specific health-care setting. Restricting the screening process to populations frequently identified as high risk (eg, adolescent females) can identify a large proportion of trafficked children but can miss other vulnerable populations that have been less well-studied (eg, boys, transgender youth) and/or those for whom validated screening tools are not yet available (eg, preadolescents). Instead, one might decide to screen according to other criteria, such as type of chief complaint, focusing on health and mental health conditions commonly associated with child trafficking. (112) Having a protocol in place to outline the population to be screened, the resource to be used for universal education, the timing of these activities, and the roles of providers is critical. (95)(96)(97) Delegation of responsibilities can help incorporate the new activity into existing clinical practice.

Screening and universal education are unlikely to be successful if not administered using a trauma-informed, rights-based, and culturally sensitive approach. (85)(118)(119) Using a trauma-informed approach, the clinician is aware of, and sensitive to, the potential influence of previous traumatic experiences on the behavior, beliefs, and attitudes of a patient. (94) A child who has been exploited has likely experienced numerous episodes of trauma during the trafficking

Table 5. Quick Youth Indicators of Trafficking

1. It is not uncommon for young people to stay in work situations that are risky or even dangerous simply because they have no other options. Have you ever worked, or done other things, in a place that made you feel scared or unsafe?
2. Sometimes people are prevented from leaving an unfair or unsafe work situation by their employers. Have you ever been afraid to leave or quit a work situation due to fears of violence or threats of harm to yourself or your family?
3. Sometimes young people who are homeless or who have difficulties with their families have very few options to survive or fulfill their basic needs, such as food and shelter. Have you ever received anything in exchange for sex (eg, a place to stay, gifts, or food)?
4. Sometimes employers don't want people to know about the kind of work they have young employees doing. To protect themselves, they ask their employees to lie about the kind of work they are involved in. Have you ever worked for someone who asked you to lie while speaking to others about the work you do?

An affirmative answer to 1 or more questions indicates a positive screen. This should be followed by a comprehensive assessment for trafficking experiences using the Trafficking Victim Identification Tool, (120) the Human Trafficking Interview and Assessment Measure, (121) or a service provider with trafficking expertise.

period and, in many cases, significant trauma during his or her life before exploitation. (51) In response to this trauma, the child might have developed attitudes of fear and distrust of others, low self-esteem and self-agency, and expectations of harm from others. (122) Kya might begin using drugs or alcohol to cope with the immense stress of sexual exploitation under the control of the gang. She might adopt an attitude of defiance and hostility to defend herself from threatened harm, even in situations where there is no threat. Les might have learned that the only value he has is in his body and that the only way to communicate with others is sexually. These attitudes, beliefs, and behaviors can be manifest in patient interactions with health-care professionals. Kya might lash out at medical staff; Les might say something sexual to the male physician during his examination. If the provider is able to recognize the traumatic origin and the potential function behind these behaviors (ensure survival, seek an emotional or social connection, express a need), it is easier to respond appropriately, using a calm, supportive, nonjudgmental approach. (122)

Trauma-informed care places a heavy emphasis on fostering the patient's sense of safety. (123) Clearly, the presence of a suspected trafficker in the health-care setting threatens the physical safety of the patient and staff and requires careful attention to established safety policies and procedures. But just as important is the need to help the exploited patient feel psychologically safe during the health visit. This can be accomplished by taking several steps:

1. *Separate the patient from his or her companion(s) before asking sensitive questions.* (110) To Daraja's companion one might say, "Here at XYZ clinic we begin each visit by talking with our patients alone, so we can obtain basic information and prepare them for the exam. Daraja, I need you to come with me now; Mr Smith you can stay here in the waiting room and I'll be out to get you in a bit." One is not asking permission; one is informing Mr Smith of the standard clinic practice. (Alternative methods include removing the patient from the presence of the companion by announcing that the child needs to go to the radiology or clinical laboratory department or to the restroom to provide a urine sample. Or the staff may request that the companion leave the examination room to complete additional registration paperwork.)
2. *Establish a sense of privacy and safety.* (85) The provider should use a quiet room that is free from frequent interruptions. The pediatrician might ask about Daraja's basic needs. "Are you warm enough? Would you like a glass of water?" It is important to take time to build rapport by asking nonthreatening questions about the patient's favorite activities, the things they enjoy. (124)
3. *Maintain transparency.* (85)(125) Feelings of anxiety about the unknown and lack of control over a situation can cause tremendous stress. The pediatrician can alleviate much of that stress by being completely transparent about all the steps of the health visit. For example, the pediatrician can explain the purpose of asking sensitive questions and ensure that the patient understands that answering questions is optional. The pediatrician can discuss specific components of the examination, of forensic evidence collection, of diagnostic testing, and of treatment and why each component is recommended before asking permission to proceed with each of these steps. The patient needs to be assured that the patient has control over the situation and can refuse elements of this process (with notable exceptions related to medical emergencies). Transparency implies providing truly informed consent for each step of the visit. This process removes anxiety about the unknown and helps empower the patient to take some control.
4. *Minimize repeated traumatization.* (85)(125) Some clinical procedures might trigger memories of exploitation, so it is important to be sensitive to these possibilities. (116) If Kya has been blackmailed by gang members who video recorded her being sexually assaulted, she might become very anxious if a clinician uses a camera to photograph an injury. Understanding this possibility, the pediatrician can talk to Kya about the need to take a photograph and ask her permission before taking the camera out of the drawer. If she refuses, written descriptions of the injury will suffice for documentation.
5. *Ask only the questions necessary to provide good healthcare.* (110) The clinician should stay focused on questions directly related to safety, health, and the child's well-being and should avoid asking irrelevant questions that could trigger anxiety and distress. Although some potentially traumatizing questions might need to be asked, the pediatrician should be sensitive to body language and word usage that signal patient distress.
6. *Use of a friendly, calm, nonjudgmental tone.* (80)(81)(88)(89)(126)(127) The clinician should avoid any suggestion of blame or shame. It is helpful to listen more than speak and to demonstrate respect for the patient and all that the patient has experienced. Trafficked and exploited children may well expect medical staff to judge them harshly, stigmatize them, and treat

them with open disrespect. It is critical that the staff do not reinforce these expectations but instead demonstrate the respect so often withheld by traffickers and other exploiters.

The United Nations Convention on the Rights of the Child (119) outlines critical human rights for every child. Several of those rights are particularly relevant to the health-care of trafficked children, including the right to respect by others, to information provided in a way that is understandable, and the right to express an opinion. It is critical that a patient have the opportunity to share his or her thoughts and concerns and be empowered to actively engage in his or her health-care. This can be facilitated by asking the child whether there are any questions about what is being discussed or recommended (eg, why collection of forensic evidence is advised) and whether there are any opinions about what services would be helpful after discharge.

The right to confidentiality is of paramount importance to all patients but even more so to those who have experienced exploitation and trafficking. (125) Before beginning to ask sensitive questions it is very important to discuss the limits of confidentiality in the health-care setting. (110) Not only are these limits related to mandatory reporting obligations in which information must be shared with authorities, but they also apply to documentation of sensitive information in the electronic health record (EHR). Clinicians need to be aware of both the benefits and the potential harm involved in this documentation and be familiar with strategies used by their health-care institution and EHR to protect sensitive information. Although information related to health, mental health, and safety is important for continuity of optimal patient care, documentation can increase the risk of certain types of information (eg, STI status, trafficking concerns, substance use) being seen by guardians, traffickers, or others who might gain access to the records, respond negatively, and harm the patient. Many exploited patients are concerned that sharing information about their situation will lead staff to exhibit bias and discrimination; the patients feel shame and humiliation about their circumstances. And they might worry that information in the medical record can be used against them in legal proceedings (eg, child custody hearings, immigration hearings). It is important for patients to realize that despite all efforts on the part of health systems to protect patient confidentiality, a practitioner cannot guarantee and does not have absolute control over who can access confidential information. Even sophisticated protection systems can be designed to allow sensitive information to be shared on the patient portal or with outside actors (eg, payors, legal) and medical staff pursuant to applicable law or policy. Patients need to know about this limitation and about the use of *International Classification of Diseases, Tenth Revision, Clinical Modification* codes regarding human trafficking (128)(129) (Table 6) so that they can make informed decisions about the sensitive information they share. As an example, a provider might say to the patient:

> "I typically include in your health record any information you tell me that I think is important to your health, safety, and well-being. While our clinic takes several measures to protect your confidentiality, other care providers are able to read my notes and I cannot guarantee that other people, including administrators and others, won't get access to at least portions of your records. So, if we talk about something personal that you do not want included in your record please tell me and we can talk about how to handle it." At the end of the visit, the provider can ask, "Is there anything we've discussed that you do not want included in your records?" If the patient identifies information that he or she wants excluded (eg, substance use, commercial sexual exploitation), the pediatrician can explore the concerns the patient has and whether the information is truly necessary to document. If it is information that is important for continuity of care, or is required by law or policy, the provider should explain this to the patient and discuss options for documentation. For example, the clinician may be able to convey important information using abbreviations not typically understood by the lay public or document the information in a "confidential" area of the record that has restricted access. If a child does not want the provider to use the *ICD-10* codes for child sexual exploitation or forced labor, the pediatrician can use alternative codes that describe the medical or mental health condition being treated (eg, insomnia) or the social determinants of health (eg, code Z62—problems related to upbringing).

Among the most important rights of any patient is to receive optimal health-care that is free of bias and discrimination. (119) This is of particular importance when working with exploited children, who often face stigma and bias at many levels. Trafficking and exploitation disproportionately affect persons of color, (15) those identifying as LGBTQ+, (40) and children living on the street. (21) Cultural biases against these groups, as well as against non–US citizens and those living in poverty, can have a profound negative effect on the quality of services available to exploited children. Entrenched social views about prostitution can further jeopardize access to good care. (88)(130) It is extremely important that pediatricians carefully consider their own biases and the ways these

Table 6. *ICD-10-CM* Codes for Human Trafficking (128)

ICD-10-CM CODE/SUBCATEGORY	CODE DESCRIPTION
T74.51[a]	Adult forced sexual exploitation, confirmed
T74.52[a]	Child sexual exploitation, confirmed
T74.61[a]	Adult forced labor exploitation, confirmed
T74.62[a]	Child forced labor exploitation, confirmed
T76.51[a]	Adult forced sexual exploitation, suspected
T76.52[a]	Child sexual exploitation, suspected
T76.61[a]	Adult forced labor exploitation, suspected
T76.62[a]	Child forced labor exploitation, suspected
Y07.6	Multiple perpetrators of maltreatment and neglect
Z04.81	Encounter for examination and observation of victim after forced sexual exploitation
Z04.82	Encounter for examination and observation of victim after forced labor exploitation
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z91.42	Personal history of forced labor or sexual exploitation

ICD-10-CM=International Classification of Diseases, 10th Revision, Clinical Modification.
[a]Subcategories require additional characters to complete the code.
Adapted from the American Hospital Association. Factsheet: *ICD-10-CM* coding for human trafficking. Available at: https://www.aha.org/factsheet/2018-factsheet-icd-10-coding-human-trafficking.

biases can manifest in their work so that they can take steps to manage the expression of these views and remain nonjudgmental and accepting of each patient. (118) It is also important to take action when witnessing bias and discrimination in the health-care setting, to protect patients and staff, and to eliminate any actions that can foster a culture of intolerance and stigmatization.

An example of confronting bias and discrimination in the health-care setting is as follows:

> You are treating 14-year-old Kya, who was brought to the emergency department by police after being identified in a sting operation. You overhear one staff member say to another, "If she hadn't made such bad decisions she wouldn't be in this situation." You turn to this person and say calmly, "I overheard you talking about the patient in room 55 and it made me very uncomfortable. I think this child needs our help and support, not our blame and judgment. We all have our own biases, our own feelings. But we can't let them interfere with providing compassionate care. You're a great clinician who treats your patients with dignity and respect. Can you do that for this one, as well?"

When working with exploited children, a clinician needs to demonstrate respect for, and sensitivity to, cultural differences involving nations, regions, religions, genders, sexual orientation, races, and ethnicities. (118)(119)(125)(131)(132) There is tremendous cultural variation in the US population, but in addition, many trafficked and exploited persons are brought to the United States from other countries. (133) Particularly common origin countries include those in Latin America and Southeast Asia. (133) When working with exploited children, the clinician can encounter a variety of cultural differences that impact provider-patient interactions. (134)(135)(136)(137) For example, a patient might assume a major power differential in his or her relationship with the pediatrician, expecting the clinician to dominate the conversation and make all treatment decisions. The interaction might become awkward when the physician takes a more egalitarian approach, using trauma-informed techniques to encourage the patient to ask questions, voice opinions, and participate in decisions. Gender roles and cultural taboos about sex and sexuality can be extremely important, and respecting a patient's desire for an examiner of a particular gender is advisable whenever possible. (117) Cultural views about sex outside of marriage, prostitution, and gender identity can have a profound effect on how a patient views his or her own situation and describes it to the clinician. (136) Patients can have very different views regarding their life situation (fate versus divine punishment), the cause of their health problems, the acceptable ways to manifest illness, and the ways they expect clinicians to treat their health problems. (118) Emotional distress can be manifest and interpreted in ways that are impacted by cultural views regarding mental health. (136) Discussion of emotions might be taboo in certain cultures; some languages might lack words to describe certain emotions. Although providers cannot be experts in all cultures, an awareness of one's own views regarding these issues, a sensitivity to the words and body language of the patient, and an openness to varied perspectives can vastly improve the nature of patient-provider interactions. When conversations seem to flounder, it can be beneficial to consider whether there are cultural differences in communication styles dictating how direct one is expected to be when speaking with others or how a person is expected to convey

disagreement or doubt. (135) The clinician might consider possible variations in views about the relative importance of the individual versus the family (individualism versus collectivism) (134) and the possibility that simple behaviors may convey very different messages across cultures (eg, lack of eye contact indicating respect versus deception). The clinician can seek help from a professional interpreter, who can assist the clinician in identifying signs of patient distress during an examination or answer questions about the patient's culture. When fluency in English is in doubt, it is advisable to obtain a professional interpreter. The provider should not rely on family members or patient companions to interpret during the medical visit, especially because that person might be involved in a child's exploitation.

Further information about cultural beliefs and practices can come from speaking with leaders and others in the community, talking to staff at relevant community service organizations, such as those serving refugees and asylum seekers, or seeking online resources such as A Practical Guide to Implementing the National CLAS Standards (2016). (137)

If a lucid patient declines to answer questions or participate in care decisions, the clinician should consider possible reasons, including a lack of understanding by the patient (eg, language barrier, cognitive impairment), confusion, fear, anxiety, another emotion, and cultural beliefs and attitudes (see previously herein). There is no correct way to respond, but the provider can be guided by consideration of the patient's human rights and by the trauma-informed approach. That is, the patient's best interest must assume top priority and dictate all actions of providers. The child's right to information that is delivered in a way that the child can understand, the child's right to exercise choice regarding the information the child shares, and the degree to which the child engages in making decisions about care need to be respected. Information needed by the clinician might be available from someone else or in the EHR. Or it might need to be obtained at a later date. The pediatrician might go back and try to build more rapport before asking sensitive questions or might gently ask about how the child is feeling and whether there is something they can do to make the child more comfortable. The child might want to have the companion in the room during the interview, in which case the provider must be very careful about discussing sensitive issues. Ultimately, an empathic, nonjudgmental approach is advised, with respect for the child's choice to remain silent, with good documentation of the visit in the EHR.

EXAMINATION AND DIAGNOSTIC TESTING/ TREATMENT

Clinicians need to comply with relevant laws regarding examination and treatment of a child and the collection of forensic evidence without guardian consent. (110)(138) The trauma-informed, rights-based approach extends to the physical and anogenital examinations, diagnostic evaluation, and treatment plans. Detailed descriptions of these aspects of the evaluation for suspected human trafficking are available. (110)(117)(139) Briefly, components of the initial evaluation for suspected labor or sex trafficking include a comprehensive physical examination to assess patient affect, nutrition, hydration, and development. Acute and chronic medical conditions should be identified and treated. Documentation of genital and extragenital (including oral) injuries is indicated, with thorough written description and photography (if feasible). For cases of sexual exploitation, a sexual assault evidence kit might be indicated and a detailed anogenital examination completed. (The kit and genital examinations can be completed by a member of a sexual assault team if available). Before completing a pelvic examination on a female patient it is important to determine whether this is truly necessary (eg, need for forensic evidence collection from cervix, suspicion of pelvic inflammatory disease or injury, retrieval of a foreign body). This part of the examination can be particularly traumatic for youth, so careful consideration of the reason for completion is indicated. For prepubertal children, a pelvic examination typically is conducted under anesthesia. STI testing and prophylaxis should be offered to the patient, following guidelines by the Centers for Disease Control and Prevention. (140) Pregnancy testing and emergency contraception should be offered to female patients. Drug/alcohol testing can be considered, especially if the patient reports recent periods of memory loss or appears intoxicated. Laboratory testing for malnutrition, anemia, lead toxicity (or other toxic exposures), hemoglobinopathies, vitamin and mineral deficiencies, and infections endemic to a child's home country might be indicated. Immunizations might be needed, as well as vision/hearing testing and family planning with contraception. For foreign national trafficked children, guidance on medical screening and care can be obtained from the American Academy of Pediatrics Immigrant Child Health Toolkit. (141)

REPORTS AND REFERRALS

Practitioners need to follow mandatory reporting laws for suspected abuse and exploitation. (16)(110) Care should be taken to explain to authorities that the patient is a child in

need of services and not an offender in need of punishment (eg, "child prostitute" or "undocumented immigrant"). Advocating for the rights and the needs of the child is critical, especially when reporting concerns to personnel with limited experience handling child trafficking and exploitation. The pediatrician should be transparent with the patient about the need to make a mandated report and offer the child options for how the report is made (eg, child remains in the room during the phone call; child is out of the room; child participates in making the report on speaker phone). This provides the patient with some control over a potentially frightening situation. Also important to discuss are possible safety issues related to reporting and working with the child, caregivers, and authorities to mitigate these risks. Concerns about trafficker retaliation should be taken very seriously, and efforts should be made to protect the patient and staff.

Many trafficked and exploited children have myriad needs, which requires a holistic, multidisciplinary approach to aftercare. (142) Clinics and hospitals should have a protocol for handling reports and referrals and a list of available community and national resources. (95) Any nonmandated referral requires the permission of the child. (110)(117) Ideally, health-care personnel should already have obtained relevant information from potential referral organizations (eg, the age/sex of clientele accepted, services provided, hours open, and fees associated), and have established a relationship with staff so that referrals can be made appropriately and smoothly, minimizing anxiety for the patient. If a health professional is not aware of community resources, has questions about child trafficking, or needs assistance making a report to law enforcement, the health professional can contact the National Human Trafficking Resource Center Hotline (1-888-373-7888), a 24/7 national resource for professionals, trafficked persons, and the public. Help might also be available from state or local human trafficking task forces or local child advocacy centers.

Although other organizations might be able to assist with housing, food, education, job training, immigration, legal concerns, and crisis intervention, the health professional should consider the health- and mental health–related needs of the patient. Reflecting on the information gleaned from screening and history-taking, the pediatrician might determine that the child needs an easily accessible, cheap, or free medical home for immunizations, primary and reproductive care, contraception (including long-acting reversible contraceptives), and anticipatory guidance. A referral for trauma-focused mental health assessment and possible therapy is helpful for many patients, and these services often are provided by child advocacy centers. A child might benefit from services related to obstetric care, substance misuse treatment, dental health, or physical rehabilitation. These referrals should be discussed with the child in a way that engages the patient and encourages questions and opinions. If the child is willing to accept a referral, a phone call by the clinician to the referring agency can be made while the patient remains in the office/hospital (eg, a warm handoff). Or the child might be willing to accept information for future use. If the child refuses suggestions for referrals, there is still a benefit in having discussed options such that the child is aware of available resources.

PREVENTION

The pediatrician's role is not limited to identification and early intervention for children actively being trafficked and exploited. There is a major need for clinicians to provide primary prevention to patients and caregivers. (143) Many of the risk factors for child trafficking and CSEC can be identified through screening and addressed with anticipatory guidance and community referrals. Providing access to an organization that supports LGBTQ+ youth can prevent a child questioning their sexual orientation from engaging in high-risk online behavior in an effort to "find someone who understands." A youth who often runs away from home can benefit from a referral to a shelter; a child living in a dysfunctional family might need a child protective services report or a teen hotline or mental health referral. The caregiver might need access to a parent hotline, parenting classes, or support groups. Both children and caregivers need anticipatory guidance on safe and appropriate online behaviors to minimize the risk of online child sexual exploitation.

CONCLUSION

Human trafficking and exploitation can have profound effects on the health and well-being of affected children and their families. Prevention, identification, and early intervention are in the purview of the pediatrician. Many trafficked children and those at risk seek medical care around or during their period of exploitation, affording clinicians the opportunity to offer services and support. Screening, universal education, and provision of resources can identify at-risk children and prevent exploitation or assist those experiencing trafficking in receiving help. A trauma-informed, culturally sensitive, and rights-based approach to patient care affords the greatest likelihood of building the trust and comfort needed for patients to be

able to discuss their situation and their needs. Although definitive disclosure of human trafficking is not the goal of the pediatric provider, risk assessment and offers of resources and referrals can be lifesaving to a child.

Summary

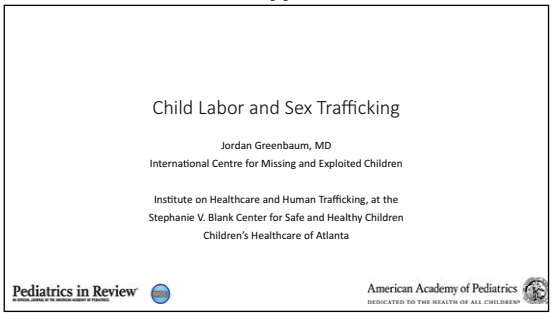
- Based on strong research evidence, (9)(45)(54)(63)(64)(65)(66)(67)(68)(69)(70)(71) human trafficking and exploitation are associated with significant negative health and mental health conditions, including traumatic injury, infection, substance misuse, posttraumatic stress disorder, depression, and suicidality.
- Based on strong qualitative and quantitative research, (21)(43)(46)(47)(48)(49)(50)(51)(52)(53)(54)(55)(56) risk factors for trafficking and exploitation occur at the individual, group, community, and societal levels. Particularly common risk factors include runaway/homeless status, child protection/juvenile justice involvement, previous child abuse, marginalization associated with lesbian/gay/bisexual/transgender/queer/questioning/other status, family dysfunction, poverty, migration, community and family violence, and cultural beliefs and practices.
- Several studies conducted in various areas of the United States indicate that many health professionals lack training on human trafficking and trauma-informed care. (1)(85)(86)(87)
- Short screening tools have been developed specifically for the health-care setting to assess risk of child trafficking. These tools have shown effectiveness in clinical settings; one of these tools has been validated. (104)(108)(109)(111)(112) Universal education and resources have also been promoted for commercial sexual exploitation of children. (113)(114)
- Based primarily on qualitative studies and consensus statements, (78)(79)(81)(82)(89)(95)(97)(98)(110)(117)(118)(119)(122)(123)(126)(127) it is recommended that pediatricians use a trauma-informed, rights-based, culturally sensitive approach when interacting with trafficked or at-risk patients.

QI PROJECT SUGGESTION

- Create a clinic protocol for child trafficking and implement a child sex trafficking screening process for adolescent patients. Track numbers of patients screening positive, number of patients with evidence of child sex trafficking (per information gleaned from patient, chart, other persons), and types of services/referrals offered.

References for this article can be found at http://pedsinreview.aappublications.org/content/42/12/639.

***To view teaching slides that accompany this article, visit* https://pedsinreview.aappublications.org/content/42/12/639/tab-supplemental.**



PIR QUIZ

1. A medical student asks you to discuss child trafficking at the next meeting of the pediatric interest group. You plan to present case studies that illustrate risk factors for child trafficking and discuss barriers that exist at the practice, provider, and patient levels for the identification of exploited youth in health-care settings. The identification of trafficked adolescents can be hindered most by which of the following?

   A. Lack of physical evidence of harm.
   B. Lack of legal protection.
   C. Lack of history of previous childhood traumatic events.
   D. Trafficked youth are unaware their situation is exploitative.
   E. Trafficked youth do not seek medical care.

2. A 15-year-old boy was arrested for breaking and entering while in the company of 2 young adult males. At intake to a juvenile detention center he complains of a swollen left ankle injured during the arrest. He discloses that he is a runaway and has been living on the streets for "many" months. He has obtained money by begging and received shelter and marijuana in exchange for delivering drugs. When available he uses marijuana daily. There is no history of use of other drugs, including alcohol. He reports a total of 3 sexual partners and no symptoms or history of sexually transmitted infections. Physical examination findings include a moderately swollen left ankle with no bruising. Although he resists an examination for range of motion of the left ankle, he is able to bear weight on the ankle and walks with a limp. The remainder of his physical examination findings are normal. Among the following studies, which one is most likely to be abnormal or positive in this patient?

   A. Complete blood cell count with differential count.
   B. Serologic test for complete metabolic profile.
   C. Radiography of the left ankle.
   D. Screen for sexually transmitted infections.
   E. Test for tuberculosis.

3. A 15-year-old girl presents to a teen clinic seeking treatment for a pruritic rash. She and her mother are homeless and have been living in a local shelter for 2 months. The rash has findings consistent with scabies, and a treatment regimen is prescribed. The girl's history of homelessness is a concerning risk factor for exploitation. Which of the following is the most appropriate next step for further evaluation of this girl's risk of child sex trafficking?

   A. Administer the Short Screen for Child Sex Trafficking.
   B. Conduct an expanded interview to elicit disclosure of exploitation.
   C. File a report with child protective service.
   D. Refer her to a child advocacy center.
   E. Refer her for mental health services.

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4. The staff of a high school health center is initiating a practice improvement plan to facilitate the recognition of teens at risk for exploitation. The staff has received training that is inclusive of risk factors, clinical indicators, bias, and use of a screening tool. School and community partners have been identified to provide support services for identified at-risk youth. The clinic staff endorses a trauma-informed approach for patient care. Trauma-informed care places an emphasis on which of the following measures?

   A. Fostering physical and psychological safety to develop patient trust.
   B. Guaranteeing for an adolescent patient absolute confidentiality.
   C. Providing universal education about exploitation and service resources.
   D. Providing access to the services of a social worker or case manager.
   E. Providing a "warm handoff" to onsite mental health counseling.

5. A 16-year-old girl admitted to the hospital with acute abdominal pain, vomiting, and dehydration is diagnosed as having pelvic inflammatory disease. Urine nucleic acid amplification testing is positive for chlamydia and gonorrhea. She has had 4 sexual partners in the past year. Six months ago she presented to a health department clinic requesting emergency contraception for unprotected intercourse. At that visit she chose to continue use of condoms and declined offers of additional contraceptive methods. In addition to persons of color and children living on the streets, groups of youths with which of the following characteristics are most likely to be disproportionately affected by trafficking and exploitation?

   A. Attention-deficit disorder.
   B. Conduct disorder.
   C. Living in foster care.
   D. Oppositional defiant disorder.
   E. Sexual minority.