Adolescents and Labor Trafficking

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Published version

ROOD, Corey, RICHARD, Stephanie, MURPHY, Laura, EINBOND, Julia, IANNARONE, Alison, AMATO, Alessandra and LEE, Hayoung (2020). Adolescents and Labor Trafficking. In: TITCHEN, Kanani E. and MILLER, Elizabeth, (eds.) Medical Perspectives on Human Trafficking in Adolescents A Case-Based Guide. Springer Nature, 69-112.

LABOR TRAFFICKING: A Review

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Abstract:
While many people, including medical professionals, have become familiar with the reality of sex trafficking of minors in the United States, very few people recognize that children and youth – even those who are U.S. citizens – can be trafficked for labor as well. Simply put, labor trafficking is the United States legal term for inducing a person to work or provide services through force, fraud, or coercion. This chapter will begin by defining and describing the problem, common forms of labor trafficking among children and youth, and vulnerabilities and risk factors in the population. Case studies will present the reader with opportunities to improve understanding of definitions and epidemiology, and hone skills in the identification of risk factors and red flags, medical evaluation and treatment, resource identification, and reporting.

Keywords:
Labor trafficking, forced labor, modern slavery, immigrant labor, child labor

Introduction

* **Mary**, a young Mexican girl, was forced to peddle tamales on the street and was sexually assaulted in her family's home. While she was peddling on the street, a woman noticed bruises on her body and called the police. Police dropped Mary off at the local homeless shelter where she waited for help [ME1]for over two months before being identified as a child trafficking victim by a staff member.

* **Jessica** was 17 when she was recruited to sell magazines in the southern United States. She was forcibly transported and made to work in various locations in the United States and finally escaped when she was 18. She went to a police department for help. The police department considered her homeless and did not identify this as a labor trafficking case.

* **Liz and Marty**, two American youths were homeless after their families kicked them out of their homes. They answered a website advertisement for au pair services. Once they were flown

to the host family's home, they were forced to work every day and sexually assaulted by the father of the household, who used drugs to sedate them.

* **Marco**, 16, was forced to smuggle drugs into the United States. He was violently beaten and forced to watch as a friend was killed in front of him. Marco was arrested for selling drugs and sentenced to time in juvenile hall instead of being identified as a victim of human trafficking.

* In Ashland, Ohio, a federal jury convicted three individuals of engaging in a labor trafficking conspiracy after the group held a **cognitively disabled woman and her child** against their will and forced them to perform manual labor.[18] In addition to beatings and threats with vicious animals, the traffickers also threatened the mother with the possibility that authorities might take her child away.[19] The traffickers forced the mother to hit her child while they recorded video, so that they could threaten to show the video to authorities in order to have the child removed.

At its core, the crime of human trafficking is about exploitation for labor or services. The labor or commercial sexual service is the element needed for this crime that distinguishes it from other crimes against children. People often forget that human trafficking of adolescents includes **both** sex and labor trafficking. Medical and mental health professionals must be vigilant in understanding both sides of the commercial exploitation of children so that no vulnerable and exploited child remains unidentified and unassisted.

Adolescent labor trafficking is often less identified and understood today partly because reports and media coverage across the country highlight only child sex trafficking, and focus on the link between child sex trafficking and the child welfare system.[1] In comparison to child sex trafficking, the issue of child labor trafficking in the United States is less researched and less frequently highlighted by the media. However, the limited evidence available demonstrates the

need for those who work with vulnerable children to pay equal attention to this issue. For example, in Florida, twenty-four U.S.-citizen children were involved in a labor trafficking scheme through which they were forced to sell items door to door until they were identified by an off-duty Florida Department of Child and Families worker.[2] A similar scheme was identified in Colorado, where an anti-trafficking organization helped minors who were trapped in magazine sales crews.[3] Adolescent labor trafficking victims have been identified in a diverse array of industries, including agricultural work, restaurant service, hair braiding, domestic work, forced peddling, and a range of illegal work activities.[4] For example, in California, a newspaper reported the horrific tale of a girl who ran away from foster placement and was then kidnapped, confined in a metal box, sexually assaulted, and only allowed outside to cultivate marijuana for her captors.[5] Adolescent labor trafficking victims are more likely to be identified if protocols and screening are put in place in medical and mental health facilities. However, child labor trafficking victims will continue to be exploited and abused if those best positioned to help them continue to ignore this issue, believe this does not occur in the United States, or focus only on identifying sex trafficking.

Who is A Victim of Adolescent Labor Trafficking?

Commercial sexual exploitation and forced labor are both included in the federal definition of human trafficking. The Trafficking Victims Protection Act (TVPA) of 2000, Section 103(9) defines "severe forms of trafficking in persons" as:

> (A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.[6]

On the surface, identifying labor trafficking victims appears more complex than identifying sex trafficking victims, because the legal definition does not include all minors engaged in labor. , According to U.S. law, an adolescent who is working is not necessarily considered a victim of labor trafficking, as would be the case with any minor caught up in commercial sex trade. However, put most simply, any child providing labor or service through force, fraud or coercion is a victim of labor trafficking. Therefore, the key information for practitioners to grasp is the legal definitions of **force, fraud, and coercion**.[7,8]

It may be easiest to identify cases of labor and sex trafficking that involve **force**, which can be defined as physical violence or physical restraint. Force is the mechanism of control that people commonly associate with human trafficking – violent beatings, people forcibly restrained when not working, violent threats to the victim or his or her family members. These and other forms of violence are included in the definition of "force." Other cases involve people who have been lured into work through **fraud**, by which we mean false or misleading contracts, trickery, or false promises. Some adolescent labor trafficking victims are told they will be paid, but then they perform the work without receiving remuneration. For a case of fraud or unpaid wages to be considered trafficking, typically the person has to believe that they cannot walk away from the job. In these cases, fraud may be accompanied by threats or psychological trickery that convinces the worker that they are beholden to remain in the job and will not be allowed to walk away from the job. This usually involves some degree of coercion as well.

Indeed, adolescent labor trafficking victims, like sex trafficking victims often have cell phones, attend school, work in environments with unlocked doors, or might be left alone for periods of time because the trafficker has instilled a fear in the victim so great that they cannot leave or disobey their trafficker's orders because of the invisible barriers of psychological **coercion**. For this reason, some people describe human trafficking as a "prison without walls."

This type of coercion can start with set rules, veiled threats, monitored phone use, threats about immigration status or calling the police, connections with dangerous individuals, isolation, or threats to others around the victim. The adolescent victim, vulnerable to adult power and influence, subjectively believes that serious harm will occur to them if they do not continue to perform labor or services at the trafficker's request and feels it is impossible to refuse to work or leave the bad work situation.

Although the legal definition of coercion is complex, in practice, a simple framework can guide identification of child labor trafficking cases

Two important points about coercion, especially in child and youth labor cases, are:

(1) The definition of coercion [9] explicitly includes "threats," "abuse of the legal process,"[10] or a "scheme or plan" that causes someone to keep working. This definition is broad enough to cover a range of means by which a trafficker will exploit a child's labor or services.

(2) The definition of coercion centers around the idea of "serious harm" and this is defined as a broad range of harm that can be nonphysical and includes financial and reputational harm. The legal definition also specifically takes into account the circumstances and background of the victim, so a minor labor trafficking victim will generally not need to demonstrate the same degree of coercion as an adult victim.[11]

Non-legal practitioners may find it challenging to distinguish between child labor exploitation and child labor trafficking. Child labor exploitation includes unpaid wages, unsafe working conditions, and specific prohibition on ages and hours when children can work.[12] The key distinction between labor exploitation and labor trafficking is whether the child has decided to work or if a third-party has manipulated the child into believing they must work or else suffer some kind of harm. Medical and mental health practitioners should not worry about trying to distinguish between child labor exploitation and child labor trafficking. The red flags for each are similar and the same steps should be followed to provide support and protection for the child.

Labor trafficking happens to both foreign nationals and citizens of the United States. In fact, someone may first be smuggled – illegally transported across a border - and may even agree to pay a debt for the smuggling; but the voluntary crossing of a border can become labor trafficking if that child or youth is later made to perform some labor or service.

Epidemiology

Unfortunately, we do not have a clear portrait of how prevalent child labor trafficking is in the United States. Studies have provided unreliable ranges of numbers of children who are at risk of trafficking, but the truth is that there are no effective surveys that capture this crime and no studies that have successfully quantified the number of victims. Very few adolescent labor trafficking cases have been prosecuted at the federal level to date, and only a few law enforcement agencies have accurately identified the cases that they have encountered.

That said, adolescent labor trafficking is indeed a form of victimization that requires the attention of medical professionals. Because labor trafficking is forced labor, it may occur in any industry.

Polaris Project recently listed seventeen different "types" or sites of labor trafficking occurring in the United States alone. Those included sites where adolescents seek their first jobs, including the entertainment industry, landscaping, restaurants and food service, traveling sales crews, carnivals, peddling and begging, domestic work, agriculture, construction, and forestry.[13] In addition, it is not unusual for work in illicit trades, such as the drug trade, stealing or other gang-related work, to be compelled through force or coercion. Young people are sometimes forced to engage in this illicit work by a family member, neighbor, or friend, who does not allow them to choose the work or to leave it. It is important to understand these often-complex dynamics and check our own personal biases that sometimes lead us to conclude that a juvenile has chosen to engage in criminal activities, when in fact they may be a child labor trafficking victim. In many cases, sex and labor trafficking overlap, particularly in situations in which adolescents who are forced to sell sex are also forced to sell drugs or steal for their traffickers.

No conclusive research has proven that trafficking affects racial/ethnic minority communities (African American, Latin American, or Native American) more than white, as most studies of trafficking are focused on people who are already marginalized in some way and therefore face increased vulnerability to trafficking regardless of race/ethnicity. As poverty and other vulnerabilities fall along the fault lines of communities marginalized on the basis of race/ethnicity in the United States, it is likely that some racial/ethnic minorities are likely to be disproportionately affected by trafficking. More details regarding labor trafficking of adolescent populations within illicit trades can be found in chapter X of this textbook.

Risk Factors

Children and youth who immigrate to or seek refuge in the United States experience a particularly high vulnerability to labor trafficking for a number of reasons. Whether documented or undocumented, young people traveling across borders often seek work to support themselves and their families. Those whose families arrive on legal temporary H2A and H2B work visas are contractually tied to the employers who sponsor them. Some employers take advantage of fears surrounding immigrant legal status and deportation to force immigrants to work without pay, to convince them that they cannot leave, to force them into illicit work, or to compel their children to work alongside them.[14] Unaccompanied minors crossing the borders are at increased risk of labor trafficking, because they lack a protective support system and are wary of law enforcement and fear deportation.[15] More details regarding labor trafficking among the immigrant adolescent population can be found in chapter Y of this textbook.

Adolescents who are U.S. citizens also are at risk for labor trafficking, and a number of factors influence this risk. Young Americans who are economically, socially, or educationally marginalized, as well as those who struggle to find employment because of disability, sexuality, gender identity, addiction, or socioeconomic background are vulnerable to traffickers. Young people who have left school, who have criminal histories, who identify as transgender, or who lack adult guidance may feel they have few formal employment options, leaving them to seek riskier work. A history of extreme poverty, homelessness, or engagement in the foster system can often mean a history of extreme deprivation, and getting basic needs met becomes an everyday challenge that may leave a young person vulnerable to exploitation. Homeless youth in particular are vulnerable to offers of lucrative work that sound "too good to be true."[16] Evidence suggests that lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth may be up to five times more

likely than heterosexual and cisgender youth to be victims of trafficking, due to increased susceptibility that comes with rejection and alienation often experienced by LGBTQ youth.[17] Substance abuse may also leave young people vulnerable due to poor judgment. Some adolescents may engage voluntarily in illicit trades to maintain their drug habits; however, their addiction also renders them vulnerable to those who sell/supply drugs. This vulnerability maybe be the coercive means a trafficker uses to force youth to engage in the illicit trade themselves.

Some youth with developmental deficits and low cognition who have trouble discerning dangerous situations may become involved with people who exploit them. An individualized education program (IEP) then may be a warning sign of vulnerability to trafficking.

Clinical Presentation

The health care setting (including primary care, dental, mental health, and emergency rooms) is a place where patients and clients can present when in need of physical and/or psychological assessment and healing. Human trafficking exacts a significant physical and psychological toll on its victims that all too often brings victims to the doors of the medical institution. Trafficked persons may present alone or may be accompanied by other victims and potentially even their traffickers. The healthcare professional has a unique opportunity to identify potential exploitation, answer questions about personal health, provide treatment interventions, help navigate resources and referrals, and report to agencies who are better equipped to investigate potential victimization and crimes.

Lederer et al found in 2014 that of the 107 female sex trafficking survivors they surveyed, ages 14 to 60 years, nearly 88% made at least one visit to a medical provider during their period of

victimization.[20] In 2016, Chisolm-Straker et al expanded this investigation to include labor trafficked victims. Interviews with 173 human trafficking survivors of all ages from the United States showed that 68% of those survivors sought medical attention while being trafficked. The most common location for medical presentation was the emergency department, but other locations ranged from mental health providers to primary care. In addition, 27% received dental care.[21] Chief complaints included physical injury, reproductive health concerns, infections, substance abuse, suicidality and other mental health concerns.

Table 1. Medical facilities most often frequented by trafficking victims

Facility Location	**% Sex Trafficking Victims Presenting to Health Care (Lederer)[20]**	**% Sex and Labor Trafficking Victims Presenting to Health Care (Chisolm-Straker)[21]**
Any visit to medical care	87.8	68
Emergency Department	63.3	55.6
Planned Parenthood	29.6	
Primary Care Provider	22.5	47.8
Urgent Care Clinic	21.4	Combined with emergency[KET2]
OB/GYN	19.4	25.6
Public Health Clinic	19.4	

Dental		26.5
Other	13.3	13.6
Unknown		0.9

The most common physical complaints reported by trafficking survivors include neurological complaints such as headaches, migraines, dizziness, neuropathies and chronic pain. Other common complaints include severe weight loss, malnutrition, loss of appetite, acute and/or chronic physical injury, cardiovascular and pulmonary complaints, gastrointestinal complaints, dental problems including tooth decay and loss, and chronic overuse of joints and back. Many survivors report being victims of physical violence including being hit, kicked, punched, beaten with an object, threatened with a weapon, or strangled .[20,21,22,23,24,25,26,27]

The United States Preventive Services Task Force (USPSTF) and other leading medical institutions such as the World Health Organization (WHO) and the American Academy of Pediatrics (AAP) recommend routine screening and care for immigrant/refugee, homeless, incarcerated, and underserved populations. Such recommendations and best practices can be applied to the medical screening and management of minor and young adult victims of human trafficking.[22,26,27,28,29,30] Victims of labor trafficking in particular may suffer from chronic exposure to the elements, industrial exposures to caustic chemicals and poisons, physically exhaustive work conditions, poor living and sleeping accommodations, and malnutrition. General health concerns for these populations should guide providers to evaluate for immunization status, cognitive and/or developmental delays, poor oral hygiene, chronic

musculoskeletal and neurological complaints or limitations, cardiovascular or respiratory complaints, anemia, vitamin and mineral deficiencies, and exposure to such communicable diseases as tuberculosis.[20,21,22,23,24,25,26,27]

Although often subtle, psychological health consequences of the physical and psychological trauma of exploitation are pervasive. The effects of such trauma on the developing body and mind can be consequential. Most studies looking at the psychological effects of exploitation have surveyed only sex trafficking survivors. Those survivors self-report personal diagnoses that include PTSD, suicidality, depression, anxiety, eating disorders, shame or guilt, nightmares, and more. Victims who are willing to disclose non-prescription substance use have reported dependence on various substances including tobacco, alcohol, marijuana, cocaine, crack cocaine, methamphetamine, heroin, other opiates, ecstasy, and/or PCP. Highly addictive substances such as cocaine, methamphetamines, heroin and opiates are often used for two leading reasons: used by traffickers to control their victims and used by trafficked person to cope with their own physical and psychological trauma.[20,21,22,23,24,25,26,27]

Although similar data for labor trafficking victim is not available, practitioners who serve labor trafficking victims report similar medical and mental health issues.

Medical Management Approach

Health recommendations for victims of sex and labor trafficking overlap greatly. Unique medical recommendations for best practices are available for assessing and managing victims of acute sexual assault, more often seen with sex trafficking but not exclusively. Many service providers have observed that that sexual assault or rape may be one of the most common means of controlling female labor trafficking victims.

The complex trauma experienced by survivors of trafficking often causes hesitancy, anxiety, and even reluctance to disclose the details of their exploitation and victimization. However, trafficked persons may be willing to disclose current details about their situation if such candor will improve the medical care they will receive. Approaching these patients in a trauma-informed, patient-centered, culturally sensitive manner is crucial.[20,26,30,31] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), an institutional program, organization, or health system that is trauma-informed "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[32] It cannot be emphasized enough that the medical encounter should be structured in such a way that puts the patient or client at the center of the evaluation, uses trauma-informed history taking and exam techniques, and provides an overall environment that is inviting, calm, and safe.

Begin an encounter by introducing one's self, the medical team members, and building rapport. This will require time and active listening, which may mean that a member of the medical team with greater time flexibility may need to begin the encounter. Understand that in order to most effectively move toward more sensitive and personal questions and topics, with the hope to gather honest information, the medical team needs to establish good rapport and discuss as part of that rapport-building the limits of confidentiality. This demonstrates transparency, shows respect for the patient and their individual choices, and will ideally help avoid a sense of betrayal or additional trauma when authorities such as law enforcement and/or child protective services have to get involved. Remember that informed consent, as outlined in many medical policies

and protocols at individual medical institutions and clinics, is necessary in order to move forward with examination and additional workup (see more on mandatory reporting below). This is part of the rapport-building process and adds to medical transparency.

The healthcare team needs to explain the process of the medical encounter, including reasons for asking particular screening questions, how the physical examination will be conducted, who will need to be present for the exam, and any additional testing, evidence collection, or medication recommendations. Informed consent means that a patient or client does have the right to refuse to answer questions or participate in an exam or evidence collection. If safety is maintained, the patient's wishes should be respected. Keep in mind that best practices would dictate that informed consent for these questions, evidence collection, examination and testing be done in a non-coercive manner and only when the patient or client is fully able to consent. Such conversations should not occur while a patient or client is intoxicated, under the acute influence of a cognition or mental status altering drug or medication, or is unconscious. Avoidance of force, coercion, or manipulation is strongly encouraged as a standard of medical care generally, unless force is necessary to ensure the immediate safety of a patient, client, or staff. This is particularly important when interacting with patients who may be victims of trafficking, and therefore are acutely triggered by force, coercion, and manipulation. Also, keep in mind that pre-adolescent minors may not developmentally understand more formalized screening questions and conversation around these topics. Such history gathering my need to be simplified or be conducted in the setting of a forensic interview before the medical intervention[KET3].

After rapport building and informed consent, victims may still be reluctant to disclose exploitation especially if threats of harm have been made or actual harm has occurred to them or their friends and family. In the medical setting, the primary provider or therapist should consider

further targeted history gathering when contextual information and risk factors suggest potential trafficking. Particular vulnerabilities that pertain to labor trafficking include homelessness, running away or being kicked out, immigration or refugee status, undocumented and unaccompanied minors, and involvement with any other forms of exploitation. Using open-ended questions that solicit narrative description from the patient may facilitate greater understanding for the medical team. Even after obtaining a complete, factual history, the lack of a disclosure of victimization does not rule out trafficking. If the medical team continues to be reasonably concerned for exploitation in any form, this concern should be shared with the appropriate agencies for further investigation if the patient is a minor.

The general, non-acute medical management of victims of trafficking (Table 2) is much like other initial medical clinic patient encounters. A thorough and complete medical history is needed, and it is recommended that this occur with the patient alone. A validated (if available), or thoroughly vetted, method to screen for such exposures as human trafficking, dating violence, trauma symptoms, and suicidality is highly recommended.[ME4] Of course, with any screening method, there must be a response system in place to provide immediate interventions, referrals, and resources for all positive screens. Following the history, and with the patient's consent, a complete physical examination should be performed, which should include an anogenital examination[ME5]. It is highly recommended, especially when working with a potentially exploited patient population, that a chaperone (second licensed medical professional) accompany any provider performing an anogenital or breast exam. This protects both the medical professionals and the patient alike.

Table 2. General, non-acute medical management of minor victims of trafficking[33,34]:

1. Complete[KET6] medical and social history, review of systems, and physical examination
2. Evaluation of hydration, nutrition, and growth; include head circumference or BMI as indicated
3. Documentation of old/recent injuries
4. Anogenital examination, with photo- or videodocumentation if possible
5. Assessment of development; include screening for motor, cognitive, and speech delays
6. Assessment of vision and hearing
7. Assessment of dental hygiene and oral health
8. Evaluation of immunization records and starting appropriate catch-up immunizations during the same visit
9. Assessment for anemia, lead, tuberculosis, and other potential exposures (chemical or infectious); consider other testing for vitamin/mineral deficiencies if indicated; consider testing for infectious diseases that are endemic in patient's home country if indicated
10. Assessment for mental health concerns
11. Screen for urine and/or serum alcohol and drugs of abuse, as clinically indicated
12. Test for pregnancy and sexually transmitted infections as indicated; include gonorrhea (GC), chlamydia (CT), trichomonas (trich), HIV, Hepatitis B & C, and syphilis (exposure history should guide anatomical site testing for GC, CT, and trich)

Adolescent Hesitance to Disclose

The examples provided in this chapter show the diversity of ways that traffickers use force, fraud, and coercion to exploit adolescents and youth. Because of the nature of this crime, many individuals who are being trafficked will not self-identify as victims, since they often experience intense shame and distrust of authority figures.[35] Self-identification is also difficult for adolescent labor trafficking victims, like child sex trafficking victims, because many victims feel emotionally bonded or physically dependent on their traffickers.[36] Similarly, both labor and sex trafficked minors are often arrested for the crimes their traffickers force them to commit, and get caught up in the juvenile justice system.[37]

Trafficked Persons May Not Self-Identify

These factors often contribute to an adolescent's lack of apparent interest or psychological capacity to escape the situation of trafficking. Survivors report that they do not typically self-identify as victims of human trafficking, and often state that they don't know what "human trafficking" is.

Trauma Bonds

Many young people experience what mental health professionals call "trauma bonding," which is to say that they feel connection, loyalty, or even love toward the person who is trafficking them. Trauma bonds can be formed when children seek attachment in the face of extreme danger, or "when there is no access to ordinary sources of comfort, people may turn towards their tormentors."[38]

Familial Trafficking

When a trafficker is a family member or close friend, children often find it difficult to resist the wishes of their elders or close relations. They come to believe that they will get in trouble or be considered defiant if they walk away, or that they will leave the safety of their only protection. If they feel they have nowhere else to turn or no other opportunities for work, they will avoid leaving even the worst working conditions.

Threats and Fear

Sometimes, if they are involved in illicit work, such as in the drug trade, they will fear walking away from their criminal connections or debts they may have incurred in the course of the work.[16] Furthermore, they may have been explicitly threatened or had the safety of their loved ones threatened, which coerces them into remaining in the trafficking situation. For all of these reasons, children not only do not identify themselves as victims of trafficking but are also quite afraid of escaping and disclosing their abuse.

Screening and Identification

Identification of victims of trafficking, especially labor trafficking, is admittedly quite difficult for medical professionals. Unless risk factors and clinical indicators are identified from the history and physical examination, these patients often go unidentified and return to their exploitative situation. Therefore, awareness and recognition of various clinical indicators of trafficking will speed identification. Such clinical indicators may be the victim's physical presentation, present or past medical or social history, and/or physical examination findings. Additional evidence may be found in laboratory testing for sexually transmitted infections (STIs), drugs or alcohol, immunization status, tuberculosis testing, or radiologic imaging. Table 3 provides a list of potential trafficking risk factors or "red flags" that medical professionals should key into as potential signs of trafficking victimization.[26] Medical professionals should use such indicators to help guide their history taking, examination, and laboratory and radiologic screening. Also in their normal practice, it is a good idea for medical practitioners to ask all adolescents if they engage in any kind of work, if it affects their health, and a pointed question about whether any third party receives payment for the adolescent's work.

Table 3. Potential "Red Flag" Indicators of Human Trafficking[26]

Medical Presentation	Medical & Social History	Physical Findings	Other Concerns

Accompanied by over-bearing and/or unrelated adult ("friend" or "Uncle") Accompanying adult does not allow the minor or youth to answer medical questions Changing or unknown demographic information Suicidality Acute physical or sexual assault Drug intoxication or sleep deprivation causing disorientation or sedation Preventable work-related injury, injury caused by employer or employer's staff	Past suicidality Runaway, throwaway or homeless Significant school truancies or absences Child maltreatment including physical or sexual abuse, or neglect Exposure to intimate partner violence as a child, or teen dating violence Involvement with Child Protective Services or the Juvenile Justice System Substance abuse history Self identifies as LGBTQ and any of the above Has a mental health diagnosis and any of the above	Evidence of inflicted trauma Withdrawn, scared, fearful, and/or timid around accompanying adult Signs of substance use or withdrawal Stated age is older than appearance & unable to verify with valid I.D.	New to country (immigrant, refugee, or undocumented) Doesn't speak English Concerning work or living conditions Little or no pay; long hours; not allowed to leave, sleeps at work Threatened or physically injured by employer or employer's staff History of drug mulling, drug smuggling or selling

Assessment Tools

Medical professionals may have a difficult time initiating a conversation around exploitation and exposure to violence[ME7].

A standardized tool to assess for labor trafficking may help to start the conversation and may also identify risks or exposures that the medical team previously had missed. Such tools are *not* a

replacement for trauma-informed care and the building of healthcare provider-patient rapport and trust. While there are no magic-bullet questions, and keeping in mind that the goal of the healthcare professional and patient interaction is *not* disclosure, several key questions about human trafficking may provide important insights. In general, screening questions should use youth-friendly terminology, should avoid using the term "human trafficking" (an often misunderstood and unclear term) and should focus on survival and resilience activities[ME8] to identify potentially trafficked adolescents. Some examples of assessment questions to identify labor trafficking are found in TableX.

1. Some teens have a hard time living at home and feel that they need to run away. Did you ever run away from home?
2. Some teens are "kicked out" of their home or the place they were staying. Did you ever get kicked out of your home or the place you were staying?
3. Some teens have been involved with the police for running away, for breaking curfew, for shoplifting, or something else. There can be many different reasons. Did you ever have problems with the police?
4. Were you (or anyone you work with) ever beaten, hit, yelled at, raped, or made to feel physical pain for working slowly or for trying to leave the place you work?
5. Did you ever work without getting any payment, or without getting the payment you were promised?
6. Did you ever work at a job and someone else received your payments instead of you?
7. Did someone where you work (or have worked) ever threaten you or make you feel scared or unsafe?
8. Did someone where you work (or have worked) ever tell you to lie about your age?

9. Do you have access to your identification documents?
10. Did you ever miss school because you had to work?
11. Did an older person outside of your family ever ask you to leave home with them and offer you work?
12. Did you ever get arrested or commit a crime that you felt someone else forced you to do?
13. Did you ever do something like hold or sell drugs, or other things that may have gotten you in trouble, for someone else[KET9]?

As of this writing, few studies have assessed the validity of trafficking screening tools with adolescent and youth populations for both sex and labor trafficking. Some have been validated solely with adult populations but could be applicable to adolescents and youth. [6,39,40,41,42,43] Finding the right time and the right tool may be important to effective assessment. Medical professionals should make sure any tools they consider adopting can assess for both sex and labor trafficking. The following are a few examples of recommended validated tools.

Researchers with **John Jay University and the Urban Institute** validated the Human Trafficking Screening Tool (HTST), a 6-question short tool as well as a 19-question longer version that screens for both labor and sex trafficking experiences.

Covenant House New Jersey in partnership with researchers from Mt. Sinai Hospital tested the validity and sensitivity of a shorter version of the previously validated HTIAM-14. Their Quick Youth Indicators for Trafficking screening tool (or QYIT) had 87% sensitivity and is useful for non-expert intakes as well as more in-depth counselor and social worker assessments. The QYIT

questions allow for rapport building that may encourage youth to disclose abuses. These yes/no questions may be used at any stage in working with youth[ME10].

These, and other screening tools, are useful for screening for labor trafficking. Regardless the screening tool, it is important that questions are asked by the appropriate personnel and in a private setting. The screening tools suggested here can be utilized on intake by any member of hospital or clinic staff, so long as the questions are only asked in a yes/no/don't know fashion. Staff who are untrained in counseling or social work should not engage youth in prolonged conversations about experiences of exploitation. In a clinical, counseling, or case management setting, the questions can be asked first as yes/no/don't know, and then the youth can be asked to expand on their answers to determine the extent of the exploitation. Regardless of the venue or the interviewer, the conversation about these issues should be non-judgmental. Services should be offered to anyone who is identified as a trafficking victim, regardless of the kind of work they engaged in. Remember too that exploitative labor situations that are not tantamount to trafficking can still be traumatic or can negatively affect youth, so they should be assisted with services and counseling, as well.

A standardized screening instrument for adolescents and youth should be worded as simply and concretely as possible, trying to keep to a fifth grade reading level. Questions should be prefaced with informed verbal consent and review of the limits of confidentiality. The patient or client should be counseled regarding the nature of the questions, how honesty can help providers make correct medical decisions, and that they will still receive medical care even if they refuse to answer any or all of the questions. It is recommended that the patient answer these questions

alone without the influence of a caregiver, accompanying friend or family, caseworker, clergy, law enforcement, victim advocate, or attorney.

Patients come from all walks of life, cultures, nationalities, and backgrounds. It is best practice for medical institutions to use professional interpreting and translating services so that patients can communicate their care needs and can best understand the extent of their personal health services and management. Do not use an interpreter from the family, friend, or another individual accompanying the patient to your institution. Keep in mind that an accompanying person could be the trafficker or indirectly involved with the exploitation or violence. In addition, many communities are small and tightly woven, so information about an exposure or perceived "conduct" of an individual may leak to the community and cause serious collateral trauma and stigma.

Case study 1: Identifying labor trafficking in a clinical setting

Roberto is a 17-year-old Hispanic boy presenting to the emergency department for abdominal pain, nausea, and vomiting. You are a pediatric intern on an emergency medicine rotation. Triage vital signs indicate low-grade fever and tachycardia. You find Roberto lying in bed. He is accompanied by his Caucasian mother and four siblings of different ethnicities. Roberto informs you that pain started in the mid-abdomen region several hours ago while working on the farm. He denies any trauma to his abdomen. The pain is now in the right lower quadrant. The pain is severe and is worsened by movement and walking. When you ask about family history, Roberto's mother responds, "No family history that I'm aware of. Roberto was adopted when he was nine. He has been healthy since he has been with us."

You speak to Roberto in private to conduct a confidential psychosocial assessment. Roberto reveals that he lives with his adopted parents and twenty siblings ages 2 to 25 on a farm outside the city. Regarding work on the farm, Roberto describes that they grow their own food. He continues, “There are a lot of rules in the house. We are not allowed to go out. Our parents want us to be busy with studying and working on the farm.” You screen for safety and Roberto responds, “My parents are strict, but they are not abusive”. You learn from Roberto that he and his brother Kevin will be moving to Tennessee to stay and work with their family friends to help that family out and so that his parents can “get a break”. He feels okay with the move because he “does not like the lifestyle” here.

You ask Roberto more about the kind of work that he and his siblings do on their farm. He describes operating large tractors, hay-bailing equipment, cow milking machinery, operating other heavy machinery, gathering eggs, and even butchering some livestock for their family’s meals and to sell. You follow up this question with an inquiry into how old they are when they start doing these jobs around the farm, specifically the heavy machinery and butchering animals. He states that he was 10 when he started the “harder stuff”. You ask about their routine, and he states that they are up sometimes at 4:00 am and not wrapping up until after dark. He states that sometimes he has to miss school when deadlines or big orders come in. You ask if he is ever told to lie about the work that he has to do on the farm, or how old he was when he started certain jobs. He states that he is told not to tell about having to miss school to work, and they are not allowed to tell that they often drive the tractors and other equipment by themselves.

You then examine Roberto. On his abdominal exam, you do not hear bowel sounds; he is most tender to palpation in the right lower quadrant and has rebound tenderness. You order a complete blood count (CBC) with differential and an abdominal ultrasound. The ultrasound

reveals a leukocytosis at 18,000 and a dilated appendix with multilayered appearance of bowel without evidence of an appendicolith or adjacent fluid. With a confirmed diagnosis of non-perforated appendicitis, you call surgery and plan for admission[ME11].

Mandatory Reporting

Although every state law is different, physicians, nurses, and other health-care workers, counselors, therapists, and other mental health professionals are all generally considered mandatory reporters[47] of child abuse and neglect by parents or guardians of a child, and must report suspected abuse or neglect to local state child welfare agencies. Typically, a report must be made when the medical or mental health care professional suspects "or has reason to believe that a child has been abused or neglected….or observes a child being subjected to, conditions that would reasonably result in harm to the child."[48]

Mandatory reporting laws in trafficking cases, especially child labor trafficking cases, are less clear because often the trafficker is often not the parent or guardian. Recognizing the unique nature of the crime of human trafficking, states have expanded child abuse definitions to explicitly include trafficked children, **but the majority only explicitly expand this protection to child sex trafficking victims.**[49] According to a survey of state law conducted by the Department of Health and Human Services in 2016, only seven states expanded the definition of child abuse to include **"labor trafficking, involuntary servitude, or trafficking of minors…"**while at the same time 21 states had explicitly expanded their definition to cover sex trafficking.

The explicit inclusion of trafficking within the state definition of child abuse is significant as it enables child welfare agencies to respond to reports of trafficking as child abuse—regardless of whether the trafficker is a parent or guardian. Often, state child welfare systems are the only wrap-around services available in communities to provide the comprehensive services child victims of trafficking need. Although, a legal argument can and should be made that any child victim of labor trafficking should per se meet the definition of neglect by a parent or guardian, medical and mental health providers should be aware of their state's definition of child abuse and neglect when formulating protocols and response to this issue in their state and community. Further when developing protocols, medical professionals should be aware that mandated reporting can diminish a minor's willingness to disclose abuse and could disrupt the caregivers ability to establish trust with the patient.[50] Medical professionals may find reporting to be intimidating or overwhelming so we would encourage those who have concerns for exploitation or maltreatment to involve collegial support such as nursing and social work. Approaching the reporting process and the conversations with families can be overwhelming and intimidating. Understand that as a medical professional, you are uniquely positioned to advocate for your patients and clients. They are all too often relying on you to recognizing the signs of exploitation and to open the conversation that will recognize, accept, and believe their disclosures.[KET12]

Case Study 2: Identifying labor trafficking in a mental health setting

Samantha is a 20-year-old woman who is attending her first appointment with a therapist to discuss general social anxiety. You are a mental health professional in a private practice caring for patients with history of trauma. Samantha was referred to you by a social worker at a local job skills training program.

Samantha states, “I am here because the person at the job skills agency said that you are very nice”. Y[KET13]ou ask if there is anything in particular she wants to talk about. She states, “I struggle with insomnia[ME14] and I generally don’t feel very motivated to leave the house, but I know I need to get a job for a better living situation”. Her answers are terse and spoken in a very quiet voice with her head lowered. She describes her ideal job to be something that doesn’t require her to talk to many people. She says that she enjoyed her job as a caregiver. “I cared for a young boy with a learning-disability for five years”. Samantha was sent to live with the couple because her own family could not support her. There, she was required to care for their disabled son, who was “severely emotionally disturbed”. Samantha feels she had a good relationship with the boy, and she had taken very good care of him. She feels like he was her brother, and she misses him very much.

Samantha would like to continue to work as a caregiver, but after the last situation, she is not sure if it is safe to work in other people’s homes. She discloses that for four or five years, she was allowed to leave the house only for school, and she was not allowed to have any friends, go on dates, or participate in any school activities. She worked to care for the child and clean the home seven days a week. You begin to suspect this is a case of labor trafficking in the form of domestic servitude, but it is not clear. You decide to administer the QYIT screening questions[ME15] to determine if it is likely that she was trafficked. You give her a tablet with the questions listed, explain the nature and purpose of the tool, and then leave her to privately answer the questions[KET16]. Upon review and discussion of the questions and answers, Samantha said “yes” to, “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. Did this job make you feel scared or unsafe?” She won’t make eye contact, but she does admit that she was beaten and/or verbally

abused if even a scratch appeared on the child. One day when the boy merely fell down while crossing the street, the parents punished her by beating her with a brush and locking her in her room for several days.

You continue to review the QYIT responses and find that she replied "yes" to, "Sometimes people are even prevented from leaving an unfair or unsafe work situation by their employers. Did you feel afraid to leave or quit a work situation due to fears of violence or threats of harm to yourself or your family?" She says that she was very confused at the time. She wanted to quit the job, but it wasn't really a job exactly. She felt she could not leave or report the situation to anyone because the people had taken her in when her family couldn't support her. She didn't want to disappoint anyone, but she really did want to go out with friends and attend dances and parties. You ask what happened to eventually end her time with that family? She reports that she only left because her mother changed churches and moved far away to escape the control of the church leaders. You ask if the family she was working for was a part of that same church, and Samantha nods "yes". Samantha states that she had recently found the courage to leave their home because of what her mother did, but she is struggling to find stable employment and housing.

When you review the last question, "Did they ever ask you to lie while speaking to others about the work you do?" you see that she responded "yes". She responds with, "Well, I wasn't really supposed to talk about anything about my work, but they never made me openly lie about it. I am terrible at telling lies anyway. I think everyone just assumed I was the boy's sister or his babysitter. So it wasn't a big deal to always see me with him."

You reflect on the fact that it seems that the girl performed unpaid work for years, was threatened with violence, and was coerced into thinking that she was not able to walk away from

the job. However, babysitting is not the typical picture you have of labor trafficking. You ask her if she wants to talk to a legal advocate or a police officer about this situation and she immediately says “no”. You support her decision by stating that she is free to choose. You then provider her with resources and contact information for supportive agencies and shelters.

[KET17][ME18]

Mental Health Treatment Modalities[KET19]

Despite an ever-evolving knowledge of the victimization and growing criminal enterprise that is human trafficking, there remains a significant void of evidence-based research to determine best practices for mental health professionals working with these populations. In the often referenced publication by Lederer et al in 2014, survivors self-reported an average of 12 mental health diagnoses [ME20]during their trafficking victimization (including poor sleep, nightmares, anxiety, depression), and an average of 10 such concerns after leaving.[20] These women were interviewed as survivors of sex trafficking. We unfortunately do not have good data to understand the mental health effects of labor trafficking on families and individuals, adults or youth. Potential mental health complications from acute or chronic labor trafficking are likely to include depression, anxiety, panic attacks, acute stress[ME21], PTSD, depersonalization, substance dependence, and suicidality.[44,45]

Baldwin et al (2014) described the effects of psychological coercion in human trafficking. They found that all survivors they interviewed experienced “[ME22]nonphysical coercive tactics at the hands of their traffickers. Such manipulative tactics were used by traffickers to remove the dignity and autonomy from their victims. All too often these psychological coercive methods

were mixed with physical and sexual assault to cause even more damage and produce even more control.[46]

Even in the absence of robust evidence to support the application of trauma therapy modalities to youth survivors of labor trafficking, here are a few of the modalities that mental health providers are initiating. Multisystemic therapy (MST), dialectical behavioral therapy (DBT), trauma-focused cognitive behavioral therapy (TF-CBT), and child and family trauma stress intervention (CFTSI) for PTSD prevention are among the leading modalities being tested and studied currently.[44] In addition to any of these modalities is the need to address any substance use disorders and suicidality.[1,4,6,7,44,45] Addiction recovery programs that include medication treatment should be used, preferably programs that are trauma-informed and have training and understanding on the effects of trafficking and exploitation. Working as a multidisciplinary medical and therapy team to assess and address the comprehensive health needs of survivors will be the best approach for survivors to find their path to recovery and long term resilience.

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