HEROES

Novel Strategies to Fight Child Sexual Exploitation and Human Trafficking Crimes and Protect their Victims

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D7.3 – Development of guidelines of awareness and victim's assistance resources addressing to governments and stakeholders to follow on investigation and prosecution of THB and CSA/CSE crimes

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Abstract (for dissemination)

The Multidisciplinary Teams Framework, directed at local and national multi-disciplinary teams, provides guidance, based on best practices, on how to appropriately care for children experiencing, or at risk of Trafficking in Human Beings (THB) and Child Sexual Abuse / Child Sexual Exploitation (CSA/CSE). This framework, to be tailored to specific national/local needs, follows a child-centric approach, focusing on prevention, investigation, service provision and prosecution. The goal is to ensure the non-revictimisation of affected individuals and their families through the care process, and provide a guide for the proper intervention of actors and proper use of resources for criminal prosecution.

Keywords	Multidisciplinary Teams, Child-Centric Approach, Trauma-Informed Care, Trafficking in Human Beings, Child Sexual Abuse / Child Sexual Exploitation, Capacity Building.

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Executive summary

The HEROES deliverable 7.3 contains a framework, directed at local and national multi-disciplinary teams (including government, law enforcement, social services, medical professionals, NGOs, victim advocates, and others), which provides guidance, based on best practices, on how to appropriately care for children experiencing, or at risk of Trafficking in Human Beings (THB) and Child Sexual Abuse / Child Sexual Exploitation (CSA/CSE). The focus exclusively on children (<18 years) stems from the knowledge that exploitation and trafficking of adults differs from that of children in many important ways. This framework follows a child-centric approach, focusing on prevention, investigation, service provision and prosecution. The goal is to ensure the non-revictimisation of the affected individual and their family through the care process, and provide a guide for the proper intervention of actors and proper use of resources for proper criminal prosecution.

The framework intends to be used as a template when developing a local, regional, or national Multi-Disciplinary Teams (MDTs) protocol to address THB/CSA/CSE. Intended for use in low-, medium and high-resource settings, in countries varying widely in cultural beliefs and practices, economic resources, laws and legal systems, social conditions and government infrastructure, the framework's guidance is necessarily general and widely applicable. The framework for MDTs outlines general principles and strategies for building and maintaining a comprehensive, multidisciplinary collaborative approach to the prevention, recognition, assessment, intervention, investigation and prosecution of THB, CSA and CSE. It aims to ensure that children experiencing THB/CSA/CSE and their families receive services that meet their holistic needs, in ways that respect child rights, empower the child and caregiver, promote healing, minimise the risk of re-victimisation, and minimise emotional distress during the intervention process, through creating the structure to enable consistent information-sharing and collaboration between MDT members. It also seeks to improve the quality of criminal investigations of THB/CSA/CSE and promote successful prosecution of offenders, as well as to enhance the quality of evidence identified for civil litigation. The framework provides the general structure needed to create MDTs that are effective in the local/national context. It includes a sample MOU, a description of the role of MDT members, and information regarding the trauma-informed, rights-based approach to working with the affected child and their families.

This framework is the product of a multidisciplinary collaborative effort between child-serving professionals from low-, medium- and high-resource countries. It represents work by individuals with varied experience and perspectives on trafficking in human beings, child sexual abuse and child sexual exploitation (THB/CSA/CSE), individuals with a commitment to inter-agency, cross-discipline cooperation, and coordination. It is built on the existing evidence base for the effectiveness of multidisciplinary team (MDT) collaboration as identified in a review of published and gray literature, and relies on the fundamental child rights outlined by the United Nations Convention on the Rights of the Child.

Abbreviations

ARV	Antiretroviral
CAMH	Centre for Addiction and Mental Health
CPS	Child Protective Service
CRC	United Nations Convention on the Rights of the Child
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
CSE/A	Child Sexual Exploitation and/or Abuse
FE	Forensic Evaluation
FI	Forensic Interview
HBV	Hepatitis B Virus
HEROES	Novel Strategies to FigHt Child Sexual Exploitation and Human TRafficking Crimes and PrOtect thEir VictimS
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
ICMEC	International Centre for Missing and Exploited Children
ICMEC CH	International Centre for Missing and Exploited Children, Switzerland office (Official HEROES partner)
ICMPD	International Centre for Migration Policy Development
ID	Intellectual Disabilities
LE	Law Enforcement
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Other
NGOs	Non-Governmental Organisations
MDT	Multi-Disciplinary Team
MOU	Memorandum of Understanding
PEP	Post-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infection
STS	Secondary traumatic stress
THB	Trafficking in Human Beings
UN	United Nations
UNICEF	United Nations Children's Fund
VT	Vicarious traumatisation
WHO	World Health Organisation

Definitions

Child sexual abuse (CSA): The World Health Organisation defines CSA as follows, "The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials."34

Child sexual exploitation (CSE): Per the Luxembourg Guidelines, CSE involves engaging a child in a sexual activity in exchange for something (or the promise of such).35 According to the United Nations, the term refers to "Actual or attempted abuse of a position of vulnerability, power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another."36

Trafficking in human beings (THB): Per the Palermo Protocol, severe trafficking in persons involves, "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."37 Importantly, the protocol indicates that when the definition is applied to children (<18 years of age), the 'means' described are not required.

Trauma: According to the Canadian Centre for Addiction and Mental Health (CAMH), "Trauma is the lasting emotional response that often results from living through a distressing event." [8] Trauma may occur when an individual experiences one or more events or conditions they perceive as physically or emotionally harmful or life threatening. In response to such an event a child may show various signs of traumatic stress including nightmares, changes in eating habits, social withdrawal, aggression, difficulty controlling emotions, anxiety and other symptoms in the mental, physical, social, emotional, or spiritual domains.38

Vicarious traumatisation (VT): VT refers to the effects on professionals working with traumatised persons, including changes in their views of self, others, and the world. It refers to the cognitive changes the professional experiences in response to learning about others' trauma.

Traumatic stress: A normal reaction by an individual in response to abnormal events or circumstances. This may involve a wide variety of reactions including, but not limited to, anxiety, depression, sadness, anger, aggression, hyperarousal, changes in sleep and eating patterns, and social withdrawal. In most cases, these reactions resolve over time, but in the subset of individuals with persistent symptoms that disrupt daily functioning, treatment may be beneficial.

Post-Traumatic Stress Disorder (PTSD): A psychiatric disorder that may develop in response to a major traumatic event (actual or threatened), and which includes symptoms in 4 major categories (intrusion symptoms; avoidance of stimuli associated with the trauma; negative alterations in cognitions and mood; and significant changes in arousal and reactivity associated with the trauma event). Symptoms must cause clinically significant distress or impairment in functioning and persist more than 1 month.39

Secondary traumatic stress (STS): The signs/symptoms of post-traumatic stress that affect a person who learns about the trauma and adversity of another individual.

Rights-based, child-centred care: Care that is based on the basic human rights outlined in the Convention on the Rights of the Child1 (ex., right to voice, information, confidentiality, respect, dignity, etc.) and care that prioritises the child's best interests in all decisions and actions involving that individual.

Trauma-informed approach: An approach to working with others that acknowledges the impact of trauma on the feelings, beliefs, cognitions, and behaviours of impacted individuals and incorporates this awareness into behaviours, policies, and practices so as to minimise causing further distress, and to facilitate resilience and healing.

Culturally responsive: Cultural responsiveness involves learning from and relating respectfully to people of one's own and other cultures. It recognises and respects the variety of cultural values, practices, and beliefs, and emanates from cultural curiosity, inclusivity, recognition, and dignity.

Mandated reporter: Persons who, by law, are required to report to authorities when abuse, neglect, or exploitation of another is suspected. Countries and states may differ on the persons defined as mandated reporters, and the exact conditions required to report. Typically, the reporter is required to contact law enforcement, and/or child protective service agencies when the suspected victim is a child.

First responder: This term may have a variety of meanings but in the current context it refers to individuals (often adults interacting with children) who learn of possible THB/CSA/CSE and are in a position to offer assistance and/or report their concerns to authorities. Common first responders are pedagogues, caregivers, health and mental health professionals and others working in child-serving organisations.

Forensic/Investigative interview: A semi-structured interview of a child who is thought to be a victim or witness of a crime, conducted by a trained professional in an objective, child-centred and trauma-informed manner that is legally defensible and designed to assist in a criminal investigation.

Extended forensic evaluation: In some cases, a child may not make a clear disclosure of THB/CSA/CSE during an initial investigative/forensic interview yet there is reason to believe a crime may have occurred. The MDT may collectively decide to conduct a limited number of follow-up sessions (using the same interviewer or an alternative professional), to allow the child to build trust and report any abuse that may have occurred.

1. Introduction

1.1. Purpose of the Framework

This framework is the product of a multidisciplinary collaborative effort between child-serving professionals from low-, medium- and high-resource countries. It represents work by individuals with varied experience and perspectives on child trafficking in human beings, child sexual abuse and child sexual exploitation (THB/CSA/CSE), individuals with a commitment to inter-agency, cross-discipline cooperation, and coordination. It is built on the existing evidence base for the effectiveness of multidisciplinary team (MDT) collaboration, and the fundamental child rights outlined by the United Nations Convention on the Rights of the Child.1

The framework may be used as a template when developing a local, regional, or national MDT protocol to address THB/CSA/CSE. Intended for use in low-, medium and high-resource settings, in countries varying widely in cultural beliefs and practices, economic resources, laws and legal systems, social conditions and government infrastructure, the framework's guidance is necessarily general and widely applicable. When using the framework to design a particular protocol, adjustments will be needed to reflect cultural, economic, social, and legislative conditions. The protocol will need to outline collaborative practices that are feasible and sustainable in the local context. Those developing the protocol must consider the policies and procedures of each agency participating on the MDT and acknowledge that these, as well as local and national laws, may take precedence over the protocol in some circumstances. Adjustment and adaptation may be accomplished by a multidisciplinary steering committee. This committee may also oversee and govern the implementation of the MDT collaboration and review the protocol at specified intervals to update it, as new legislation is passed and/or agency policies and procedures change over time.

Where the text is *[in bold, bracketed and italicised]* below, specific local information should be inserted (for example, *[the geographic area covered by the protocol]; [names and contact info for MDT members and resources]).*

1.2. What Does Multidisciplinary Collaboration Entail?

To promote child and family healing, minimise re-traumatisation and optimise criminal justice efforts in response to THB/CSA/CSE, many countries and regions have developed strategies to promote cross-agency, multidisciplinary collaboration among the professionals engaged in prevention, recognition, intervention, investigation and prosecution activities.2-6 In this framework, these strategies will be referred to as 'multidisciplinary teams' (MDTs), regardless of whether the strategies define discrete 'teams' of professionals or simply emphasise collaborative activities between staff of relevant agencies/organisations. There is no prototype for optimal MDT collaboration and a variety of models have been developed across the globe,3 including but not limited to Thuthuzela Centres in South Africa,7 One-Stop Centres in India, Malawi, and many low- and middle-resource countries,8-10 integrated service centres within hospitals,3,11 Barnahaus centres in Europe,12 and child advocacy centres in the United States.13 Within these categories of MDT organisation there is additional variation,3 often regarding the number and type of partners involved, services offered and overall goals of the team. A relatively large MDT typically involves a private/public partnership between government agencies, NGOs and other private institutions who serve children experiencing or at risk for THB/CSA/CSE.

MDTs may function at a local, regional or national level covering one or more counties/parishes/jurisdictions/states. Their composition varies according to community needs and resources but generally includes professionals from organisations/agencies involved in preventing, identifying, assessing, investigating and prosecuting cases of suspected/confirmed THB/CSA/CSE, and in serving impacted children and their families.13 Typically these include the agencies/stakeholders listed below (See

Section I, "MDT Composition"). Teams may also seek membership from organisations that serve children at particular risk for THB/CSA/CSE, such as asylum/refugee centres, NGO's serving street-based children, organisations serving LGBTQ+ youth, organisations providing immigration assistance, and organisations serving marginalised ethnic, racial or religious groups.13 For MDTs that focus primarily on systemic issues related to the community response to THB/CSA/CSE, it is important to include adults with lived experience of childhood exploitation and abuse, and caregivers of victimised children, as these perspectives are critical in developing policy, programs and systems change.14

Some MDT models involve actual physical colocation of MDT members, including representatives from the government agency providing child protective services, and law enforcement. Some have a specific location where children and families are brought to meet with multiple MDT members for combined services (e.g., a Chikwanekwane).8,11,15 Still others have no specific building that hosts collaborative services and no colocation of MDT members. For example, MDTs may involve a network of representatives from varied organisations and agencies, that simply communicate online, by phone or with regular inperson meetings, to discuss individual cases of THB/CSA/CSE, or to discuss broad, systemic issues related to MDT collaboration. These may involve groups of professionals within a given city or county, or within a state, province, or country.16 The nature of the MDT model in any given community must be consistent with cultural, geographic, social, and economic factors in the region, as well as the needs of the population served.

1.3. One-Stop Service Model6,8,10

In some jurisdictions, the MDT will provide multiple services and engage in collaborative practices at a specific location, such as a One Stop Centre. Important considerations for the centre include, but are not limited to, the following:

- Ensure a child-friendly environment suitable for all ages, for lesbian/gay/bisexual/transgender/queer/questioning/other (LGBTQ+) youth, and for clients from varied cultures. Input from those with lived experience may be very useful when designing the centre.
- Install ramps or lifts to ensure access for children, caregivers an MDT member with mobility challenges.
- Implement child safeguarding policies.
- Establish the location near public transportation or arrange transportation assistance for families.
- Ensure privacy and confidentiality through effective policies and procedures, and conditions in the physical environment (e.g., soundproof interview rooms; keep child/family separated from suspected perpetrator).
- Ensure adequate safety measures are in place to manage stressful situations and or emergencies; ensure staff are trained in these procedures and aware of safety measures.
- Provide adequate space and equipment for team meetings, forensic interviews (FI), team observation of FIs, etc.
- Establish a safe, secure system for storing client data.
- Address information-sharing restrictions and codify system of sharing client information among MDT members as appropriate (e.g., establish legislation allowing information-sharing; establish clear plan for obtaining release-of-information from guardians; address the issue in MDT member MOUs, etc.).
- Build and maintain an efficient case-tracking system.
- Ensure staff are trained in trauma-informed, rights-based, culturally sensitive, child-centred care.
- Provide client/family materials in appropriate languages; have professional interpreters available during visits.

1.4. Evidence Base for MDT collaboration

Multidisciplinary collaboration in the investigation of crimes against children has been recommended in multiple international directives, conventions and reports.1,17-24 The evidence base for the effectiveness of an MDT model in child protection cases is relatively small but growing.3,25 A search of the published literature on varied types of MDT approaches to child physical and sexual abuse found some evidence that supports the collaborative model, although results were mixed.2 When compared to cases managed according to standard practices, typically with no or limited organised MDT collaboration, cases involving MDTs tended to have better criminal justice outcomes associated with activities occurring relatively early in the justice process (for example, police involvement in cases).26 However, results were mixed in the effectiveness of MDT collaboration in percentage of criminal charges filed/prosecutions for abuse (positive result vs no difference), and with respect to percentage of convictions.27 Generally, studies have shown that MDT collaboration is associated with increased and/or more efficient use of mental health services.28,29 Some (but not all)30,31 studies have found positive impacts for MDTs when examining child protection outcomes (e.g., rates of substantiation, time to substantiation, rates of referrals for services, and time to police involvement) and MDT process outcomes (e.g. increase in police involvement of cases and in joint investigations; decrease in number of interviews of the child).2,26,27,31 MDT training on a child-centred, trauma-informed approach to child interactions was viewed as very helpful in studies in South Africa and Zambia.3 A study in the US found that MDT success was related to breadth of professional representation on the team, as well as the existence of organisations providing services to affected children and families.25 When comparing MDT vs standard practice, one study found increased caregiver (but not child) satisfaction with the MDT response;32 and another found greater rates of children receiving medical services.33 A study of MDT collaboration in Malawi and Zambia demonstrated increased police referrals for health care of individuals experiencing sexual/gender-based violence (SGBV) after launching the collaborative approach, including multisectoral training.3 Intensive, multisectoral training of MDT professionals in a Kenya study resulted in increased collaboration, improved forensic care, an increase in knowledge regarding SGBV, and increased convictions of perpetrators.4 Together, these studies provide some evidence for the effectiveness of MDT collaboration of varied types, although it is important to note that results have been mixed and not always positive. For example, one study found formal MDT collaboration was associated with increased rates of referrals to service agencies but no difference in family engagement or case outcomes.31 Another showed that an increase in access to legal services for survivors of SGBV did not necessarily lead to increased use of those services.3 The evidence base is relatively limited and dominated by US-based studies of child advocacy centres. Additional research is needed to assess the effectiveness of other MDT models and of MDT collaboration in low- and middle-resource countries;3 to identify which MDT characteristics are most effective; and to determine which models may be most helpful in given contexts. Nonetheless, international best practices continue to include multidisciplinary collaboration, and this framework is based on existing evidence regarding the important components of a collaborative approach.

An MDT addressing THB/CSA/CSE cannot be effective without demonstrated commitment from top-level leaders of organisations participating in the collaboration. It is important for stakeholders to fully understand and to support the provisions and requirements for MDT participation, including roles, responsibilities, MDT goals, staff time and resource commitments. A memorandum of understanding is helpful in facilitating consensus and commitment among partners. While cultural, social, and legal factors will influence the content of the MOU and structure of the MDT, the elements contained in the MOU below are relevant in many contexts (see Section III).

The framework begins by outlining the foundations of a MDT, then provides relevant definitions for terms related to THB/CSA/CSE, and a sample MOU. It includes sections on providing trauma-informed, child-centred, culturally responsive, and rights-based care, and on strategies for working with children of varying age and developmental abilities. The framework outlines procedures for multidisciplinary collaboration

among team members, describes roles and responsibilities of members, and outlines key services relevant to the MDT. Finally, the framework addresses THB/CSA/CSE prevention, and discusses secondary traumatic stress/vicarious trauma that may be experienced by MDT members. The appendices include additional resources.

1.5. Methodology of the Framework as part of the HEROES project

This framework is one of the activities developed as part of the HEROES (Novel Strategies to Fight Child Sexual Exploitation and Human Trafficking Crimes and Protect their Victims) project which aims to provide a comprehensive solution that encompasses three main components: Prevention, Investigation and Victim Assistance. The HEROES project's main objective is to use technology to improve the way in which help and support can be provided to those who experience THB and/or CSA/CSE. The Multidisciplinary Team Framework will assist stakeholders in establishing a coordinated, collaborative, trauma-informed and child-centred approach to suspected THB/CSA/CSE that optimises child/family service provision, criminal investigation, and prosecution efforts. The framework may be used by stakeholders as a template to create an MDT protocol that guides the collaborative process and is tailored to the needs of the community, country or region to which it applies.

The MDT framework is the product of an interdisciplinary initiative involving experts in child protection from low-, medium- and high-resource countries, as well as extensive desk research regarding the use of MDTs in the field of child protection (including published, peer-reviewed studies and gray literature (e.g., reports and guidelines published by large global organisations). The project was led by the International Centre for Missing and Exploitation Children (ICMEC), as part of the HEROES grant. An initial draft was created on the basis of a review of existing research, as well information gleaned from semi-structured interviews of 15 child protection professionals from 13 countries (Pakistan, Mongolia, Moldova, UAE, India, Nigeria, Kenya, Ireland, Colombia, Lithuania, Portugal, Bulgaria, and Spain). Including the work group chair, the following professions were represented: law, psychology, medicine, law enforcement, NGO director and organisational, local or regional coordinator. Participants reviewed and edited the initial draft, and this was reviewed by HEROES grantees, leading to the final framework.

2. The protocol

Framework for a Multidisciplinary Team Protocol on the Response to Child Sexual Abuse, Child Sexual Exploitation and Child Trafficking in Human Beings

I. Foundations of the MDT Protocol

Why a protocol is important

The purpose of an MDT protocol is to **outline general principles and strategies** for building and maintaining a comprehensive, multidisciplinary collaborative approach to the **prevention, recognition, assessment, intervention, investigation and prosecution of child trafficking, sexual abuse, and sexual exploitation** (THB/CSA/CSE).

Purpose:

The purpose of an MDT protocol is to outline general principles and strategies for building and maintaining a comprehensive, multidisciplinary collaborative approach to the prevention, recognition, assessment, intervention, investigation and prosecution of child trafficking, sexual abuse, and sexual exploitation (THB/CSA/CSE).

An MDT protocol serves as a guideline and is not intended as legal evidence of a standard of care. Compliance or noncompliance with the document is not intended for use in trial or court as relevant evidence. In case of any interpretation or conflict, or for requirements not addressed herein, the law will always take precedence. In addition, case specific conditions may require that certain components of the protocol are not followed; this should be determined on a case-by-case basis.

Goals:

The protocol aims to:

1. Ensure that children experiencing THB/CSA/CSE and their families receive services that meet their holistic needs, in ways that respect child rights, empower the child and caregiver, promote healing, minimise the risk of re-victimisation, and minimise emotional distress during the intervention process. This is accomplished through consistent information-sharing and collaboration between MDT members,
2. Improve the quality of criminal investigations of THB/CSA/CSE and promote successful prosecution of offenders.
3. Enhance the quality of evidence identified for civil litigation.

Objectives:[13,15,34]

The objectives of this Protocol are to:

1. Facilitate a unified, collaborative investigation and response to suspected THB/CSA/CSE.
2. Share information and strategies to ensure optimal service provision and improve the quality of criminal investigations/prosecutions, as well as reduce conflicts between professionals and organisations, and minimise work duplication.
3. Identify and effectively address the holistic needs of the child victim and family, making the best interest of the child the highest priority, while ensuring safety, privacy and confidentiality, consistent with the United Nations Convention on the Rights of the Child.1
4. Minimise distress to the child and family during the assessment, service provision, investigation, and prosecution of THB/CSA/CSE cases.
5. Utilise the varied expertise and resources of multidisciplinary professionals to:
   a) Obtain multiple perspectives regarding a case,
   b) Facilitate better-informed decisions about a case,

c) Generate better outcomes in child and family services, child well-being, and in arrests and successful prosecutions.

6. To ensure standardised and coordinated data collection regarding THB/CSA/CSE

Activities of the THB/CSA/CSE Multidisciplinary Team: (See also, Section VIII)

1. In order to efficiently support children who have experienced THB/CSA/CSE and their families, MDT members need to implement:
2. A written MDT protocol that describes the roles and responsibilities of each MDT member and outlines a national referral mechanism whereby there are multiple recognised points of entry for children who have experienced THB/CSA/CSE to be recognised and served.
3. Consistent communication between members with timely information-sharing as appropriate.
4. Cross-reporting of allegations (law enforcement and child protection/child welfare service workers).
5. Joint investigations and collaborative interviewing, preferably with videorecording of child interviews.
6. Referrals for child and family services to organisations within the MDT and to outside organisations, with consistent follow up during and after the criminal investigation to ensure continuity of care.
7. Regularly scheduled multi-disciplinary case review meetings that help ensure every child/family receives needed services as is possible. Attendance in-person or via videoconferencing is strongly advised.
8. Data tracking with ongoing monitoring and periodic evaluation of MDT activities and functioning, as well as trends in the dynamics of THB/CSA/CSE.
9. Regular meetings of agency leads to discuss systemic issues related to the MDT process and protocol, as well as the results and recommendations of the periodic evaluation.
10. Participate in prevention initiatives to raise awareness within the community and decrease the risk of child victimisation.

Common functions of the THB/CSA/CSE Multidisciplinary Team:

1. Conduct a comprehensive child protection investigation that minimises trauma to the child/family.
2. Assess the safety of the child, immediately and over the longer term.
3. Determine the strengths and needs of the child and family.
4. Provide holistic services to assist the child's recovery and improve family functioning.
5. Successfully investigate and prosecute offenders when appropriate, holding them accountable for their crimes.
6. Raise awareness of THB/CSA/CSE within the community.

Target Audience:

1. This protocol is relevant to all MDT members, as well as other community professionals working with children experiencing THB/CSA/CSE and those at risk of exploitation and abuse. Professionals who are not members of the MDT will benefit from knowing the structure and function of the collaborative approach so that they may more easily work with team members to prevent, report, and respond to THB/CSA/CSE.
2. MDT composition 13,15,25
3. According to best practices, MDT's are composed of the following individuals:

4. Coordinator of MDT (may have dual role with one of the MDT organisations)
5. Government child protective service workers
6. Law enforcement personnel
7. Prosecutors
8. Members of judiciary and/or other legal professionals (ex., a lawyer who represents children), depending on laws and on the structure of the MDT
9. Medical/forensic professionals, ideally with experience working with children exposed to trauma, abuse, and exploitation
10. Mental health professionals, ideally with experience working with traumatised children and their families
11. Representatives from agencies working with children in conflict with the law (for example, a juvenile liaison officer in the republic of Ireland, who works with underage offenders)
12. Victim and/or family advocates
13. Staff from nongovernmental organisations (NGOs) that provide services to individuals who have experienced or are at risk of THB/CSA/CSE, or offer prevention programs and outreach related to THB/CSA/CSE
14. Representatives from congregate care centres that provide housing to children who have experienced THB/CSA/CSE

Additional members may be added, as appropriate. For example, it is useful to consider the following:

1. Border police
2. Educators and/or representatives of the Ministry of Education
3. Child hotline/helpline staff

For the subgroup of the MDT that meets to discuss systemic issues related to protocol implementation (as opposed to discussing specific cases), it is useful to invite the leaders of the above agencies/organisations as well as the following:

1. Caregiver of a child who experienced THB/CSA/CSE, or the survivor, themselves (provided the survivor is developmentally and emotionally able to participate without sustaining harm)
2. Leaders of child-serving community organisations
3. Leaders of migrant/refugee assistance organisations
4. Leaders of organisations that provide housing to vulnerable populations

[Edit above and insert additional members of MDT as indicated]

In some communities, regions or countries it may be very difficult to bring members of a large MDT together for regular case review meetings. In this case, it may be helpful to form a ‘core group’ of MDT members that meets regularly, with ‘ad hoc’ members brought in as needed (for example, border police when there is a transnational case of THB/CSA/CSE). The composition of the MDT will necessarily vary with the resources and limitations of the community.

Geographic Scope:

[Insert description of target area of MDT coverage, for example, a given city, region or country.]

Overview of the Multidisciplinary Team Approach (MDT) in THB/CSA/CSE

Trafficking in human beings, child sexual abuse and exploitation (THB/CSA/CSE) are major global public health problems. Per the International Labour Organisation, approximately 1 million children were subjected to commercial sexual exploitation in 2016.35 In a global systematic review and meta-analysis of child sexual abuse, CSA prevalence estimates ranged from 8 to 31 % for girls and 3 to 17 % for boys.36 Individuals subjected to THB/CSA/CSE may experience a plethora of emotional, behavioural and physical adverse consequences. Impacts include increased risk for post-traumatic stress disorder, major depression, anxiety disorders, sexually transmitted infections and other sexual health and reproductive problems, HIV/AIDS, physical injury, and early pregnancy.37-40

Beyond health and mental health care, children experiencing THB/CSA/CSE often have myriad other needs including housing (if the child is not safe to return home or has no home); education; job skills training; immigration relief, interpretation services, crisis intervention and financial resources. For many children and families, healing and recovery must occur alongside criminal investigations and prosecutions. The sheer number of stakeholders involved in providing services and pursuing criminal justice may be overwhelming to affected children and their caregivers, and this may lead to their confusion, distress, and distrust of authorities, as well as to very limited access to appropriate services. In many areas of the world, child-serving professionals and their organisations work in relative isolation in response to THB/CSA/CSE.34 Information is not shared; resources are not organised; service efforts are not coordinated, and the family must assume responsibility for orchestrating their own healing. Social, psychosocial, health and legal outcomes suffer. This multi-agency, multidisciplinary team (MDT) protocol addresses these shortcomings by outlining procedures to promote cross-agency, multidisciplinary collaboration, to minimise re-traumatisation of children and families, and to optimise prevention, recognition, intervention, investigation, and prosecution activities related to THB/CSA/CSE. It outlines roles and responsibilities for MDT members including mandated reporters, law enforcement, government child protection workers, prosecutors, victim advocates, medical and mental health professionals, and other service providers.

Successful multidisciplinary collaboration entails:[3,9,10,13,15,22,23,25,34,41-44]

- Commitment of leaders of the organisations/agencies comprising the MDT to the success of the team and to multidisciplinary collaboration. This includes commitment of staff time, necessary technology, financial support and other resources to support the MDT activities. Leaders should ensure that agency/organisation standard operating procedures include a statement that at least one staff member participate in the MDT and all staff members receive training on the MDT and on THB/CSA/CSE
- Formal recognition of the MDT by state government, with accompanying MDT funding included in the state budget, along with provisions that authorise interagency collaboration and information sharing
- Strong leadership within the MDT, itself in the form of a steering committee (comprised of decision-makers) and MDT coordinator
- At least one ‘champion’ to advocate for MDT collaboration, including development and ongoing, sustained implementation of the protocol
- Standardised policies and procedures in the form of a protocol that:
    - Is supported by a memorandum of understanding (MOU) signed by leaders of organisations and agencies participating in the MDT
    - Clearly defines the goals and objectives of the MDT (e.g., focus mainly on investigation/prosecution vs. provision of child services vs. focus on both). Ideally, the MDT prioritises both child/family services, which are virtually always needed, and criminal investigation/prosecution, which is pursued in some but not all cases.
    - Clearly establishes that the child’s best interest is, and should always be, the highest priority for the MDT. The rights of the child outlined in the CRC1 are embraced, including but not limited

to, providing the child/family with relevant information about their case, empowering the child/family to voice their opinions in all decisions related to them and to have an active role in safety planning and service provision consistent with age and development; the rights to confidentiality and privacy, as well as cultural sensitivity and care that is free of bias/discrimination.

- Is founded on the concept that the needs and desires of every impacted child/family are unique so that services and assistance must be tailored to meet the specific needs in each case.
- Describes the roles/responsibilities of MDT members,
- Codifies strategies for appropriate information-sharing and collaborative teamwork (including what information can/should be shared and procedures to follow to allow sharing). It is critical to have consistent, open communication between members, with tactical information sharing in the context of privacy and confidentiality laws and policies; existing challenges to cross-agency information sharing must be addressed. This may involve a formal data protection protocol and agreement10 or creating legislation that establishes the MDT and allows information exchange between members. If information sharing may only occur with guardian consent, the protocol should very clearly define who is responsible for obtaining consent, and outline strategies to ensure consent/nonconsent is documented. MDT members responsible for obtaining consent should receive training on the trauma-informed approach to address consent issues so that caregivers do not feel pressured to consent or sign forms without clearly understanding what information is to be shared and with whom.
- Outlines the step-by-step procedure to be followed when managing a case of suspected THB/CSA/CSE, from initial referral of the case to provision of child/family services that extends beyond the period of criminal investigation, to case closure.
- Establishes multiple pathways in which a child may come to the attention of MDT members and receive services. Multiple reporting channels helps ensure vulnerable children are recognised and served.
- Outlines the trauma-informed, child-centred, rights-based approach to working with children who may have experienced THB/CSA/CSE and their families
- Establishes procedures to address and resolve conflicts within the MDT
- Provides information regarding risk factors and possible indicators of THB/CSA/CSE and a standardised, validated screening measure(s) to screen for risk.
- Provides a directory of available child/family services and prevention programs, as well as MDT member agency/organisation contact information
- Establishes formal agreements with key service providers, such as an organisation offering paediatric mental health services, and a children's hospital forensic institute and/or medical clinic where staff are trained in treating paediatric trauma and sexual violence. This helps to ensure standardised reliable services for children and families.
- Addresses vicarious trauma/secondary traumatic stress
- Outlines process for ongoing monitoring and evaluation of the MDT process and impact, with evaluation results used to make necessary changes to MDT
- Defines steering committee to oversee MDT function, resolve conflicts, make changes to the MDT and to ensure sustainability.
- Establishes an MDT coordinator to address day-to-day details of MDT function and ensure ongoing collaboration and compliance with the protocol
- Describes process for effective dissemination of the protocol to stakeholders, including education on use of the protocol

- Inclusion in the standard operating procedures for each organisation that at least 1 staff member participate in the MDT and all staff members receive training on the MDT

- Initial and regular supplementary training of child-serving professionals is critical in establishing a thorough understanding of the similarities and differences in THB/CSA/CSE dynamics, in the experiences, health impacts, and psychosocial needs of children, as well as in the requirements for criminal investigation. Training includes:
    - Annual, cross-professional training of MDT members on the protocol; the definitions and dynamics of THB/CSA/CSE (including similarities and differences); online CSE as a form of abuse; and the trauma-informed, rights-based, child-centred approach to child/family interactions. The training should cover updates to laws and policies; a review of available child/family services; specific training on the negative impact of stigma; and strategies to increase cultural responsiveness.
    - Training for all mental health providers serving affected children and families on the impact of trauma and traumatic stress, the child-centred, trauma-informed approach to working with clients, and basic strategies needed to provide psychoeducation and teach techniques for stress management. Where resources are available, children needing specialty care should be referred to mental health clinicians trained specifically on child trauma and evidence-based therapies for children who have experienced sexual violence. Clinicians should be aware of the similarities and unique challenges in serving children who have experienced THB vs CSE vs CSA.
    - Training for frontline professionals who, while not part of the MDT, may be first responders in the recognition of children exposed to THB/CSA/CSE. This includes some police officers, teachers, labour inspectors, religious leaders and health professionals, among others. Consider creating 'check-lists' or short manuals that outline professional responsibilities when THB/CSA/CSE is suspected.
    - Training on THB/CSA/CSE in police academies, and training programs in law, medicine, nursing, psychology and social work
- A negotiated, shared vision and goals that are valued and accepted by all MDT members and their organisations.
- Awareness of MDT members of existing resources for children and families and effective strategies for cross-agency referrals within and external to the MDT.
- Integration of community-based organisations into the MDT, to help facilitate ser-vice provision
- Use of standardised screening tools when feasible, or use of evidence-informed and standardised questions assessing risk of THB/CSA/CSE appropriate for the local population
- Use of standardised definitions that are harmonised with international standards and national laws
- Regular team meetings to facilitate information sharing and maintain critical relationships among members. Meetings may vary in goals, from focusing on individual case reviews, to broad, high-level discussions of systemic issues regarding MDT function and sustainability.
- Commitment by each member to appropriately protect the private information of children and families
- Clearly established guidelines on appropriate documentation by MDT members
- Understanding of the cultures defining each MDT agency/organisation
- Thorough understanding of members' roles and responsibilities, as well as their organisations' limitations
- Engagement in serious preplanning for MDT development. This may include hosting a roundtable of agency/organisation leaders to discuss the merits and challenges associated with the multidisciplinary process and begin planning the MDT developmental process.

- Attention to 'turf' issues (potentially opposing views of roles/responsibilities of MDT members with disagreements over control)
- Collaborative networking to develop and maintain professional relationships with all members feeling equally valued and respected
- Interdependence, shared power and mutual gain of participants and their organisations
- Participating in primary prevention activities to raise awareness of THB/CSA/CSE, reduce risk within the community and address social stigmas related to THB/CSA/CSE. Such efforts may include school education programs, town hall sessions for parents, and media campaigns.
- Conduct a 'community mapping' exercise to identify public and private organisations that provide resources to address vulnerability factors as well as those facilitating trauma healing.
- Ensure that children/families are assigned a case manager to facilitate service provision during and after investigation
- Work with the media to educate on the child-centred, trauma-informed approach to reporting THB/CSA/CSE, the need to avoid stigmatising, victim-blaming language and a respect for the privacy of affected children and families.

II. Definitions of Common Terms

Multiple definitions for 'child sexual abuse', 'child sexual exploitation' and 'trafficking in human beings' have been proposed by international conventions and guidelines, regional declarations, national, and state laws. Further, the practical implementation of these definitions may vary between state agencies and institutions. The definitions used in this document are the product of international, multidisciplinary collaboration. The term, 'child' refers to any individual who is less than 18 years of age.

[Adjust definitions below to reflect relevant local and national laws and policies.]

Child sexual abuse (CSA): The World Health Organisation defines CSA as follows, "The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials." 45

[Notes]

Child sexual exploitation (CSE): Per the Luxembourg Guidelines, CSE involves engaging a child in a sexual activity in exchange for something (or the promise of such).46 According to the United Nations, the term refers to "Actual or attempted abuse of a position of vulnerability, power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another." 47

[Notes]

Trafficking in human beings (THB): Per the Palermo Protocol, severe trafficking in persons involves, "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."48 Importantly, the protocol indicates that when the definition is applied to children (<18 years of age), the 'means' described are not required.

[Notes]

Trauma: Trauma encompasses the effects that may occur when an individual experiences one or more events or conditions they perceive as physically or emotionally harmful or life threatening and that have lasting negative effects on that person's functioning and well-being, including mental, physical, social, emotional, or spiritual dimensions.49

[Notes]

Vicarious traumatisation (VT): VT refers to the effects on professionals working with traumatised persons, including changes in their views of self, others, and the world. It refers to the cognitive changes the professional experiences in response to learning about others' trauma.

[Notes]

Traumatic stress: A normal reaction by an individual in response to abnormal events or circumstances. This may involve a wide variety of reactions including, but not limited to, anxiety, depression, sadness, anger, aggression, hyperarousal, changes in sleep and eating patterns, and social withdrawal. In most cases, these reactions resolve over time, but in the subset of individuals with persistent symptoms that disrupt daily functioning, treatment may be beneficial.

[Notes]

Post-Traumatic Stress Disorder (PTSD): A psychiatric disorder that may develop in response to a major traumatic event (actual or threatened), and which includes symptoms in 4 major categories (intrusion symptoms; avoidance of stimuli associated with the trauma; negative alterations in cognitions and mood; and significant changes in arousal and reactivity associated with the trauma event). Symptoms must cause clinically significant distress or impairment in functioning and persist more than 1 month.50

[Notes]

Secondary traumatic stress (STS): The signs/symptoms of post-traumatic stress that affect a person who learns about the trauma and adversity of another individual.

[Notes]

Rights-based, child-centred care: Care that is based on the basic human rights outlined in the Convention on the Rights of the Child1 (ex., right to voice, information, confidentiality, respect, dignity, etc.) and care that prioritises the child's best interests in all decisions and actions involving that individual.

[Notes]

Trauma-informed approach: An approach to working with others that acknowledges the impact of trauma on the feelings, beliefs, cognitions, and behaviours of impacted individuals and incorporates this awareness into behaviours, policies, and practices so as to minimise causing further distress, and to facilitate resilience and healing.

[Notes]

Culturally responsive: Cultural responsiveness involves learning from and relating respectfully to people of one's own and other cultures. It recognises and respects the variety of cultural values, practices, and beliefs, and emanates from cultural curiosity, inclusivity, recognition, and dignity.

[Notes]

Mandated reporter: Persons who, by law, are required to report to authorities when abuse, neglect, or exploitation of another is suspected. Countries and states may differ on the persons defined as mandated reporters, and the exact conditions required to report. Typically, the reporter is required to contact law enforcement, and/or child protective service agencies when the suspected victim is a child.

[Notes]

First responder: This term may have a variety of meanings but in the current context it refers to individuals (often adults interacting with children) who learn of possible THB/CSA/CSE and are in a position to offer assistance and/or report their concerns to authorities. Common first responders are pedagogues, caregivers, health and mental health professionals and others working in child-serving organisations.

[Notes]

Forensic/Investigative interview: A semi-structured interview of a child who is thought to be a victim or witness of a crime, conducted by a trained professional in an objective, child-centred and trauma-informed manner that is legally defensible and designed to assist in a criminal investigation.

[Notes]

Extended forensic evaluation: In some cases, a child may not make a clear disclosure of THB/CSA/CSE during an initial investigative/forensic interview yet there is reason to believe a crime may have occurred. The MDT may collectively decide to conduct a limited number of follow-up sessions (using the same interviewer or an alternative professional), to allow the child to build trust and report any abuse that may have occurred.

[Notes]

III. Sample Memorandum of Understanding (MOU)

This memorandum of understanding (MOU) and associated protocol represent a commitment by social service and criminal justice agencies, as well as relevant child-serving organisations in [insert geographic area covered by protocol] to participate in multidisciplinary collaboration to identify, assess and serve children who have experienced THB/CSA/CSE and their families, and to investigate and prosecute offenders. With a goal of improving the response to THB/CSA/CSE in [insert geographic area covered by protocol], the undersigned agencies and organisations commit to engaging in the cooperative, collaborative practices outlined in the protocol, and to periodically reviewing and revising the protocol as conditions change. They commit to providing necessary resources, technology, funding and staff time to facilitate MDT success and sustainability.

The protocol is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal. The protocol shall not limit or otherwise restrict a prosecuting attorney in the exercise of his or her discretion nor in the exercise of any otherwise lawful litigative prerogatives. The law controls the provisions of the protocol. The protocol does not replace agency/organisation policies and procedures.

MDT members will:

a. Adhere to the protocol to the extent possible unless special circumstances dictate an alternative approach.

b. Receive training regarding:

   I. The MDT protocol: All members of the MDT will receive training on the purpose and appropriate use of the protocol, as well as cross-training between team members, so professionals fully understand the roles, responsibilities and limitations of each agency involved. Training will be repeated regularly, to educate new members and remind existing members of key concepts and updates to laws and policies.

   II. THB/CSA/CSE: Training will include the definitions, scope, and dynamics of THB/CSA/CSE, with an emphasis on local and national conditions. Risk factors, potential indicators, and challenges to identification will be discussed, as well as strategies for recognising children experiencing or at risk of THB/CSA/CSE. Characteristics of offenders, as well as strategies used for recruitment and control of targeted children will be described. Training will address the impact of traumatic experiences on child physical and mental health, and ways MDT professionals may support the child and family in recovery. Available community services will be reviewed. Training will involve discussion of the negative impact of stigma as well as strategies to increase cultural responsiveness.

   III. Additional training specific to the professional roles of MDT members is also indicated, per agency/organisation protocol (e.g., investigative techniques related to cybercrime for use by law enforcement; skills for mental health professionals when working with children who experience THB/CSA/CSE).

   IV. The child-centred, rights-based, trauma-informed, and culturally responsive approach to working with children and families. See Section II.

c. Attend scheduled continuing education sessions throughout the year (this may entail guest speakers presenting at MDT meetings on issues related to THB/CSA/CSE).

d. Make the best interest of the child the highest priority in any decision or action impact-ing the child/family.

e. Ensure that any action taken on the case does not place the child or family at increased risk of harm, or minimises potential harm

f. Practise a child-centred, rights-based, trauma-informed, and culturally responsive approach to working with children and families

g. Share case information appropriately with the child and non-offending caregiver (respecting their rights to access information while obeying laws and policies surrounding privacy/confidentiality, respecting ethical and professional standards of practice, and protecting the integrity of criminal investigations). Verbal and written information should be conveyed in the preferred language of the child/family in a way that both child and caregiver can understand. Questions should be encouraged and answered with all possible transparency.

h. Respect the child and family's rights to a voice in decisions affecting them by actively seeking their input throughout the duration of the case. Information provided to the child, and consideration of their requests should be consistent with their developmental stage and cognitive abilities.

i. Take steps to minimise repetitive questioning of children and non-offending caregivers by sharing information, co-attending forensic interviews, and collaborating on activities related to the assessment and investigation of the case.

j. Take steps to ensure that all the adults around the child are protective and will not pressure the child to disclose, withhold or retract information.

k. Prioritise family preservation when in the best interest of the child; when not feasible, consider providing specialised care outside the child's home/family. (e.g., temporary measures in organisations or specialised care centres serving children who have experienced THB/CSA/CSE).

l. Treat other professionals, children, and families with dignity, respect and compassion

m. Provide services that are free of bias and discrimination against families, children, and other professionals. MDT members will take action if bias/discrimination is exhibited by others in the workplace, consistent with agency/organisation policies and procedures.

n. Collaborate and coordinate with other involved MDT agencies, sharing relevant information, decisions and actions consistent with privacy and confidentiality laws and policies. Maintain open communication with others involved in the case, as much as possible.

o. Participate in regular MDT meetings to discuss collaboration/coordination efforts and current cases. These meetings should be closed to the public.

p. Participate in, and abide by, the MDT conflict resolution process as needed (see protocol)

q. Designate a professional to serve as MDT coordinator and provide adequate funding to cover this position.

r. Create a protocol steering committee that oversees protocol implementation and meets at least annually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying its provisions.

Participating agencies commit to:

1. Providing adequate resources for staff to engage in MDT practices (e.g., staff to attend meetings, engage in joint investigations, etc.).

2. Contributing resources to the steering committee, and MDT coordinator as indicated [insert de-tails here].

3. Ensuring staff participating on MDT have relevant experience, knowledge and skills working with children who have experienced THB/CSE/CSA.

4. Ensuring appropriate measures are implemented to protect child/family privacy and confidentiality.
5. Supporting the procedures for conflict resolution among MDT members (see protocol).

This MOU is valid for [insert number] years.

By signing below, signatories indicate adoption of this MOU and the corresponding protocol on Child Sexual Abuse, Exploitation and Trafficking in Human Beings.

[Insert signature blocks for all member agency representatives to sign and date.]

IV. The child-centred, rights-based, and culturally responsive approach to interacting with children and families[1,3,20,44,49,51,52]

This section applies to ANY professional speaking with a child, including during an initial disclosure or forensic interview (FI), while a medical provider is obtaining a history, or when a professional is interacting with a child during the course of the investigation and/or during service provision. (Please refer to definitions of 'rights-based, child-centred care', the 'trauma-informed approach' and 'cultural responsiveness').

Some particularly relevant rights that apply to *both children and adult caregivers.*

Whether speaking to a child about upcoming court procedures or working with a caregiver to create a safety plan, professionals should be cognizant of, and respect, the basic human rights outlined in the United Nations Convention on the Rights of the Child (CRC)1 and national laws and protocols supporting the CRC. Table 1 lists some particularly relevant rights that apply to both children who have experienced THB/CSE/CSA and their adult caregivers.

Table 1: Basic Rights of Children (and Adults) in Cases of THB/CSE/CSA (for full list refer to UN CRC[1])

The child's best interest shall be a primary consideration in all actions involving the child
Right to protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment, or exploitation, including sexual abuse
Right to protection from economic exploitation
Right to obtain relevant information, to be given in a way that the individual can understand (informed assent/consent)
Right to express views and be heard, appropriate to the child's age and development
Right to privacy and confidentiality
Right to consideration of special needs (age, disability, etc.)
Right to dignity, self-respect
Right to respect of cultural and religious beliefs and practices, and to treatment without bias or discrimination
Right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness

The right to treatment that is free of bias and discrimination cannot be overemphasised. Children who experience THB/CSE/CSA often are exposed to multiple types of discrimination, many related to the trauma experience itself (e.g., stigma against 'prostitution'; view that child victims of sexual violence are 'dirty' or 'tarnished'), but also to conditions that render the child vulnerable to THB/CSE/CSA (e.g., foreign-born status, street-based living conditions; non-binary gender identity; physical or intellectual disability). Such discrimination may originate with the lay public and professionals alike. It may be extremely distressing to both child and caregiver and may hinder the ability of a professional to build trust with the child and family and to provide assistance. MDT members must ensure that their own personal biases are not allowed to influence professional behaviour and maintain zero tolerance for discriminatory behaviour by other members. The MDT will establish a formal system allowing children, caregivers, and professionals to lodge complaints anonymously regarding discrimination identified during the course of the team's work. The information submitted will be reviewed by the MDT coordinator, and relevant MDT members, with involvement of the steering committee as indicated. Data summarising the complaints will be organised and maintained in a secure database and reviewed regularly.

[Insert specific details of measures to be taken to prevent and respond to bias and discrimination in the activities of the MDT.]

Children who have experienced THB/CSE/CSA and their nonoffending caregivers may experience prominent symptoms associated with their trauma; this is known as 'traumatic stress'). These symptoms may reflect the body's efforts to cope with the anxiety, fear and other negative emotions associated with the trauma. For

example, extreme anxiety may preclude a child from paying attention to the person attempting to assist them, may impede memory of event details, may lead to transient dissociation whereby the individual seems to distance themselves from their immediate surroundings. Somatic complaints such as seemingly unexplained head, back and stomach aches may signal emotional distress, as may sudden mood swings. Significant trauma of any sort--be it the THB/CSE/CSA events being addressed in the investigation, or another major traumatic event experienced earlier in an individual's life (e.g., prior death of a loved one, or physical assault)--may negatively impact the traumatised child/caregiver's views of themselves and the world around them.49 They may come to view themselves as powerless, worthless, and undeserving of respect. They may view the world as a dangerous place, and the people they encounter (including MDT professionals) as threatening and potentially harmful. As a result, they may adopt behaviours, views and attitudes that reflect these beliefs and serve to protect them from a hostile or threatening situation. Some of these attitudes and behaviours may be maladaptive in situations outside of the trauma setting (e.g., substance use, aggression, suspiciousness, paranoia, marked social withdrawal). They may also negatively impact others who interact directly or indirectly with the individual, including MDT professionals.

It is imperative that the MDT professional understand the potential impact of trauma on the child and caregiver, taking into account the prior trauma events when interpreting an individual's behaviours, statements, perspectives, and beliefs. Understanding the underlying function of a given behaviour (for example, irritability and hostility as a protection mechanism against feared harm) allows the professional to avoid responding in an unhelpful way (e.g., defensiveness, hostility) and instead remain open, non-judgmental, and supportive. The basic tenets of a trauma-informed approach are summarised in Table 2. It is also critical to understand, and to communicate with both child and caregiver, that symptoms of traumatic stress represent normal reactions to abnormal events. That is, their presence does not indicate psychosis or 'craziness'. While some traumatised individuals will go on to develop post-traumatic stress disorder, major depression and other mental health disorders,53-57 many will experience transient traumatic stress symptoms and recover over time, especially when receiving emotional and other support from family and other trusted persons.

Table 2: Concepts of a Trauma-Informed Approach[49,51,58]

Concept	Attitudes & BEHAVIOURS of Professional
SCREEN FOR TRAUMA (THB/CSE/CSA)	The professional is aware of vulnerability factors and potential indicators of THB/CSE/CSA and asks questions to assess the level of risk.
ENSURE SAFETY	The professional actively works to increase the child/caregiver's physical comfort (meets with individual in a warm, private, child-friendly, quiet environment; addresses basic physical needs) and decrease stress and anxiety. The professional follows a protocol to maximise the safety of the child, family and staff; and interviews the child outside the presence of those who accompany them to the visit. A professional interpreter is used when there are concerns of language fluency (family members or companions are NOT used to interpret). No action is undertaken that will jeopardise the safety of the child.
DEMONSTRATE RESPECT	The professional explains the purpose of the visit and the reasons behind each step (for example, the reason for asking personal questions; the function of the physical exam or the purpose of the psychological assessment) and answers the child's/caregiver's questions before seeking assent/consent for each step (consistent with the child's developmental capacities). The provider seeks and accepts the individual's perspective and respects their decisions as feasible and appropriate A. They actively listen and remain non-judgmental and open.
BUILD TRUST	The professional takes time to build rapport with the child/caregiver; demonstrates an interest in learning about who they are and their situation; avoids making assumptions. The professional demonstrates empathy and concern for the individual's well-being.

ENGAGE AND EMPOWER	The professional actively encourages the individual's questions and opinions, facilitates a 2-way discussion, and asks the child/caregiver for their thoughts about their situation/condition and the best way to address it. The provider encourages them to make choices and take control whenever possible throughout the visit.
USE A STRENGTH-BASED APPROACH	The professional identifies and emphasises the child/caregiver's strengths and resiliency and acknowledges that the individual is the expert on his/her/their life.
MAINTAIN TRANSPARENCY	Before asking personal questions, the professional explains any limits of confidentiality in a way the child/caregiver understands. They review who may have access to information obtained during the visit (e.g., access to documentation), and under what circumstances. They explain what will happen during the visit and keep the individual updated on activities occurring during the visit.
DEMONSTRATE SENSITIVITY TO DIVERSITY	The professional is aware of, sensitive to, and respectful of, differences that may exist between themselves and the child/caregiver (e.g., differences in culture, nationality, race, ethnicity, religion, gender, or sexual orientation). They actively seek to understand the individual's beliefs and perspectives as these pertain to their physical and mental health, their life, and their situation. The professional accommodates the individual's preferences whenever these are safe for the person, possible and feasible, and when they represent the best interest of the child. They respect the desire of the child/caregiver to be served by a professional of a specific gender when possible.
MINIMISE RE-TRAUMATISATION	The professional limits their questions to those needed to perform their duties, assess safety, and promote the child's well-being. They avoid questions that are irrelevant and that may trigger anxiety and distress. The professional monitors the individual for verbal and nonverbal signs of emotional distress throughout the visit. They provide reassurance and support and have resources available to manage major psychological distress. They implement procedures to ensure that the child/caregiver does not have to repeat her/his/their information multiple times.
PROVIDE RESOURCES/REFERRALS	The professional or designee creates and regularly updates a list of local, regional, and national resources for the myriad needs of children and families who experience THB/CSE/CSA or are at risk for abuse and exploitation. Ideally, the professional establishes relationships with community service agencies and uses a 'warm hand-off approach' B to a referral agency when possible. Community referral information is provided to the child/caregiver in a way they understand, considering language, literacy, age and cultural factors.
ENSURE PRIVACY AND CONFIDENTIALITY	The professional and the facility maintain strict protocols on documentation and release of information that respect the child's right to privacy and confidentiality. Staff receive training on maximising confidentiality and are held accountable for maintaining high standards.

A: Respecting a child/caregiver's decision about evaluation and treatment assumes there are no health or safety issues that require emergent care, such as uncontrolled bleeding, or place the child's wellbeing in jeopardy. It includes due consideration of the child's developmental capabilities.

B: "Warm hand-off" refers to the professional directly contacting the service agency to discuss and arrange the referral or assisting the child/caregiver with making contact before leaving the professional's facility.

Table adapted from "Improving physical and mental health care for those at risk of, or experiencing human trafficking & exploitation: The complete toolkit, 2nd edition"59 with permission.

V. Speaking with Children of Varying Age and Developmental Status[60-65]

Excellent resources describing the science of child interviewing are available and inform the basis for this section.60-64,66,67 Evidence-based forensic interview protocols are also available.68,69 The information below is intended for use by MDT members in their day-to-day practice; formal, legally-admissible forensic interviews should be conducted by professionals with more22 specialised training (see also Section VIII).

Very young children (e.g., 4 years of age), and many children with intellectual disabilities (ID) are able to provide important information about their experiences, but caution must be taken to consider developmental capabilities and other factors when interviewing a child. The ability of an individual to recall and describe experiences depends on many factors,62,67 including (but not limited to).

- Child factors:
    - Age/developmental status
    - Temperament (impacts how child attends to, and interprets event)
    - Understanding of event(s) in question
    - Coping skills for managing stress
    - Intelligence
    - Information-processing skills
    - Language skills
- Interview factors:
    - Format of questions asked
    - Demeanour of interviewer
    - Content and quality of interview preparation (e.g., rapport-building, discussing expectations)
    - Pre-interview factors (number of times child has been questioned/interviewed and how they have been questioned)
- Event factors:
    - Time between event(s) and interview
    - Number and type of events
    - Child as witness to the trauma of another vs child directly experiencing the event

Acknowledging tremendous variation between children of similar age, and the variation in a given skill demonstrated by a child under different conditions, the following outline may be helpful to MDT professionals (see Table 3). Interviews of children with mild ID should generally be targeted at their 'developmental age' while those with more severe disabilities may benefit from questions appropriate for levels lower than their developmental age. (For more information on interviewing children with ID, see Lamb, et al., 2018; pp137-160).[62]

Table 3: Age- and Developmental Stage- Related Changes in Children's Ability to Describe Their Experiences[52,60-63,65]

Young Children		
Often are able to….	**Usually cannot…**	**They may…**
Answer open-ended questions (broad, and cued invitations), although they may give relatively few details per question	Report how many times an event occurred (although may be able to distinguish between 'one time' and 'more than one time')	Be reluctant to admit they do not know an answer or do not understand
Answer 'who' and 'what' questions, using their own words/terms	Provide a reliable sequence of events (e.g., timeline)	May try to guess if they don't know the answer
Interpret and answer questions very concretely	Tell when something happened or why it happened	May be suggestible to leading questions

	Collect things into adult-like categories ("Has anything like this ever happened to you?")	
	Keep track of pronouns easily	
	Pay attention for extended periods (keep interview to <20 minutes)	

School-Aged Children		
Often are able to…	**Often or Usually cannot…**	**They may…**
Provide idiosyncratic details (e.g., smells, visual details in environment, bodily sensations)	Reliably provide the time of day and month of year or the season when event occurred	Remain relatively concrete, although some abstract thinking is emerging
Provide narratives that are better organised	Give reliable report of frequency of events.	Have a strong sense of responsibility and shame for what happened
Report the age abuse started/stopped		Be reluctant to admit they do not know an answer or do not understand
Correct mistakes introduced by misleading questions		May try to guess if they don't know the answer
		Still make errors with pronoun references
		Become confused when questions include double negatives
		Be very concerned about family's reaction to events, and whether they are believed

Adolescents		
Often are able to…	**Often or Usually cannot…**	**They may…**
Provide a coherent narrative (gradually improves throughout teen years)	The ability to provide event details and to construct coherent narratives are not as well developed as an adult	Be very concerned about peer approval
Provide more details of event(s)		Be concerned about negative parental reactions
Understand some abstract concepts		Be easily embarrassed and easily intimidated
Perceive and integrate emotions and intentions of others into the narrative		Feel shame and guilt about events
		Be vulnerable to suggestive questioning due to feeling pressure to answer 'correctly'.

General tips for speaking with children of all ages, and with adults include:

- Take time to build rapport before asking sensitive questions. This stage allows the professional to build trust with the child/caregiver, assess the ability of the child/caregiver to provide a narrative, and to assess conversational skills and vocabulary. In addition, it allows the child/caregiver to 'practice' providing narratives and answering open-ended questions.
- Provide an explanation for why you need to ask questions and make it clear that participation by the individual is voluntary (e.g., informed consent/assent).
- Discuss the importance of the child/caregiver:
    - Letting the professional know if they
        - do not understand a question
        - do not know the answer to a question
        - feel uncomfortable with a question or want to stop or take a break
    - Talking only about events that the child/caregiver knows actually happened, not about those that may have happened

- Use open-ended questions (broad questions and cued invitations) as much as possible. Even very young children and children with ID are able to answer questions in this format. (See below for discussion of question format.)
- Frame your questions so the child is aware of the topic to be discussed; announce topic changes with a new frame ("We've been talking about your day in the park. Now I'd like to talk about what you did this morning.")
- Clarify terms (e.g., 'had sex'; terms used to describe genitals) and then use the child's terms.
- Make questions short, simple, and inclusive of only one idea. Avoid strings of clauses.
- Avoid phrasing questions in the negative, and especially using double negatives.
- Avoid frequent use of pronouns; instead repeat the name of the person in question.
- If the answer given by the child appears odd or nonsensical, think about how the question was phrased. It may have been an abstract question that the child interpreted very concretely.
- Remain objective and neutral; avoid asking only the questions that will affirm your assumptions or showing approval/disapproval for certain answers.
- Be aware of nonverbal communication, including your own. Do not show surprise, anger, disgust, or other reactions that may be construed by the individual as shaming or blaming.
- Avoid correcting or interrupting the individual during a narrative. You can return to the issue later when the child/caregiver has finished their answer.
- Remember that a narrative may be incomplete. Initially children may provide limited detail as they assess your reaction. Stress experienced at the time of the interview may also impact memory retrieval and disclosures.
- Young children may begin to use words before they truly understand their meaning, particularly prepositions (for example, before, after; inside, between).
- End the session on a neutral or positive note. Ask the child/caregiver if they have any questions or concerns.

Question Format

"Tell me everything you can remember about _____."

While many different types of questions are routinely used in everyday conversations, certain formats are preferred when speaking with children about forensic issues. Specifically, when it is important to maximise the likelihood of obtaining accurate information about an event, it is preferable to use 'open-ended' questions. These rely on a child's free recall, with no additional clues to help with memory retrieval. There may be broad open-ended questions (e.g., "Tell me everything you can remember about _____.") or more focused open-ended questions that restrict a child to a segment of the narrative (e.g., "You mentioned you went into the bedroom. Tell me about the bedroom," or, "You said he left the house. Tell me about what happened after he left the house." Open-ended questions allow the child to choose what they want to discuss within the scope of the topic and expand on the subject based on their own recollections. These types of questions are the most reliable and most likely to yield accurate information from children of all ages, and from those with intellectual disabilities.

"You mentioned you went into the bedroom. Tell me about the bedroom,"

One may obtain a great deal of information from a child simply relying on a sequence of open-ended questions. However, in many cases (with adults and children), narratives prompted by open-ended questions will lack some details and the professional may need to ask more focused/direct questions. These still rely

"You said he left the house. Tell me about what happened after he left the house.

on free recall, but provide direction to a child, using information already mentioned by the individual. Examples include “who”, “what” and “where” questions.

Option-posing questions (e.g., multiple-choice and yes/no questions) are less reliable question formats to use when questioning children and make use of a child’s ability to recognise a piece of information as having been encountered in the past, rather than relying on their ability to retrieve information from long term memory storage. In general, these question formats should be avoided, especially with younger children, and if used, should be followed by free-recall questions to confirm. Finally, leading questions (which introduce information the child has not mentioned) and suggestive questions (those that imply an expected answer) may well generate an inaccurate response due to a child being confused with the introduction of new information or wanting to please the questioner by providing the answer they assume is desired. Examples of such questions include, “What did she say to you before she left? (when the child has not indicated that the person in question said anything at all) (leading), and “Surely you refused to send him the photograph, didn’t you?” (suggestive).

VI. Procedures for Responding to THB/CSA/CSE

Strategies for Information Sharing and Data Protection:

It is extremely important for MDT members to establish an agreed upon safe, secure method of sharing case information with one another, and storing case data. This may require legislation that specifically recognises the authority of the MDT and permits data-sharing between MDT organisations, or establishment of a formal data protection protocol and agreement. A signed release of information should be sought from the caregiver, with explanations of the nature of the MDT; who will have access to what information; and how that information will be protected. The release should have a specific time limit. The information sharing and data protection procedures should be explained to the child (as developmentally appropriate) and caregiver in a way they can understand, using professional interpreters as needed. The procedures must be consistent with legal, ethical, and professional standards of practice, as well as with existing laws regarding data protection. Potential strategies may entail online password protected databases located on a secure server; encrypted email; etc. The exact strategies used will depend on the resources, relevant laws, and other local factors.

[Insert specific details about how information will be communicated among MDT members, who will obtain the consent to release information (ROI), where this ROI will be documented, and how child and family confidentiality and privacy will be ensured.]

Cross-reporting: When an allegation of THB/CSA/CSE has been made, it is important for law enforcement and the agency/organisation responsible for child protection/child welfare to notify one another promptly so that arrangements may be made to collaborate on components of the investigation. In some jurisdictions, additional organisations/agencies may be included in this process of immediate notification (for example, relevant NGOs or health providers). A formal process for cross-reporting is a necessary element of the MDT protocol; this may take the form of a flow diagram indicating reporting processes for all pathways of entry into the THB/CSA/CSE investigation/services. The MDT should identify multiple ways vulnerable children may be identified by professionals and reported for concerns of THB/CSA/CSE, in order to minimise the risk of affected children being overlooked.

[Insert specific details describing the cross-reporting process between law enforcement and child protective service agencies, as well as any other MDT agency/organisation that requires immediate notification of an allegation. Possible strategies include establishing a central 'hotline' that receives reports from all stakeholders, with staff subsequently notifying relevant MDT members via text message, or telephone calls; or establishing an app that automatically notifies key MDT members whenever a report is received.]

Joint investigation: Joint investigation activities include a range of cooperative efforts between MDT members, including, but not restricted to, the following:

- Two or more members co-participating in or observing an interview of witnesses and stakeholders.
- MDT members observing another member conduct a forensic interview of the child.
- Members sharing information about interviews previously conducted by one party (e.g., a written witness statement obtained by law enforcement is shared with the child protection worker).
- Discussion among MDT members prior to an interview to determine relevant questions to be asked.
- An MDT member reviewing their report with one or more other members to explain the content and conclusions, discuss next steps and facilitate referrals for services (e.g., healthcare provider discussing results of forensic examination with law enforcement and communicating with NGO staff regarding child/family service needs identified during the medical visit).
- Sharing other information relevant to the case, such as photographs, and information from records regarding prior assessments/investigations involving the child, family, or alleged offender.

- Communicating among MDT members to follow up on earlier activities, referrals, etc.

[Insert specific details describing any further strategies for joint investigation.]

Flow Diagram of Entire Investigation/Service Provision Process

The MDT will establish and implement a formal step-by-step- process for receiving reports of suspected THB/CSA/CSE, conducting criminal investigations and psychosocial assessments, obtaining necessary child/family services, prosecuting the criminal case and ensuring appropriate post-investigative follow up of holistic child/family services. This will be outlined in one or more flow diagrams. Data will be collected and reviewed periodically to monitor compliance and address challenges encountered by family and MDT members. Data may be gathered through surveys of families and MDT members as well as review of case records. Challenges identified through data analysis will be addressed by the MDT coordinator and steering committee.

Multidisciplinary Case review

The MDT will meet regularly [insert weekly/monthly/quarterly] to discuss active THB/CSA/CSE cases. The meetings will be scheduled and facilitated by the MDT coordinator (alternatively, [insert name of agency/organisation]). An agenda and a list of cases will be distributed [insert number of days] prior to the meeting. Members are expected to review the agenda and come ready to report updates on the listed cases. Members may request discussion of other cases, but sufficient time must be given to the coordinator to include this information on the agenda. At the outset of each meeting the facilitator will review the goals of the session and confidentiality requirements. The participant sign-in sheet will include a commitment to maintain confidentiality.

The purposes of the case review meetings are to:

1. Ensure MDT members are aware of relevant information to help guide the investigation and plan appropriate child/family services for active cases
2. Foster appropriate referrals to meet the needs of the child and family
3. Ensure child/family services are delivered
4. Clarify apparent discrepancies, resolve issues, and answer questions to facilitate the investigation and service provision
5. Continue to cross-train on roles/responsibilities of MDT members
6. Foster networking and collaboration between MDT members
7. In some jurisdictions, meetings may also serve as venues for short continuing education opportunities (invited speakers) and for representatives from new NGOs to describe their services

[Insert additional purposes for case review meetings.]

Feedback System and Conflict Resolution:

MDT members, children and families will have access to a formal system allowing anonymous feedback regarding MDT activities. The information submitted will be reviewed by the MDT coordinator and relevant MDT members regularly, with involvement of the steering committee as indicated.

[Insert a description of the specific strategy for feedback; it may involve suggestion boxes; satisfaction surveys; or other mechanisms for communicating complaints and suggestions.]

In the course of collaborating on difficult and highly stressful cases of THB/CSA/CSE, conflict among MDT members is inevitable. While many conflicts may be resolved informally, or with involvement of MDT agency supervisors, some may be relatively complicated and may require involvement by leadership of the MDT. It is important to have a formal conflict resolution process in place that is familiar to all team members and

rigorously followed. This process should describe the activities, roles, and responsibilities of relevant members as they review, discuss, resolve, and document conflicts. Periodic review of documentation regarding MDT conflicts will assist the steering committee in initiating important systems change to improve the overall collaboration process and the efficiency of the MDT.

An example of conflict resolution may include the following: The MDT coordinator is notified of the conflict by another MDT member or by the members involved in the conflict. The coordinator interviews the involved parties and gathers relevant information. They present this information to the steering committee, who discuss the information and decide on an appropriate course of action. The coordinator summarises the conflict in a confidential log with appropriate redaction of identifying information, and outlines the outcome of the process, including recommendations for change. The log of MDT conflict management is reviewed periodically by the steering committee to help drive MDT evaluation and improvement.

[Insert a description of the specific strategies for conflict resolution.]

VII. Roles of MDT Members

The role of the mandated reporter is to recognise and report to authorities when there is a reasonable suspicion that THB/CSA/CSE has occurred. "Reasonable suspicion" or related term may vary in definition according to national law. The reporter need not be certain of abuse/exploitation. This individual is considered a 'first responder' since they may be the first professional to learn of the suspected THB/CSA/CSE.

The reporter need not be certain of abuse or exploitation. A report should be made when there is a **reasonable suspicion** that THB/CSA/CSE has occurred

[Insert relevant mandatory reporting law here, as well as a list of professionals who qualify as 'mandated reporters'. Insert instructions on who to call to make a report, and what information is needed when making a report.]

Mandatory reporters should consider the following when working with suspected victims of THB/CSA/CSE and their families:

- The best interests of the child must be the highest priority.
- While interacting with the child, minimise questions about the THB/CSA/CSE, limiting your focus to obtaining information critical for your role as a first responder. Your role entails.
    - Assessing if there is reasonable suspicion for THB/CSA/CSE (remember, a mandated reporter does NOT need to be certain THB/CSA/CSE has occurred, but only have a reasonable suspicion/concern)
    - Assessing the immediate and short-term safety of the child (and other children who may be affected)
    - Assessing the immediate need for medical or psychiatric evaluation/care. Indications for immediate care include bleeding, pain, injury, complaint of a discharge from the genitals, obvious physical distress, change in mental status, suicidal ideation, evidence of psychosis, etc.). Emergency medical services should be contacted.
- Consider the safety of the child when deciding to report to authorities, and when deciding if it is appropriate to notify the caregiver that a report is being made.
- Consider the intended and unintended consequences of making a report to authorities and take steps to mitigate negative outcomes and ensure the safety of the child.
- A major role for the mandatory reporter is to provide support and reassurance to the child and nonoffending caregiver. See Table 4 and Sections IV and V for additional guidance.

Table 4: Support for Child Who has Disclosed THB/CSA/CSE

Helpful Strategies	Strategies to Avoid….
Thank the child for telling you what happened	Implying shame or blame
Assure child they are not in trouble	Denigrating the reported abuser/exploiter
Validate their feelings	Assuming the child's perspective matches yours
Assure child the abuse/exploitation is not their fault	Imposing your views of the situation onto the child
Assure child you take the allegation very seriously and you are here to help	Asking irrelevant, traumatising questions
Be transparent about the need for a report to authorities	Making promises you cannot keep
Empower child to share their feelings, concerns	Challenging the child's statement, implying disbelief
Remain non-judgmental, open	Allowing pre-conceived notions, stereotypes, and biases to affect your reaction to the allegation

Law enforcement AND Government Child Protective Service Workers (CPS)

The roles of law enforcement personnel (LE) are to 1) determine if a crime has been committed, 2) conduct an investigation to identify and apprehend the offender and build a criminal case, and 3) file appropriate criminal

charges. (NOTE: A description of specific duties of LE personnel in conducting a criminal investigation for suspected THB/CSA/CSE is beyond the scope of this protocol. Guidance should be sought from agency standard operating procedures, policies and protocols. Additional resources are available.22,70-72

Government child protective service workers (CPS) are responsible for 1) determining if THB/CSA/CSE has occurred, 2) assessing risk and ensuring the safety of the child (an ongoing process), 3) determining the needs of the child and family, and 4) connecting them to appropriate services. The terms used for this position vary with the country; staff are typically government employees.

In addition to following agency/organisation policies and procedures and national reporting mechanism requirements, LE and CPS workers should practise open communication and joint investigative activities between themselves and other MDT members, as outlined in Section VI. Staff should minimise the number of times a child is questioned, using a trained forensic interviewer or other MDT member with advanced child interviewing skills to conduct the in-depth conversation with the child regarding the allegations of THB/CSA/CSE. When LE and CPS staff do speak with the child, the strategies outlined in Sections IV and V should be followed. Prior to beginning the conversation with the child, staff should determine exactly what information is needed to make immediate decisions and inform next steps. Efforts should be made to obtain information from other reliable sources, if at all possible, in order to minimise questioning and avoid causing further distress to the child. DETAILED QUESTIONING OF THE CHILD SHOULD BE DEFERRED TO THE FORENSIC INTERVIEW. This interview should be scheduled as soon as is feasible. One or more MDT members should be designated to arrange the interview so there is a clear line of responsibility. Results of the interview should be made available to relevant MDT members (e.g., staff observe the interview, view the recording, or receive an interview transcript or summary). If possible, the interview should be videorecorded and stored in a safe, secure location.

Children who have experienced THB/CSA/CSE may have sustained one or more physical adverse consequences and should be offered a medical evaluation by a health worker with training on THB/CSA/CSE. This is important for all children, even if the last contact with an offender was weeks or months prior, and even if it is not clear there was sexual contact with the alleged offender(s). Please see “Medical Evaluation” in Section VIII for additional information on the reasons for prompt medical attention.

A designated member of the MDT (often LE, CPS or the MDT coordinator) should be responsible for arranging the medical evaluation and communicating with medical staff regarding results and recommendations. In some cases, a child or caregiver may refuse a medical evaluation. After gently exploring the concerns of the individual and explaining the benefits of an evaluation, the child/caregiver’s request should be respected unless a medical or psychiatric emergency is present (e.g., significant pain, injury, acute symptoms of chronic disease, life-threatening conditions, aggression, psychosis, suicidality, or other extreme emotional distress), or the request may not represent the best interest of the child. It may be feasible, and preferable, to have the child come back for a medical evaluation at another time, should they change their mind.

If available, CPS workers should offer to connect the child/family to a trained mental health professional with experience in treating traumatised children. This will allow the child to be screened for traumatic stress symptoms, and for the child and caregiver to receive important psychoeducation that can assist in the healing process. When specially trained mental health professionals are not available, MDT members should provide the child and family with basic psychoeducation to help manage acute stress related to the trauma. Please see Section VIII, “Emotional and Psychological Support of Children and Their Families.”

For children with severe, persistent symptoms related to the trauma, additional mental health treatment may be indicated, and should be culturally appropriate. Children with pre-existing chronic mental health disorders unrelated to trauma may need referral to a psychiatrist or psychologist for treatment, as well.

Other potential service needs include ongoing primary medical care; substance misuse assessment and treatment; housing, education, job skills training, financial resources, immigration legal advice; interpreter services, assistance with acculturation or repatriation, etc. MDT collaboration for identifying and obtaining

services is essential for the CPS worker; referrals may be made to service organisations inside and outside the MDT. Many countries have child helplines available and these are good sources of information regarding community service referrals. When discussing and planning possible services, child and family safety, confidentiality and preferences must be prioritised, with risk management and safety planning underlying all activities.

[Insert additional roles/responsibilities as indicated.]

Case Manager

Each child/family should be assigned a case manager to assist them in obtaining services and attending appointments and court hearings related to the criminal investigation/prosecution. The case manager helps to ensure continued inter-agency collaboration and a child-centred approach throughout the course of the case, including the time after the investigation has ended when the child/family remain in need of services. This person may be a CPS worker (see above), victim or family advocate or other professional. They maintain close contact with professionals involved in the case and provide updates on case status at MDT case review meetings.

[Insert additional roles/responsibilities as indicated.]

Prosecutor's Office

Prosecuting attorneys are responsible for determining if a case can be charged and for managing the prosecution. They work closely with law enforcement (LE) and government child protection workers (CPS), and with other MDT members as indicated. The prosecutor and legal team work to reduce the child and family's trauma related to the prosecution, minimising child testimony and contact with the alleged offender(s). They ensure the child is assigned a victim advocate (see below) to assist the family during the investigation/prosecution process and orient them to the courtroom and the court processes. The prosecutor uses all available MDT information on the case and minimises the number of times a child is questioned; when questioning occurs, they use a trauma-informed, developmentally appropriate, and rights-based approach (see Sections IV and V). They empower the child and caregiver to express opinions and ask questions during the trial preparation process, and when considering plans for case disposition. The child's views and opinions are given due weight in accordance with their age and maturity.

[Insert additional roles/responsibilities as indicated.]

Criminal and Civil Court Judges

Judges preside over the trial proceedings, maintain order, provide jury instructions (as applicable), determine facts, and make a ruling on a case (bench trial). They decide on the punishment of convicted offenders. In cases of alleged THB/CSA/CSE, it is desirable for the court to strive for the following, within the bounds of laws and regulations, and the rights of the defendant(s):

- Minimise trauma to the child victim (e.g., make efforts to reduce the time the child must be in the presence of the alleged offender; take steps to make the courtroom as child friendly as feasible)
- Make the child's best interest and safety a high priority in pre-trial, trial, and post-trial proceedings
- Minimise opportunities for child and family intimidation by others
- Use a trauma-informed, rights-based, and developmentally appropriate approach when speaking with the child
- Take steps to ensure that child and family receive services that assist in the healing process and help prevent re-victimisation
- Minimise delays in court proceedings

[Insert additional roles/responsibilities as indicated.]

MDT Coordinator

The role of the MDT coordinator is to provide day-to-day oversight of the MDT process. This person is responsible for the following:

- Scheduling, organising, and facilitating regular MDT case review meetings
- Facilitating appropriate follow-up of activities/services that are planned during case review meetings
- Ensuring that a directory of resources for child/family services is kept up-to-date and is available to all MDT members
- Organising and facilitating regular meetings of the steering committee
- Organising regularly scheduled continuing education opportunities for MDT members, and tracking attendance
- Collecting monitoring/evaluation data
- Writing annual report of MDT activities, progress, challenges
- Ensuring conflict resolution processes are followed, assisting in conflict resolution

[Insert additional roles/responsibilities as indicated.]

Forensic Interviewer

Forensic interviewers are responsible for conducting formal, objective, developmentally appropriate and legally admissible interviews of children who may have experienced THB/CSA/CSE. They should have specialised training and ongoing supervision (the latter may be obtained on-site or via videoconference with an expert forensic interviewer); they should follow an evidence-based or evidence-informed forensic interview (FI) protocol. (Please see Appendix B for resources.) Interviewers must stay informed of current relevant legislation regarding THB/CSA/CSE, and new research on forensic interviewing practices. Specific requirements for continuing education of interviewers should be included in the MDT protocol and tracked to ensure ongoing improvement in skills and fidelity with FI protocol standards.

Forensic interviewers work closely with LE, CPS, prosecutors, and other MDT members in preparing for, and conducting the child interviews. They share results of the interview, answer questions by MDT members, and testify in court as needed. Please see Section VIII for a description of the FI process.

[Insert additional roles/responsibilities as indicated. Describe specific supervisory and continuing education requirements and strategies.]

Medical Professional

Medical professionals conducting a forensic evaluation should have received training on THB/CSA/CSE and have the necessary knowledge and skills to work with affected children and their families. With the assent/consent of child and caregiver the medical professional is responsible for:

- Providing an initial medical evaluation of a child, including
    - Obtaining a history using a trauma-informed, rights based, culturally responsive and developmentally appropriate approach
    - Conducting a physical examination to assess general health and acute / chronic medical conditions
    - Assessing dental health and care
    - Evaluating, treating, and documenting traumatic injuries
    - Gathering forensic evidence if indicated
    - Obtaining appropriate diagnostic testing (e.g., sexually transmitted infections, HIV, pregnancy)
    - Offering appropriate treatment for STIs, HIV PEP or ARV, tetanus prophylaxis, HBV immunisation, and emergency contraception (as indicated)

  - Discussing results with the child and family, and offering resources and referrals (e.g., victim-serving organisations, HIV clinic, mental health service). Referrals for services should be made only with assent/consent of the child/family. The medical professional should call the referral organisation or facilitate caregiver contact with referral staff prior to the family leaving the health facility, to maximise the likelihood of follow up.
  - Summarising and interpreting the results of the evaluation in a way that MDT members can understand. A standardised form for documentation may be used, specific for cases of suspected THB/CSA/CSE.
- Medical professionals also provide follow up and ongoing care to address a child's primary and special health care needs. Primary care involves immunisations, periodic sexually transmit-ted infection testing, HIV testing, preventive health services and counselling, reproductive health services, and other testing and treatment as indicated. Providers also make referrals to medical/surgical specialists as needed.
- Medical assessment and treatment of a child who has experienced THB/CSA/CSE is best accomplished when the health facility has a protocol/guidance in place that outlines roles/responsibilities for each staff member, and describes the process for obtaining a history, conducting an appropriate physical/genital exam, gathering forensic evidence, testing for HIV and sexually transmitted infections as well as pregnancy, and offering appropriate treatment (syndromic vs in response to positive testing, vs prophylactic/presumptive), HIV PEP/ARV and emergency contraception). Links to sample protocols and guidance, as well as an online resource to assist in creating an organisational protocol may be found in Appendix B, "Medical Management of THB/CSA/CSE".

[Insert additional roles/responsibilities as indicated.]

Mental Health Professional

The role of the mental health professional is to 1) assess and manage acute psychiatric emergencies (e.g., suicidal ideation, psychosis), 2) assess trauma-related symptoms and offer culturally appropriate, trauma-focused treatment if indicated, 3) provide or refer for assessment/treatment of other mental health disorders (e.g., schizophrenia, bipolar disorder) or for substance misuse disorder. In some cases, mental health professionals also may be asked to provide developmental assessments and/or court-related assessments.

In addition to providing services to the child and family, mental health professionals serve as key members of the MDT. They assist members in understanding the effects of trauma on a child and their caregiver, and the common needs of children who have experienced THB/CSA/CSE. They participate in discussions of mental health service options for families.

[Insert additional roles/responsibilities as indicated.]

Victim Advocate

Victim advocates work directly with children and families to assist them in understanding the roles of MDT members and in communicating with service providers and other professionals as needed. They ensure families understand the investigation and prosecution processes, are oriented to the courtroom and familiar with the roles of court staff. They assist families in navigating the court system, as well as obtaining child and family services. They may accompany the child and/or the family to appointments and court appearances. A victim advocate may serve as the case manager.

[Insert additional roles/responsibilities as indicated.]

Nongovernmental Service Organisation Staff

Staff at nongovernmental service organisations have varied roles corresponding to the mission of their organisation. They may serve children and families experiencing THB/CSE/CSA, and/or those experiencing conditions that render them at risk of THB/CSE/CSA (e.g., migrant/refugee service organisations, domestic

violence shelters). They collaborate with the case manager and other MDT members in ensuring that families have access to needed services.

[Insert additional roles/responsibilities as indicated.]

Interpreters[66,73]

When there are concerns about a child or caregiver's language fluency, a professional interpreter should be used. Family members, other family companions, and staff without professional interpreter credentials should not serve as interpreters. The interpreter's role is to provide a linguistic connection between the MDT professional and the child/caregiver. They translate exactly what is said from one language to another, without omitting, editing, or revising content. They may clarify cultural meanings to avoid or resolve misunderstandings that arise during the conversation. They may also provide information to the MDT member about the child/caregiver's level of understanding during a conversation, and/or cultural nuances that are noted during a conversation. Their knowledge of cultural beliefs and practices can be very helpful in building trust with families, understanding child/caregiver perspectives and needs, and ensuring those needs are met appropriately.

The MDT must ensure access to interpreters (live vs by telephone vs by videoconference) for languages common among the local population and for deaf/hard-of-hearing children/caregivers. These interpreters need to have received training on the trauma-informed, rights-based approach, and on child development. They should not be familiar with the child or family or be from the same village/town. When possible, the gender of the interpreter should follow the preference of the child/caregiver to be interviewed. Interpreters should follow professional standards. They should remain impartial, provide accuracy in interpretation of statements made by the professional and child/caregiver, and strive to minimise cultural misunderstandings that may arise during the interview.

[Insert additional roles/responsibilities as indicated.]

VIII. MDT Services

Forensic Interview (FI)

Forensic interviews (FI) are designed to obtain a statement from a child regarding possible THB/CSE/CSA, using objective, legally defensible techniques that are child-centred, culturally sensitive, and developmentally appropriate. The interview is conducted using an evidence-based or evidence-informed structured protocol.66,68,69,74-76 FI's should be scheduled to maximise MDT collaboration, ensure that information needed by all MDT members is obtained, and minimise the need for repeat interviews. The location of the interview should be child/adolescent-friendly (although not distracting), quiet, neutral, private and (ideally) equipped with technology that allows simultaneous observation by MDT members and videorecording of the interview. MDT members not able to attend the live interview may review the recording and/or other documentation.

The process for scheduling and conducting interviews is as follows:

1. Designated MDT member notifies coordinator of the need for a FI and provides case details.
2. Coordinator arranges the FI to maximise attendance by law enforcement, the government child protection worker, prosecutor, and other designated members [adjust this list to reflect local decisions about who attends FI.]
3. MDT members meet at the FI location and discuss the case prior to the onset of the FI, exchanging information and informing the interviewer of the types of information needed from the interview. [This practice may vary with the jurisdiction; make adjustments to protocol as needed.]
4. One or more members of the MDT meet with the nonoffending caregiver/guardian to describe the interview process, obtain consent for the FI and answer questions
5. The FI commences, following strategies outlined in the formal interview protocol. Before beginning the interview, the child is informed of who may be observing the interview and who may have later access to the recording; they are notified of any videorecording that is occurring; verbal assent is obtained as developmentally appropriate.
6. When the interviewer nears the end of the interview, they excuse themselves and meet briefly with the MDT observers to determine what additional information may be needed and if any aspects of the child's statement need clarification. Additional questions may be asked of the child before closing the interview.
7. The MDT members reconvene to discuss the FI content and plan next steps.
8. One or more MDT members meet again with the caregiver/guardian to discuss next steps and any service needs that have been identified. The content of the FI (child's statement) is NOT discussed with the caregiver/guardian.
9. Depending on the location of the FI, the child may go on to receive additional services onsite such as a medical examination.
10. The documentation of the FI (e.g., recording, notes, etc.) is stored in a secure, protected location and is accessible only to authorised parties [Insert list of MDT members and others who may access the documentation]. The documentation is considered the property of [insert agency/organisation].
11. The MDT coordinator ensures that all relevant MDT members are aware the FI occurred and have access to the documentation as appropriate.

There are a number of evidence-based or evidence-informed interview protocols that are suitable for children who may have experienced THB/CSA/CSE.68,69,74-76 In general, structured interview protocols consist of several phases to the interview, including 62

- An introduction that includes an explanation of the purpose of the FI and establishes expectations for the child.
- Rapport-building phase in which trust is built between child and interviewer.
- Narrative training phase, in which the child 'practices' responding to open-ended questions by describing a neutral event. This affords the interviewer an opportunity to assess the child's linguistic and conversational abilities.
- Substantive phase that includes the child's narrative of the events involving THB/CSA/CSE. This begins with the forensic interviewer using open-ended prompts and is followed by more directive questions as needed.
- Conclusion phase when the interviewer asks the child if they have anything else they would like to add, then introduces a neutral topic to discuss. The interviewer answers any questions, then thanks the child and the session ends.

Forensic evaluation (FE)

A forensic evaluation (FE) extends the forensic interview over multiple sessions (typically 2-6) and is sometimes used when the initial interview is inconclusive, and issues remain unresolved 77. Some children may have difficulty establishing trust with the interviewer during the initial session and need more time (e.g., additional sessions) to feel comfortable discussing sensitive issues. Others may require additional time due to physical or developmental disabilities, and at times cultural factors require extended interview time. The decision to bring a child back for additional forensic interviews must be made on a case-by-case basis and involve MDT discussion, review of established criteria for FEs, consideration of the judicial process and careful analysis of the risks and benefits of the FE.

Medical Evaluation

THB/CSA/CSE is associated with a variety of adverse physical consequences, including injury, infection, unwanted pregnancy, complications of substance misuse, delay in seeking medical care for acute conditions and exacerbation of chronic diseases.38,53,78-81 Children experiencing THB/CSA/CSE may have had limited access to health care, so it is important to arrange a medical evaluation as soon as feasible. The evaluation should be completed by a health worker with training on THB/CSA/CSE.82 Prompt evaluation is important for all children with allegations of THB/CSA/CSE, even if the last reported contact with an offender was weeks or months prior, and even if it is not clear there was sexual contact with the alleged offender(s).83 Some infections (e.g., HIV, syphilis, hepatitis) may have few and subtle symptoms and signs yet have very serious health consequences and persist for years. There may be important physical sequelae that need to be documented (e.g., scarring, disfigurement), and acute or chronic medical conditions that need to be treated (e.g., poorly managed diabetes mellitus). In some cases, initial investigation may suggest only non-contact sexual abuse, with episodes of genital-to-genital contact only being discovered later in the investigation. If this sexual contact between child and alleged offender occurred shortly before authorities became involved and a medical evaluation was not sought, an opportunity for forensic evidence collection will have been missed.

The timing of the medical evaluation depends on the circumstances of the case. An evaluation should be obtained as soon as possible if any of the following is present: 84

- Child has signs/symptoms of injury, infection (e.g., genital discharge, genital pain, itching, pelvic pain, fever), acute illness, suicidal ideation, psychosis, pain, bleeding, or other significant distress
- The last sexual contact may have occurred within 24-120 hours (exact time limits vary with the age of the child and the law enforcement jurisdiction; generally shorter time limits apply to young children while limits from 72-120 hours are often applied to cases involving adolescents)

- There are concerns regarding the safety of the child

If the above criteria are not present, the medical evaluation may be delayed until the child has had some sleep and is less stressed. The examination should be conducted when an experienced clinician is available, preferably in a child-friendly setting. Siblings of the affected child and children who may have been exposed to an alleged offender should be offered a medical evaluation, given their risk of victimisation.

The components of the initial medical evaluation are described in Section VII, "Role of Medical Professional". In short, the initial evaluation seeks to address immediate medical and mental health needs and safety issues, as well as evaluating overall health and nutrition, addressing untreated medical or traumatic conditions, documenting injuries, obtaining forensic evidence if indicated, testing for infections and pregnancy, offering treatment and emergency contraception as indicated, offering community service referrals and assisting in safety planning.51,85,86 Any and all of these steps are completed only with the assent/consent of the child and guardian unless a medical emergency is present. The medical evaluation should be conducted using a trauma-informed, rights-based, culturally responsive and gender sensitive approach, tailoring patient interaction to meet developmental needs. Specific guidance on the medical management of THB/CSA/CSE is 85,87 available 51,59,65,86,88,89.

Ongoing medical care for children with a history of THB/CSA/CSE includes periodic well child checks, immunisations, periodic STI testing, reproductive and sexual health care, preventive care and anticipatory guidance. Referrals for medical, surgical, or mental health care may be indicated.

Emotional and Psychological Support of Children and Their Families

Many children are very resilient, even after experiencing major traumatic events.[90,91] Some children who have experienced THB/CSA/CSE will develop symptoms of traumatic stress (see Table 5).[92] These symptoms represent normal reactions to highly abnormal situations. They may vary in severity, expression and duration, since no two children experience and react to trauma in the same way.[93] Many children will not go on to develop severe mental health problems such as post-traumatic stress disorder (PTSD) and major depression, but a proportion of children will have persistent symptoms that disrupt daily life and may meet diagnostic criteria for these and other disorders.[94] Some may benefit from mental health treatment.

Table 5 : Common (and Nonspecific) Reactions to Trauma[95]

Trauma Reaction	Comments
Abrupt changes in behaviour; new fears	
Avoidance	Of situations, people, conversation topics
Social withdrawal	
Difficulty regulating emotions	
Irritability	
Anger, hostility, aggression	
Distrust of others, especially adults	
Regression in milestones	Especially younger children; ex., new bedwetting
Generalised fears	Very young children may have difficulty describing their fears
Recreating aspects of the trauma	In drawings, stories, sexualised behaviour, etc.
Sexual behaviours or use of sexual language not consistent with age/developmental stage	
Hyperarousal, hypervigilance	
Difficulty paying attention	May mimic attention deficit hyperactivity disorder
Anxiety/panic	May be exacerbated by memories of trauma
Hopelessness, sadness	
Physical symptoms	Nightmares, change in appetite, sleep problems, pain without apparent cause (e.g., somatic symptoms); bowel symptoms
Guilt, self-blame	
Numbness, dissociation	
Refusal to separate from caregiver	Young children
Intrusive thoughts about trauma experience	

High-risk behaviour (e.g., substance use, running away; self-injurious behaviour)	Often seen in adolescents
Concerns of being perceived as abnormal	Especially in adolescents

MDT members play a key role in providing psychoeducation to the child and caregiver and referring children with persistent and significant symptoms for further assessment by a mental health professional (see Role of Mental Health Professional in Section VII) and/or victim-service organisation providing psychosocial support. Psychoeducation may include:

- Providing the child and the caregiver basic information about how children typically respond to trauma
  - See Table 5
  - These are normal reactions to abnormal circumstances
  - Traumatic stress symptoms are not unusual
  - They do not mean the child is 'crazy,' 'bad' or 'damaged'
  - They often self-resolve but if not, treatment is available
- Discuss the concept that trauma impacts the way a child views themselves, others, and the world around them, and influences their behaviours and attitudes. Caregivers are advised to look beyond the child's behaviours (e.g., hostility, anxiety) to the potential functions of the behaviours (e.g., self-protection, a reaction to a memory of the trauma event(s)) and respond with empathy and support, realising that negative behaviours and attitudes likely reflect the child's trauma rather than being a sign of negativity toward the caregiver.
- Discuss the concept of trauma triggers (sounds, smells, sights, etc. that remind the child of trauma, and often lead to anxiety, fear, or other distress). Discuss ways caregivers can help the child identify trauma triggers and develop strategies to avoid the triggers or mitigate their impact.
- Teach the child and caregiver strategies for emotion regulation (e.g., relaxation techniques, mindfulness, yoga, specific cultural practices).

Additional messages for the caregiver include:

- The abuse/exploitation/trafficking is not the fault of the child (or their fault as caregivers). It is the responsibility of the offender.
- The child needs increased support and acceptance, especially during times of acute exacerbation of stress
- Establishing routines and maintaining a sense of 'normalcy' can help a child feel safe
- It is helpful to offer the child choices and control whenever possible

MDT members and other service providers should use a strength-based approach to empower the child and the caregiver to identify healing strategies they feel would be most effective, encourage the child and caregiver to offer their opinions in planning services and to actively engage in those services.

If psychologists and other highly trained mental health specialists are scarce or unavailable in the community, MDT members should consider exploring the possibility of elemental health services provided by experts from other regions/countries. Any mental health therapy that is offered should be culturally appropriate and acceptable to the child and family. Often this involves a combination of therapeutic strategies that incorporate cultural values, beliefs, and practices into traumafocused therapeutic modalities. Services designed to improve child and family well-being vary and may be provided by a number of organisations. For example, music or art therapy, peer support groups, group counselling, yoga classes and meditation sessions may be offered at organisations within the community. Community mapping of the available resources is important in order to facilitate appropriate referrals for care.

IX. Prevention of THB/CSA/CSE

Numerous international conventions, protocols and declarations highlight the importance of prevention in eradicating THB/CSA/CSE (see Text box for examples).

Click on each text box to access the text in question.

United Nations Convention on the Rights of the Child

Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)

The Rio de Janeiro Declaration and Call for Action to Prevent and Stop Sexual Exploitation of Children and Adolescents

American Convention on Human Rights: Pact of San José de Costa Rica.

Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography

United Nations Convention against Transnational Organised Crime and the Protocols Thereto

Declaration on the Protection of Children from all Forms of Online Exploitation and Abuse in ASEAN

Prevention efforts may occur at the primary, secondary and tertiary levels.96

- Primary prevention: Strategies targeting the general population that are designed to prevent THB/CSA/CSE from occurring. Goals include raising public awareness and empowering stakeholders to address exploitation and abuse. Examples of primary prevention efforts include public awareness campaigns, and education on THB/CSA/CSE in schools.
- Secondary prevention: Strategies targeting individuals with one or more vulnerabilities to THB/CSA/CSE, with the goal of preventing abuse/exploitation and/or detecting it at its earliest stages. Examples include screening procedures, and programs supporting street-based youth.
- Tertiary prevention: Strategies directed toward those who have already experienced THB/CSA/CSE, with the goals of minimising harm and preventing recurrence. Examples include family services, immigration relief, and mental health services.

Members of the MDT may participate in prevention efforts at all levels, and/or refer children and families to organisations providing secondary and tertiary preventive services. It is important for all MDT members to be aware of prevention programs and services available to children and families at risk for and experiencing THB/CSA/CSE and be familiar with their services and eligibility criteria. In turn, the data derived from MDT activities can help inform prevention programs, as local or national trends emerge and child/family needs change.

Capacity-building for all 3 levels of prevention is central to success.97 The MDT can facilitate training and awareness of THB/CSA/CSE prevention strategies among its members and their associated agencies/organisations, in addition to working with other professionals within law enforcement, medical and mental health, education, public health and social services. They can educate families and children about THB/CSA/CSE and refer families for services that help minimise the risk of abuse/exploitation. They can provide critical information to professionals and the public regarding the harm associated with social stigma, bias and discrimination that often impact children and families experiencing THB/CSA/CSE.

[Insert list of THB/CSA/CSE prevention programs and initiatives, with contact information. Include programs addressing risk factors for THB/CSA/CSE (for example, domestic violence prevention programs.]

X. Monitoring and Evaluation (M and E) of the MDT15

Monitoring and evaluation are critical to the success of a multidisciplinary team.3 Continuous data collection and periodic analysis identify strengths and weaknesses in MDT collaboration and inform quality improvement strategies that will maximise efficiency and improve outcomes. Data analysis also identifies important trends in THB/CSA/CSE which, when shared with key stakeholders, may inform legislative initiatives and policy decisions. Data from the MDT can help drive prevention initiatives and increase awareness of child abuse and exploitation in the region. Any information that is shared outside the MDT is anonymous, consisting of compiled data disaggregated for analysis; no individual information is included.

Possible M and E strategies include:

- Database of cases that includes demographic data, information regarding the THB/CSA/CSE allegations, MDT members involved, results of specialty evaluations (e.g., medical; forensic laboratory); investigation and prosecution outcomes, child/family services recommended; and services obtained by the family
- Qualitative surveys of MDT members regarding their perceptions of the successes and challenges in the collaboration process, and suggestions for improvement
- Feedback from children/families who have been served by the MDT (in the form of surveys, interviews, etc.)
- Feedback from agencies/organisations outside the MDT, that interact with the MDT (e.g., surveys, focus groups of victim-service organisations)

A detailed list of potential monitoring and evaluation variables is available.[3]

XI. Secondary traumatic stress among professionals

> *"The expectation that we can be immersed in suffering and loss and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet."*
> *(Remen, 2006)*

When working with children and families who have experienced THB/CSA/CSE, MDT members are exposed to graphic descriptions of abuse, exploitation, and cruelty. This can result in professionals developing 'secondary traumatic stress' (e.g., symptoms of post-traumatic stress disorder that occur as a result of learning about trauma experienced by others) (STS) and/or 'vicarious trauma' (e.g., changes in a person's views of the world in response to learning of trauma experienced by others) (VT).[98,99] Individuals respond differently to adversity (our own or someone else's), depending on a variety of factors such as temperament, coping style, work habits, prior history of trauma, and social support. STS and VT can be distressing and disruptive to those who experience it, impacting their personal and professional lives.

Some potential signs of STS/VT include:[98]

- Feeling:
    - Overwhelmed
    - Angry/irritable
    - Isolated/alienated
    - Anxious
    - Depressed
    - Cynical about work, about humanity, etc.
- Experiencing:
    - Intrusive thoughts
    - Sleep problems (e.g., nightmares, insomnia)
    - Problems with sexual intimacy
    - Numbness
    - Exhaustion
    - Difficulty concentrating, planning, making decisions
    - Pain (e.g., headaches, neck pain, back aches)
- Avoiding contact with certain families/children
- Acting impulsively, taking unnecessary risks

Strategies for preventing and reducing STS/VT may be implemented at the personal, professional and

Table 6 : Strategies for Addressing Secondary Traumatic Stress and Vicarious Trauma.[101,102]

Personal	Professional	Organisational
Identify one or more supportive individuals who understand STS/VT	Respect boundaries (yours and others')	Encourage a culture that acknowledges work-related stress and fosters support and recovery
Engage in regular exercise	Know and accept your limitations; have reasonable expectations	Organise staff debriefing sessions after very stressful events
Work on hobbies, engage in enjoyable activities	Avoid assuming responsibility for other people's problems	Ensure supervisors are aware of STS/VT and of strategies to support staff
Examine and adjust work/life balance	Share with others (debrief, but do not traumatise peers)	Accommodate staff with STS/VT (ex., time off; reorganisation of activities, of schedules)
Do not bring work home with you	Obtain ongoing professional training (general or relating to STS/VT)	Provide psychological support for those with STS/VT symptoms

Maintain a healthy diet	Prepare/plan for stressful aspects of work (ex., arrange schedule to perform stressful work when you have maximum energy)	Organise well-being activities for staff
Practice relaxation, mindfulness exercises	Monitor yourself for signs of stress	Ensure hiring process is transparent about stress encountered in work

XII. Dissemination and Maintenance of Protocol

To be effective, the MDT protocol must be easily accessible to all staff of the MDT agencies and organisations, as well as to frontline professionals who may refer children for services and investigation of suspected THB/CSA/CSE. Strategies for dissemination may include one or more of the following:

- Regular training on THB/CSA/CSE and the protocol (stand-alone training and/or inclusion at agency/organisation staff meetings)
- Regular email or social media notifications regarding the MDT, with links to the protocol
- Online self-paced module describing the MDT protocol, available for new employees as well as established staff (annual supplementary training)

[Insert additional strategies for dissemination as indicated.]

An effective protocol must reflect new policies and legislation, as well as changing dynamics of THB/CSA/CSE and changing needs of affected children and their families. The protocol will be reviewed and revised by the steering committee or a designated work group every [insert number] years (or sooner, if significant changes are indicated before that time).

4. Conclusions

The Multidisciplinary Teams (MDTs) Framework aims to provide a guide to professionals caring for children who have experienced Trafficking in Human Beings (THB) and/or Child Sexual Abuse / Child Sexual Exploitation (CSA/CSE) to ensure non-revictimisation of the child and family through the care process, and to provide a guide for the proper intervention of actors and proper use of resources. This framework offers advice and space to tailor a protocol to the relevant nation, region, or community's needs.

The framework touches upon every aspect of the care process, from the development of an MDT to the creation of a memorandum of understanding, descriptions of roles and responsibilities, as well as information-sharing and collaborative processes. It describes the child-centred, rights-based, and culturally responsive approach to interacting with children and families, speaking with children of varying ages and developmental status and the procedures for responding to THB/CSA/CSE. The framework discusses THB/CSA/CSE prevention, as well as monitoring and evaluation of MDT compliance and impact. It addresses secondary traumatic stress among MDT professionals. The framework also offers important learning points on risk factors and potential indicators of THB and CSA/CSE, and provides key resources to further assist in MDT development.

References

For the HEROES Deliverable

[1] UNICEF (1989). *Convention on the Rights of the Child text*. Available at: https://www.unicef.org/child-rights-convention/convention-text#:~:text=For%20the%20purposes%20of%20the,child%2C%20majority%20is%20attained%20earlier. Last accessed on 15.05.23.

[2] World Health Organisation (1999). *Report of the Consultation on Child Abuse Prevention, 29-31 March 1999, WHO, Geneva*. Available at: https://apps.who.int/iris/handle/10665/65900, Last accessed on 15.05.23.

[3] Greijer, S., and Doek, J. (2016). "Terminology Guidelines For The Protection Of Children From Sexual Exploitation And Sexual Abuse", *Interagency Working Group in Luxembourg*. Available at: https://ecpat.org/wp-content/uploads/2021/05/Terminology-guidelines-396922-EN-1.pdf. Last accessed on 08.03.23.

[4] United Nations (2017). "Task Team on the SEA Glossary for the Special Coordinator on Improving the United Nations Response to Sexual Exploitation and Abuse", *UN Glossary on sexual exploitation and abuse*. Available at: https://hr.un.org/sites/hr.un.org/files/SEA%20Glossary%20%20%5BSecond%20Edition%20-%202017%5D%20-%20English_0.pdf; Last accessed on 08.03.23.

[5] World Health Organisation (2008), *A Human Rights-Based Approach To Health*. Available at: https://www.ohchr.org/sites/default/files/HRBA_HealthInformationSheet.pdf. Last accessed on 15.05.23.

[6] ICMPD (2009). *Guidelines for the Development of a Transnational Referral Mechanism for Trafficked Persons South-Eastern Europe.* Available at: https://www.icmpd.org/file/download/52503/file/Guidelines%2520for%2520the%2520Development%2520of%2520a%2520Transnational%2520Referral%2520Mechanism%2520for%2520Trafficked%2520Persons%2520-%2520South-Eastern%2520Europe.pdf. Last accessed on 15.05.23.

[7] United Nations (2000). "Protocol to prevent, suppress and punish trafficking in persons especially women and children", supplementing the *United Nations convention against transnational organised crime*. Available at: http://wwwohchrorg/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersonsaspx Last accessed on 25.07.22.

[8] Canadian Centre for Addiction and Mental Health (CAMH) (2023), *Trauma*, https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma#:~:text=Trauma%20is%20the%20lasting%20emotional,regulate%20emotions%20and%20navigate%20relationships. Last accessed on 15.05.23.

[9] Substance Abuse and Mental Health Services Administration (2014). "SAMHSA's concept of trauma and guidance for a trauma-informed approach", *Substance Abuse and Mental Health Services Administration*.

[10] United Nations Human Rights (1990). "Convention on the Rights of the Child", *Office of the High Commissioner for Human Rights*. Available at: http://wwwohchrorg/EN/ProfessionalInterest/Pages/CRCaspx Last accessed on 23.07.22.

[11] European Parliament (2012). *Directive 2012/29/EU*. Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32012L0029 Last accessed on 23.07.22.

For the body of the Protocol

[1] United Nations Human Rights, Office of the High Commissioner for Human Rights. Convention on the Rights of the Child. *Available at: http://wwwohchrorg/EN/ProfessionalInterest/Pages/CRCaspx; Accessed on 7/23/22.* 1990.

[2] Herbert JL, Bromfield L. Better together? A review of evidence for multidisciplinary teams responing to physical and sexual child abuse. *Trauma Violence Abuse.* 2019;20(2):214-228.

[3] United States Agency for International Development. Impact evaluation of the "Increasing services for survivors of sexual assault in South Africa" program: Baseline report draft. 2015;Available at https://www.usaid.gov/documents/1866/drg-impact-evaluation-%E2%80%9Cincreasing-services-survivors-sexual-assault-south-africa%E2%80%9D; accessed on 7/24/22.

[4] Mulambia Y, Miller AJ, MacDonald G, Kennedy N. Are one-stop centres an appropriate model to deliver services to sexually abused children in urban Milawi? *BMC pediatrics.* 2018;18:145-151.

[5] Olson RM, García-Moreno C, Colombini M. The implementation and effectiveness of the one stop centre model for intimate partner and sexual violence in low- and middle-income countries: a systematic review of barriers and enablers. *BMJ Global Health.* 2020;5(3):e001883.

[6] Ministry of Women and Child Development, Government of India. One-stop centre scheme: Implementation guidelines for state governments/UT admirations. 2017;Available at https://wcd.nic.in/sites/default/files/OSC_G.pdf; accessed on 7/25/22.

[7] Council of Europe. Protection of children against sexual exploitation and abuse: Child-friendly, multidisciplinary and interagency response inspired by the Barnahus model. 2018;Available at https://rm.coe.int/barnahus-leaflet-en/16809e55f4; accessed on 7/24/22.

[8] National Children's Alliance. National standards for accreditation of child advocacy centres: 2023 edition. 2023;Availalbe at https://www.nationalchildrensalliance.org/wp-content/uploads/2021/10/2023-RedBook-v5B-t-Final-Web.pdf; accessed on 7/23/22.

[9] United States Department of State. Trafficking in Persons Report: July 2022. 2022;Available at https://www.state.gov/reports/2022-trafficking-in-persons-report/; accessed on 7/22/22.

[10] Haldorsson OL, Promise Project Series. Barnahus quality standards: Guidance for multidisciplinary and interagency response to child victims and witnesses of violence. 2021;Council of the Baltic Sea States Secretariat and Child Circle; available at https://www.barnahus.eu/en/wp-content/uploads/2020/02/PROMISE-Barnahus-Quality-Standards.pdf; accessed on 7/25/22.

[11] European Parliament, European Council. Directive of 2012/29/EU of the European parliament and of the council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime, and replacing Council Framework Decision 2001/220/JHA Available at https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:315:0057:0073:EN:PDF; accessed on 8/1/22.

[12] Council of Europe. Council of Europe convention on the protection of children against sexual exploitation and sexual abuse. 2012;Council of Europe Publishing.

[13] 3rd World Congress Against Sexual Exploitation of Children and Adolescents. The Rio de Janeiro declaration and call for action to prevent and stop sexual exploitation of children and adolescents. 2008;Rio de Janeiro.

[14] UNICEF. Guidelines on the protection of child victims of trafficking: UNICEF Technical notes. 2006;Available at https://gdc.unicef.org/resource/guidelines-protection-child-victims-trafficking; accessed 2/22/22.

[15] United Nations Committee on the Convention on the Rights of the Child. CRC/C/156: Guidelines regarding the implementation of the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography. 2019;Available at https://www.ohchr.org/en/documents/legal-standards-and-guidelines/crcc156-guidelines-regarding-implementation-optional; accessed on 8/28/22.

[16] Cross TP, Jones LM, Walsh WA, Simone M, Kolko D. Child forensic interviewing in Children's Advocacy Centres: empirical data on a practice model. *Child Abuse Negl.* 2007;31(10):1031-1052.

[17] Jaudes PK, Martone M. Interdisciplinary evaluations of alleged sexual abuse cases. *Pediatrics.* 1992;89(6 Pt 2):1164-1168.
[18] Hurlburt MS, Leslie LK, Landsverk J, et al. Contextual predictors of mental health service use among children open to child welfare. *Arch Gen Psychiatry.* 2004;61(12):1217-1224.
[19] Bai Y, Wells R, Hillemeier MM. Coordination between child welfare agencies and mental health service providers, children's service use, and outcomes. *Child Abuse Negl.* 2009;33(6):372-381.
[20] Goldbeck L, Laib-Koehnemund A, Fegert JM. A randomised controlled trial of consensus-based child abuse case management. *Child Abuse Negl.* 2007;31(9):919-933.
[21] Chambers JE, Roscoe JN, Berrick JD, Lery B, Thompson D. Safely Increasing Connection to Community-Based Services: A Study of Multidisciplinary Team Decision Making for Child Welfare Referrals. *Child Maltreat.* 2022;27(3):434-443.
[22] Jones LM, Cross TP, Walsh WA, Simone M. Do Children's Advocacy Centres improve families' experiences of child sexual abuse investigations? *Child Abuse Negl.* 2007;31(10):1069-1085.
[23] Walsh WA, Cross TP, Jones LM, Simone M, Kolko DJ. Which sexual abuse victims receive a forensic medical examination? The impact of Children's Advocacy Centres. *Child Abuse Negl.* 2007;31(10):1053-1068.
[24] International Labour Organisation. Global estimates of modern slavery: Forced labour and forced marriage. *International Labour Organisation, Geneva, Switzerland.* 2017;Available from https://www.alliance87.org/global_estimates_of_modern_slavery-forced_labour_and_forced_marriage.pdf. Accessed 4/28/21.
[25] Barth J, Bermetz L, Heim E, Trelle S, Tonia T. The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. *Int J Public Health.* 2013;58(3):469-483.
[26] Cole J, Sprang G, Lee R, Cohen J. The trauma of commercial sexual exploitation of youth: A comparison of CSE victims to sexual abuse victims in a clinical sample. *J Interpers Violence.* 2016;31:122-146.
[27] Ottisova L, Hemmings S, Howard LM, Zimmerman C, Oram S. Prevalence and risk of violence and the mental, physical and sexual health problems associated wtih human trafficking: An updated systematic review. *Epidemiol Psychiatr Sci.* 2016;CJO 2016 doi:10.1017/S2045796016000135.
[28] Ottisova L, Smith P, Oram S. Psychological consequences of human trafficking: Complex posttraumatic stress disorder in trafficked children. *Behavioral Medicine.* 2018;44(3):234-241.
[29] Varma S, Gillespie S, McCracken C, Greenbaum VJ. Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse Neglect.* 2015;44:98-105.
[30] Sakakida C, Tadaka E, Arimoto A. Development and validation of a new Multidisciplinary Approach Competency Scale for Prevention of Child Abuse from Pregnancy (MUSCAT). *PLos ONE.* 2021;16(4):e0249623.
[31] Okato A, Hashimoto T, Tanaka M, et al. Inter-agency collaboration factors affecting multidisciplinary workers' ability to identify child maltreatment. *BMC Res Notes.* 2020;13(1):323.
[32] Johnson LJ, Zorn D, Tam BKY, Lamontagne M, Johnson SA. Stakeholders' Views of Factors That Impact Successful Interagency Collaboration. *Exceptional Children.* 2003;69(2):195-209.
[33] Fandino Cubillos MR, Gamez Rodrigurez PV, Velasquez Aguas C, et al. Guia derecomendaciones digital paralaidentificacion y atencion inicial de ninas, ninos y adolescentes victimas de violencia sexual en el entorno digital
[34] 2020;Available at https://www.fundacionrenacer.org/wp-content/uploads/2022/06/Investigacion_impactos_2020_digital.pdf; accessed on 7/25/22.
[35] Consultation on Child Abuse P, World Health Organisation V, Injury Prevention T, Global Forum for Health R. Report of the Consultation on Child Abuse Prevention, 29-31 March 1999, WHO, Geneva. In. Geneva: World Health Organisation; 1999.
[36] Greijer S, Doek J, Interagency working group on sexual exploitation of children. Terminology guidelines for the protection of children from sexual exploitation and abuse. *Luxembourg.*

2016;Available at http://www.ilo.org/wcmsp5/groups/public/---ed_norm/---ipec/documents/instructionalmaterial/wcms_490167.pdf; accessed on 5/7/18.

[37] United Nations, Task Team on the SEA Glossary for the Special Coordinator on Improving the United Nations Response to Sexual Exploitation and Abuse. UN Glossary on sexual exploitation and abuse. 2017;Available at https://hr.un.org/sites/hr.un.org/files/SEA%20Glossary%20%20%5BSecond%20Edition%20-%202017%5D%20-%20English_0.pdf; accessed on Nov 18, 2020.

[38] United Nations. Protocol to prevent, suppress and punish trafficking in persons especially women and children, supplementing the United Nations convention against transnational organised crime. *Available at http://wwwohchrorg/EN/ProfessionalInterest/Pages/ProtocolTraffickingInPersonsaspx Accessed on 7/25/22.* 2000.

[39] Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. *Substance Abuse and Mental Health Services Administration.* 2014.

[40] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders: DSM-5.* Vol 10. Washington, D.C.: American Psychiatric Association; 2013.

[41] World Health Organisation. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. 2017;Available at: https://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf;jsessionid=37ADD6616474C995A0D79A2EE83BC1DD?sequence=1; accessed May 12, 2020.

[42] Forkey H, Szilagyi M, Kelly ET, Duffee J. Trauma-Informed Care. *Pediatrics.* 2021;148(2):e2021052580.

[43] International Centre for Missing and Exploited Children. Improving physical and mental health care for those at risk of, or experiencing human trafficking & exploitation: The complete toolkit, 2nd edition 2022;Available at https://www.icmec.org/healthportal-resources/topic/human-trafficking-toolkit/; accessed on 8/18/22.

[44] Cyr M. *Conducting interviews with child victims of abuse and witnesses of crime: A practical guide.* Oxon, OX and New York, N.Y.: Routledge, Taylor and Francis Group; 2022.

[45] Graffam-Walker A. *Handbook on questioning children: A linguistic perspective.* 3rd ed. Washington, D.C.: ABA Centre of Children and the Law; 2013.

[46] Lamb ME, Brown DA, Hershkowitz I, Orbach Y, Esplin PW. *Tell me what happened: Questioning children about abuse.* 2nd ed. West Sussex, U.K.: John Wiley & Sons, LTD; 2018.

[47] Poole DA. *Interviewing children: The science of conversation in forensic contexts.* Washington, D.C.: American Psychological Association; 2016.

[48] Justice Rapid Response. Investigating allegations of sexual exploitation and abuse of children occurring in humanitarian settings: Reflections from practice 2022;Available at https://www.justicerapidresponse.org/new-report-investigating-sea-of-children-in-humanitarian-settings/; accessed on 8/2/22.

[49] United National Office of the High Commissioner for Human Rights. Investigating allegations of sexual exploitation and abuse: A toolkit for partners. 2021;Available at https://interagencystandingcommittee.org/system/files/2021-12/Toolkit%20-%20INVESTIGATING%20ALLEGATIONS%20OF%20SEXUAL%20EXPLOITATION%20AND%20ABUSE%20IN%20HUMANITARIAN%20SETTINGS.pdf; accessed on 8/20/22.

[50] Anderson J, Ellefson J, Lashley J, Miller A, Oliinger S, et al. The Cornerhouse forensic interview protocol: RATAC. 2010;available at: https://www.cornerhousemn.org/images/CornerHouse_RATAC_Protocol.pdf. Accessed on 5/29/17.

[51] La Rooy D, Brubacher SP, Aromaki-Stratos A, Cyr M, Hershkowtiz I, et al. The NICHD protocol: A review of an internationally-used evidence-based tool for training child forensic interviewers. *J Criminological Research, Policy & Practice.* 2016;2:76-89.

[52] Miller AB, Hahn E, Norona CR, et al. A socio-culturally, linguistically-responsive, and trauma-informed approach to mental health interpretation. 2019;Los Angeles, CA, and Durham, NC: National Centre for Child Traumatic Stress.

[53] Lamb ME, Orbach Y, Hershkowitz I, Esplin PW, Horowitz D. A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol. *Child Abuse Negl.* 2007;31(11-12):1201-1231.

[54] Department of Justice UK. Achieving best evidence in criminal proceedings: Guidance on interviewing victims and witnesses, the use of special measures, and the provision of pre-trial therapy. *Available at https://wwwjustice-nigovuk/publications/guide-achieving-best-evidence-practitioner-guide; accessed on 8/22/22.* 2012.

[55] Odeljan R, Butorac K, Bailey A. Investigative interviews with children. *European Police Science and Research Bulletin.* 2015;Summer(12):18-24.

[56] Faller KC, Cordisco-Steele L, Nelson-Gardell D. Allegations of sexual abuse of a child: What to do when a single forensic interview isn't enough. *J Child Sexual Abuse.* 2010;19(5):572-589.

[57] Monnat SM, Chandler RF. Long term physical health consequences of adverse childhood experiences. *Sociol Q.* 2015;56:723-752.

[58] Hailes HP, Yu R, Danese A, Fazel S. Long-term outcomes of childhood sexual abuse: an umbrella review. *The lancet Psychiatry.* 2019;6(10):830-839.

[59] Konstantopoulos WM, Ahn R, Alpert EJ, et al. An international comparative public health analysis of sex trafficking of women and girls in eight cities: achieving a more effective health sector response. *Journal of Urban Health: Bulletin of the New York Academy of Medicine.* 2013;90(6):1194-1204.

[60] Maniglio R. The role of child sexual abuse in the etiology of substance-related disorders. *J Addict Dis.* 2011;30(3):216-228.

[61] Maniglio R. The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psych Review.* 2009;29:647-657.

[62] Kellogg N. The evaluation of sexual abuse in children. *Peds.* 2005;116:506-512.

[63] Herrmann B, Banaschak S, Csorba R, Navratil F, Dettmeyer R. Physical Examination in Child Sexual Abuse: Approaches and Current Evidence. *Deutsches Arzteblatt international.* 2014;111(41):692-703.

[64] Centres for Disease Control and Prevention, Walensky RP, Houry D, et al. Sexually transmitted infections treatment guidelines. *MMWR Rec and Reports.* 2021;70(4):1-187.

[65] World Health Organisation. Technical report: W.H.O. guidelines for the health sector response to child maltreatment. 2019;Available at https://www.who.int/violence_injury_prevention/publications/violence/Technical-Report-WHO-Guidelines-for-the-health-sector-response-to-child-maltreatment-2.pdf; accessed on Nov 17, 2020.

[66] Greenbaum J, Crawford-Jakubiak J, Committee on Child Abuse and Neglect. Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics.* 2015;135(3):566-574.

[67] International Rescue Committee, UNICEF. Caring for child survivors of sexual abuse: Guidelines for health and psychosocial service providers in humanitarian settings. 2012;International Rescue Committee.

[68] Keles S, Friborg O, Idsoe T, Sirin S, Oppedal B. Resilience and acculturation among unaccompanied refugee minors. *International J Behavioral Development.* 2018;42(1):52-63.

[69] Fritz J, de Graaff AM, Caisley H, van Harmelen A, Wilkinson PO, . A systematic review of amenable resilience factors that moderate and/or mediate the relationship between childhood adversity and mental health in young people. *Front Psychiatry* 2018;9:230-248.

[70] National Child Traumatic Stress Network. Information on child trauma. *Available at https://wwwnctsnorg/what-is-child-trauma/about-child-trauma; Accessed on 5/29/17.*

[71] National Child Traumatic Stress Network. The 12 core concepts: Concepts for understanding traumatic stress responses in children and families. *Available at http://wwwnctsnorg/sites/default/files/assets/pdfs/ccct_12coreconceptspdf; accessed on May 17, 2020.* 210.

[72] Benjet C, Borges G, Medina-Mora ME. Chronic childhood adversity and onset of psychopathology during three life stages: childhood, adolescence and adulthood. *J Psychiatr Res.* 2010;44(11):732-740.
[73] National Child Traumatic Stress Network. Age-related reactions to a traumatic event. 2010;Available at https://www.nctsn.org/sites/default/files/resources//age_related_reactions_to_traumatic_events.pdf; accessed on 8/23/22.
[74] UNICEF. Child protection systems strengthening approach, benchmarks, interventions. 2021;Available at https://www.unicef.org/media/110876/file/Child%20Protection%20Systems%20Strengthening%20.pdf; accessed on 8/24/22.
[75] Rozo J, Rivera N. Construyendo entornos protectores de la niñez como estrategia de prevención de la explotación sexual comercial. 2019;Fundacion Renacer and ECPAT Colombia.
[76] National Child Traumatic Stress Network, Secondary Traumatic Stress Commitee. Secondary traumatic stress: A factsheet for child-serving professionals. 2011;Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.
[77] Greinacher A, Derezza-Greeven C, Herzog W, Nikendei C. Secondary traumatisation in first responders: A systematic review. *European J Psychotraumatology.* 2019;10(https://doi.org/10.1080/20008198.2018.1562840).
[78] Saakvitne KW, Pearlman LA, Traumatic Stress Inst. Ctr. for Adult & Adolescent Psychotherapy L. Transforming the pain: A workbook on vicarious traumatisation. . 1996;W W Norton & Co.
[79] Terlonge P, Jorgensen U, Save the Children. Psychological first aid training: Manual for child practitioners. 2013;Save the Children, Copenhagen.
[80] Mathieu F. *The compassio fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatisation.* New York and London: Routledge; 2012.
[81] Assink M, van der Put CE, Meeuwsen M, et al. Risk factors for child sexual abuse victimisation: A meta-analytic review. *Psychol Bull.* 2019;145(5):459-489.
[82] Acharya AK. Perspective of gender violence and trafficking of women in Mexico. *International J Humanities and Social Science.* 2011;1:42-49.
[83] Dank M, Yahner J, Madden K, Banuelos I, Yu L, et al. Surviving the streets of New York: Experiences of LGBTQ youth, YMSM, YWSW engaged in survival sex. *Urban Institute.* 2015;Washington, D.C.
[84] United States Department of State. 2020 Trafficking in persons report. 2021;Available at https://www.state.gov/reports/2020-trafficking-in-persons-report/; accessed on 4/30/21.
[85] Davis J, Miles G. "They didn't help me; they shamed me." A baseline study on the vulnerabilities of street-involved boys to sexual exploitation in Manila, Philippines. *Love146.* 2015;Accessed at https://1at4ct3uffpw1uzzmu191368-wpengine.netdna-ssl.com/wp-content/uploads/2016/01/They-Shamed-Me-.pdf on Jun 4, 2016.
[86] Stop It Now! Warning signs a young person may be a target of online sexual abuse. 2021;Available at https://www.stopitnow.org/ohc-content/warning-signs-a-young-person-may-be-a-target-of-online-sexual-abuse; accessed on 8/26/22.
[87] Wells RD, McCann J, Adams J, Voris J, Ensign J. Emotional, behavioral, and physical symptoms reported by parents of sexually abused, nonabused, and allegedly abused prepubescent females. *Child Abuse Negl.* 1995;19(2):155-163.
[88] Dank M, Yu L, Yahner J. Access to safety: Health outcomes, substance use and abuse, and service provision for LGBTQ youth, YMSM and YWSW who engage in survival sex. *Urban Institute.* 2016.
[89] Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Annals of Health Law.* 2014;23:61-91.
[90] Wood LCN. Child modern slavery, trafficking and health: a practical review of factors contributing to children's vulnerability and the potential impacts of severe exploitation on health. *BMJ paediatrics open.* 2020;4(1):e000327.
[91] Barnert E, Bath E, Heard-Garris N, et al. Commercial sexual exploitation during adolescence: A US based national study of adolescent to adult health. *PHR.* 2021.

[92] Ertl S, Bokor B, Tuchman L, Miller E, Kappel R, Deye K. Healthcare needs and utilisation patterns of sex-trafficked youth: Missed opportunities at a children's hospital. *Child: care, health and development.* 2020.

[93] Adams J. Medical evaluation of suspected child sexual abuse: 2011 update. *J Child Sexual Abuse.* 2011;20:588-605.

[94] Chiesa A, Goldson E. Child sexual abuse. *Peds in Review.* 2017;38:105-118.

Annex A Risk Factors & Potential Indicators of THB/CSA/CSE

A.1 Annex Level 2 Risk Factors[80-84]

INDIVIDUAL

- History of sexual abuse
- History other maltreatment
- Street-based living
- Disability
- Member of a marginalised group
- Unaccompanied migrant minor
- Lesbian/Gay/Bisexual/Transgender/Queer/Questioning/Other status (LGBTQ+)

RELATIONSHIP

- Family violence
- Family poverty
- Family dysfunction (e.g., parental mental health issues, substance misuse, criminality)
- Parental history of child sexual abuse
- Forced migration
- Intolerance of LGBTQ+ status

COMMUNITY

- Tolerance of sexual exploitation and violence
- High crime rate
- Lack of community resources/support
- Transient male populations

SOCIETAL

- Gender-based violence & discrimination
- Cultural attitudes/beliefs (e.g., homophobia, transphobia, etc.)
- Systemic and historical racism/discrimination
- Natural disasters
- Political/social upheaval

A.2 Potential Signs of *Online Abuse*[85]

- Late night use of device
- Increased screen time or sudden decrease in use
- Stress around the need to be online
- Secretive use/hiding screen from others/hiding devices
- Angry or withdrawn when online

- Many new contacts or followers
- Poor academic performance (especially if this represents a change)
- Mental health issues
- Withdrawal from friends and family
- Multiple phones
- New and unexplained gifts or money

A.3 Potential Emotional and Behavioural Signs of THB/CSA/CSE[65,86]

Please also see Table 5 for nonspecific reactions to trauma

- Spends more time outside home without providing any details to caregivers
- Inappropriate sexual behaviour
- Fear of being alone
- Fear of specific people, situations
- Self-harm behaviour
- Companion insists on speaking for child
- Companion does not know much about child
- Companion is resistant to leaving child alone with professional
- Scripted or apparently inconsistent information provided to professional

A.4 Potential Physical Signs of THB/CSA/CSE[87-93]

- Genital discharge, pain, and/or itching
- Vaginal bleeding (nonmenstrual)
- Painful urination or defecation
- Genital or anal injury
- Injuries elsewhere on the body that appear inflicted
- Work-related injuries
- Sexually transmitted infection (especially multiple)
- Unwanted teen pregnancy
- Evidence of substance misuse (e.g., scarring along veins of extremities)
- Chronic pain (e.g., headaches, stomach aches, muscle pain)
- Exhaustion

Annex B Links to Important Resources

B.1 Child Rights

- United Nations Convention on the Rights of the Child, Committee on the Rights of the Child: General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art . 3 , para . 1) Guidance from the UN regarding how to determine the best interests of the child:
    - https://www.icj.org/wp-content/uploads/2014/10/General-Comment-CRC-14-Right-to-have-best-interests-taken-as-primary-consideration-art-3-para-1-2013-eng.pdf

B.2 Sample standards for one-stop collaborative centers

- One stop crisis center: Policy and guidelines for hospitals, Ministry of Health, Malaysia
    - file:///C:/Users/riley/Downloads/OSCC_policy%20(1).pdf
- One-Stop Centre guidelines and scheme, Ministry of Health, India:
    - https://wcd.nic.in/schemes/one-stop-centre-scheme-1
- Barnahus quality standards: Guidance for multidisciplinary and interagency response to child victims and witnesses of violence
- National Children's Alliance: Standards for Accredited Members
    - https://www.cacnd.org/wp-content/uploads/2017/10/NCA-Standards-for-Accredited-Members-2017.pdf
- National Optional Standards of Accreditation for Children's Advocacy Centers:
    - https://incacs.org/wp-content/uploads/2022/07/2023-nca-optional-standards.pdf

B.3 Medical Management of THB/CSA/CSE

- Responding to children and adolescents who have been sexually abused: World Health Organisation Guidelines, 2017
    - https://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf
- Technical report: W.H.O. guidelines for the health sector response to child maltreatment. 2019
    - https://www.who.int/violence_injury_prevention/publications/violence/Technical-Report-WHO-Guidelines-for-the-health-sector-response-to-child-maltreatment-2.pdf
- Caring for child survivors of sexual abuse: Guidelines for health and psychosocial service providers in humanitarian settings; UNICEF and International Rescue Committee; 2012
    - https://www.unicef.org/documents/caring-child-survivors-sexual-abuse
- Sexually transmitted infection treatment guidelines; Centers for Disease Control and Prevention; 2021
    - https://www.cdc.gov/std/treatment-guidelines/default.htm
- Child sex trafficking and commercial sexual exploitation: health care needs of victims, American Academy of Pediatrics, 2015

  - https://publications.aap.org/pediatrics/article/135/3/566/75479/Child-Sex-Trafficking-and-Commercial-Sexual?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000

- Improving physical and mental health care for those at risk of, or experiencing human trafficking & exploitation: The complete toolkit, 2nd edition, International Centre for Missing and Exploited Children, 2022
  - https://www.icmec.org/healthportal-resources/topic/human-trafficking-toolkit/
- Physical examination in child sexual abuse: Approaches and current evidence, Herrmann B., et al., 2014
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4215093/