Guidance: Child Modern Slavery and Human Trafficking

Published May 2022

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Child modern slavery and human trafficking

These practice guidelines aim to provide an introduction to child modern slavery and human trafficking (MSHT) as a significant health and public health concern, and guidance on the role of paediatricians in addressing child MSHT. MSHT is a serious form of child maltreatment and can lead to lifelong physical, mental, emotional, developmental, and social consequences. This is a complex area of practice, and all paediatricians are strongly advised to undertake further specialist training in child MSHT, safeguarding and trauma-informed care.

Good Practice Recommendations:

- Paediatricians will encounter victims and survivors of child MSHT and must familiarise themselves with the signs of MSHT in children and young people (CYP) and the ways in which they present to healthcare settings.
- Paediatricians must follow local safeguarding procedures and referral pathways to dedicated safeguarding professionals and other agencies (most importantly social care and the police), where MSHT is suspected.
- Paediatricians are expected to engage their existing trauma-informed care skillset at all stages of communication, healthcare and safeguarding provision.
- Paediatricians must remain alert to MSHT activity in their local area.
- Paediatricians are strongly encouraged to attend specialist training on the topic of child MSHT (see resources section: MSHT Further Training & Information).

Contents

Guidance: Child modern slavery and human trafficking 4

1. Definitions and background 4
   - 1.1. Definitions 4
   - 1.2. Modern Slavery & Human Trafficking (MSHT) 4
   - 1.3. Child Trafficking 5
   - 1.4. Forms of MSHT Exploitation 5
   - 1.5. Perpetrators of MSHT 5
   - 1.6. Ongoing Vulnerabilities 5
   - 1.7. MSHT as a CYP health and public health problem 6
   - 1.8. Child Rights and MSHT 6
2. What paediatricians need to know: 7
   - 2.1 Recognition of potential CYP MSHT victims 7
   - 2.2 Child Trafficking and Health 7
   - 2.3 Psychological Trauma and Mental Health Impacts 8
   - 2.4 Caring for potential victims in healthcare settings 8
   - 2.5 Looked After Children - initial health assessment/review health assessment 10
   - 2.6 Working with interpreters 10
3 CYP who may require special consideration 11
   - 3.1 Children of MSHT exploited parents 11
   - 3.2 Children trafficked for criminal exploitation, such as county lines 11
   - 3.3 Children within the criminal justice system 12
4. Understanding the referral processes and roles of other agencies. 13
   - 4.1 The UK National Referral Mechanism 13
   - 4.2 Roles of other agencies 14
5. Further Advice 15
6. Additional Resources 16
7. References 18
8. Appendix: MSHT Risks to Child Health & Development 19
   - 8.1. Before MSHT exploitation 19
   - 8.2. During MSHT exploitation 19
   - 8.3. After MSHT exploitation 20
9. Acknowledgements 21

1. Definitions and Background

1.1. Definitions

a. A **'victim'** of MSHT is defined as a child or adult still in the situation of exploitation.
b. A **'survivor'** of MSHT is defined as a child or adult who has exited their situation of exploitation.
c. **'Health'** is considered in line with the World Health Organisation definition as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition[1].
d. **'Safeguarding'** is defined as protecting children from maltreatment, preventing impairment of children's mental and physical health or development, ensuring that children grow up in circumstances consistent with the provision of safe and effective care, taking action to enable all children to have the best outcomes[2]. Paediatricians are strongly encouraged to attend specialist training on the topic of child MSHT (see resources section).
e. A **'Public Health Approach'** is defined as a response to a complex population health issue that involves intervention at multiple levels and is guided by a rights-based, survivor-centred and trauma-informed approach[3].
f. A **'Trauma-Informed Approach'** within an organisation, policy or response recognises that psychological trauma and its associated impacts are likely to be prevalent in a certain population, applies knowledge about the causes and impacts of trauma on individuals and populations, recognises the signs and symptoms of trauma, and strategically structures its activities to resist re-traumatisation[4].
g. **'Trauma-Informed Care'** is a trauma-informed approach to caring for CYP that emphasises the CYP's need for physical & emotional safety, trust, choice, collaboration, empowerment, and a respect for diversity in all its forms[4].

1.2. Modern Slavery & Human Trafficking (MSHT)

MSHT represents criminal acts of severe human exploitation and human rights violation. Victims number approximately 40 million globally, one in four of whom are children [5]. Indirect victims, including children of exploited parents, markedly raise the human cost of these crimes. MSHT crimes are characterised by perpetrators dehumanising victims, denying them their human rights and treating them as a commodity.

In 2020, over 10,000 potential victims of MSHT were identified in the United Kingdom, half of whom claimed they were exploited as children [6]. Due to the clandestine nature of these crimes, the count of all victims is likely to be significantly higher. British nationals represented the majority of potential victims in the UK (34%), with remaining victims from a wide range of nations across the globe [6]. It is anticipated that MSHT will escalate in the wake of the economic and societal disruption caused by the COVID-19 pandemic and mitigating policies [7].

National Referral Mechanism statistics in the UK are released on a regular basis and can be found via the Office for National Statistics website (www.ons.gov.uk) and at https://www.gov.uk/government/collections/national-referral-mechanism-statistics. Be aware that NRM data only represents victims and survivors who have been detected and if adult, have consented to the NRM process. The estimated total MSHT figures are considerably higher.

1.3. Child Trafficking

Child Trafficking is a form of modern slavery, legally defined in the UK as "*the recruitment, transportation, transfer, harbouring or receipt of a child (<18 years old) for the purpose of exploitation*"[8]. Child trafficking typically involves the perpetrator(s) deliberately relocating a child or young person (CYP) once or many times, for the very purpose of exploitation. Exploitation and abuse may also occur online and through use of mobile phones and other devices.

Whilst the term 'trafficking' has a clear legal definition, it is often used interchangeably with modern slavery or MSHT in general usage.

1.4. Forms of MSHT Exploitation

Forms of exploitation include, but are not limited to:

- Labour exploitation ('forced labour')
- Criminal exploitation (including 'County Lines' where CYP and vulnerable adults are exploited to transport illicit drugs and associated money, weapons or goods within a criminal gang model).
- Sexual exploitation
- Domestic servitude
- Financial exploitation (e.g. benefit fraud)
- Debt-bondage (victims forced to work as repayment for manipulated and escalated debt demands)
- Other forms including forced marriage, human organ harvesting and illegal adoption for the purpose of exploitation.

CYP may experience many forms of abuse, deprivation and exploitation at once or over time as a victim of MSHT.

1.5. Perpetrators of MSHT

Perpetrators may be of any gender and aged from adolescence into adulthood. Perpetrators may be from any background or social status and may present in healthcare settings as charming and attentive. Children may also be perpetrators of abuse or violence against other CYP (or adults) during the MSHT situation, including forced mistreatment of other CYP. CYP may also be forced or groomed to participate in the recruitment and exploitation of others, whilst remaining victims themselves. In some cases, this may improve conditions for them. A trauma-informed approach is vital to understand the complexities caused by psychological trauma, severe threat and the survival adaptations of CYP.

Perpetrators at any stage may be known to the child, including parents and relatives, community members, professionals, people in authority and individuals from friendship groups. Whilst kidnapping by a stranger for trafficking does occur, this is much less common than trafficking after developing some form of relationship with the child and/or their family.

1.6. Ongoing Vulnerabilities

Victims and survivors of MSHT are a particularly vulnerable group of CYP who may go unrecognised

and be misunderstood by health, social care, foster care, education, immigration and police services. CYP may also be wrongly criminalised for actions they were forced or manipulated to take during their exploitation. This is particularly the case for criminally-exploited CYP, including victims within the 'County Lines' illegal drugs networks. Recruitment, manipulation and grooming of CYP for MSHT adds to the complexity, as children themselves may not recognise they are a victim. CYP may also be persuaded to mistrust and even hate protective family members and potentially helpful professionals. In addition, MSHT during childhood may deprive CYP of normal educational, social, relational and health opportunities, including development of healthy life skills expected at their chronological age.

1.7. MSHT as a CYP health and public health problem

MSHT are significant health and public health issues within society, intersecting with many socially-located causes of health inequalities and inequity including poverty, lack of education and opportunity, racism and gender-based discrimination. MSHT is also interconnected with global issues of political unrest, war, climate change and food insecurity, migration, the global trade in illegal drugs, organised crime, unethical business practices and the demands of the global market for cheap goods.

MSHT is a CYP health problem because victims are subjected to living conditions and experiences that risk significant damage to their short and long-term mental, emotional, social and physical health and development with potential for life-long health and mental health consequences [(9)]. Such issues range from deprivation of nurture, malnutrition, injuries, physical and sexual assault, forced pregnancy or abortion, psychological violence, torture and trauma. Health issues may be exacerbated by the withholding or limitation of healthcare access [(10)]. Access to healthcare may be a particular challenge for migrant children who are also victims of MSHT. For further guidance on this refer to the RCPCH guidance on this issue [(10)].

Health risks continue after CYP exit exploitation, particularly for survivors navigating complex and frequently stressful assessment processes (including the National Referral Mechanism for human trafficking), seeking asylum, entering foster care and rebuilding life with limited resources.

MSHT is a public health problem because it affects the health and wellbeing of large numbers of people and society as a whole, cutting across boundaries of age, gender and nationality. MSHT thrives on human vulnerability, linked to both individual and population level social determinants of health, health inequities and the human rights landscape. Multiple industries are affected by MSHT across the global economy. MSHT is also connected to the abuse of technology and the internet to groom, manipulate and exploit victims locally, nationally and internationally.

1.8. Child Rights and MSHT

The UN Convention on the Rights of the Child applies to every child without discrimination, whatever their ethnicity, gender, religion, language, abilities or any other status, whatever they think or say and whatever their family background [(11)]. This includes the fundamental right to the enjoyment of the highest attainable standard of health for every human being.

MSHT represents severe child rights violations. All responses to MSHT must be rights-informed for all children, including those accused of criminal offenses. Child health professionals must take a leading role in advocating for the rights of all victims and survivors of child MSHT.

2. What paediatricians need to know:

2.1 Recognition of potential CYP MSHT victims

MSHT, as with many safeguarding concerns, is complex. Victim presentations can be diverse and exploited CYP can be challenging to identify. Health professionals must use their safeguarding, trauma-informed care skills, clinical knowledge, observation skills, communication techniques and professional curiosity to assess all CYP in a safe environment for them to share concerns.

Potential 'Red Flags' of MSHT and safeguarding concerns

- CYP inappropriately dressed for age, time of day or weather.
- Unkempt appearance or presence of unusually expensive items.
- Unusual behaviour including marked wariness, agitation, aggression, belligerence, sexualised manner, fear, timidity or submission.
- CYP appears unusually tired, sallow or sleep deprived.
- May be with an accompanying person who appears controlling or who insists on speaking for the child.
- Accompanying individual may show particularly 'charming' behaviour to staff or appear especially attentive to child.
- Healthcare attendance in association with police or social services response to social concern or criminal activity.
- Healthcare attendance related to alcohol, illegal substances, inappropriate medication use, self-harm, or suicidality.
- Delayed presentation with advanced or severely complicated health needs (including child or adolescent pregnancy/abortion) that would have been readily supported or resolved if help had been received at an early stage.
- CYP homeless or unsure of home address, current location or contact numbers of responsible adults.
- CYP is not registered with a general practitioner or school.
- CYP has no or limited local language skills.
- CYP asking for help and safety (verbally or non-verbally).
- Carer requesting help due to child's behaviour deterioration, missing episodes, drug use.

2.2 Child Trafficking and Health

Child trafficking risks extensive developmental and health harm to CYP. Before, during and after trafficking CYP may have multiple Adverse Childhood Experiences (ACEs) as well as exposure to injury, drugs and diseases.

- There is no health presentation or spot diagnosis that is unique to trafficking.
- Trafficked CYP may have no medical findings on examination, or findings that can be explained with benign reasons.
- Trafficked CYP may not recognise they are in an abusive or exploitative scenario, and may not even feel distressed.
- Health assessments of potentially trafficked CYP risk being poor quality if professionals are distracted by a CYPs lack of engagement, presentation as part of a criminal offence, or are too easily persuaded by an accompanying person that all is well.

- The health presentation of a trafficked CYP will be related to the format and context of their exploitation and wider life. For example, an unaccompanied migrant CYP in forced labour without protective equipment may present malnourished with skin conditions or occupational injuries. A British CYP exploited through County Lines may still live at home and appear clean, well dressed and generally physically well. They may be more likely to present with violent injury, drug overdose or mental health needs.

Risks to Child Health and Development before, during and after MSHT are listed in the Appendix.

2.3 Psychological Trauma and Mental Health Impacts

MSHT can be especially damaging to the health of children in the short and long term due to the impacts of abuse, deprivation of nurture and safety, interruptions in social and educational development, malnutrition and substance use on the developing brain.

Children who have been trafficked have greater risk of complex, multi-layered trauma occurring over many years (including pre-trafficking abuse and vulnerabilities). As such, CYP may demonstrate a wide range of survival and coping mechanisms at different times including hyperarousal symptoms (such as agitation, aggression, hyperactivity), hypoarousal symptoms (such as withdrawal and disengagement, slow movements and speech) and dissociation, a widely unrecognised and misunderstood problem. Children who have experienced trauma can be misdiagnosed with autism or ADHD - always consider the whole known context of the child's life and experiences.

Children who have experienced complex trauma are understandably very unlikely to trust and open up to any adult. This is logical given their experiences and never to be considered as deliberately unhelpful behaviour. When caring for survivors of MSHT, paediatricians need to have a basic understanding of trauma and its effects on children and young people and use trauma-informed care principles in all their interactions with children and young people. Such CYP require specialist trauma-recovery support.

A wide range of mental health diagnoses are associated with Adverse Childhood Experiences and MSHT including depression and mood disorders, anxiety disorders, dissociative disorders, eating disorders, Post Traumatic Stress Disorder (PTSD), Complex PTSD, and others. It is important to recognise the discreet mental health diagnosis in the context of psychological trauma in order to optimise effective treatment and care.

Risks to Child Health and Development before, during and after MSHT are listed in the Appendix.

2.4 Caring for potential victims in healthcare settings

When caring for any potential victim, paediatricians should use trauma-informed care (TIC). "*Trauma-informed methods of working are based upon an understanding of the harmful effects of traumatic experiences together with fundamental principles of compassion and respect*" [12]. In practice, TIC means understanding and recognising the possible manifestations of trauma in CYP and responding to those with compassion and without judgment. The table below outlines some practical considerations, all trauma-informed, for caring for potential victims:

General considerations	• Speak to CYP alone or with a chaperone, normalising parent / carer / accompanying individual staying in the waiting room (ie not within earshot). • Consider your team and who would be most appropriate to speak with the CYP - do you have youth workers or other allied health professionals? • Consider the space and try to minimise interruptions, such as giving the bleep to a colleague while you speak the CYP. This can help create a sense of safety. • Explain confidentiality and its limitations. • Ask them if they feel safe to talk. • Explain that they are free to choose to not answer you. They should feel in control. • Start with open, non-leading questions. • A useful phrase to use with sensitive questions is: "many CYP I have met in your situation have experienced [feeling frightened / worried/ feeling alone etc], I wonder if this has happened to you to..?" • Actively look for and promote protective factors. • Involve CYP in all decisions, even if they have no say in some of them. They need to be kept informed as much as felt safe to do so and given autonomy to make choices when possible. • Listen to what CYP have to say.
Health needs	• Address their health needs and health concerns as a priority. For example, do not ask sensitive questions to a young person who is in acute pain before effective analgesia has been provided. • Avoid getting distracted by information about drugs, smoking, alcohol use or unsafe sex in itself, look for the wider context, maintain rapport and keep listening. • Consider the developmental stage of the child and how that may affect their interaction with you. Consider how trauma may have affected their development. • Use chaperones if examining CYP on their own. • When you are planning follow ups, make sure you are confident they will come back. If not, complete what is necessary whilst the CYP is with you if possible (ie blood test, scan).
Safeguarding	• Consider capacity and ability to consent at every stage. • Involve safeguarding team, social care services +/- police. • Create a safety plan with CYP and safeguarding partners. • Admit to hospital if there is an immediate need for a place of safety and emergency foster care can not be arranged.
Referrals	• Consider referral to CAMHS or other mental health support services. • If available, refer to youth workers. • When referring CYP to social care services be clear about your concerns regarding MSHT. Also be clear that if there are no medical findings, this does not negate your safeguarding concerns. You can use trauma-informed language to explain the possible impacts on the CYP. • Refer to Independent Child Trafficking Guardians (ICTGs) for further support (see section 3). • Consider referring to independent local or national organisations for further support (see further resources section).

2.5 Looked After Children - initial health assessment/review health assessment

Use all the skills usually employed when seeing vulnerable young people, being particularly mindful of:

- The timing of your appointment, e.g. do not book a young person for an early morning review, who is in the room, cultural and language needs of the young person.
- Be sensitive and flexible with the order of your assessment and examination, following the cues of the young person; some areas may need to be left for a later or more private discussion.
- Be aware that CYP may have experienced sexual abuse in any trafficking situation, not only 'sex trafficking'.
- Communicate your findings clearly, including trauma concerns even if no physical findings and the need for additional emotional health support the young person can engage with.
- For unaccompanied asylum seeking children:
- Ensure young people realise the assessment does not form part of the age assessment or immigration processes.
- Utilise evidence and resources available (UASC Health www.uaschealth.org, RCPCH UASC Health Guidance Refugee and unaccompanied asylum seeking children and young people - guidance for paediatricians: https://www.rcpch.ac.uk/refugee-and-asylum-seeking-children), including specific proformas if available that consider the particular vulnerabilities of unaccompanied asylum seeking young people and additional health risks related to country of origin, disease exposures, migration experiences and post-migration health and life skills.

2.6 Working with interpreters

- Use professional interpreters. If a family member insists on translating, use a quiet space and clearly explain that we have a duty to use professional interpreters for consultations. Do not alert that person of your MSHT concerns and create trust that you are here to look after the CYP.
- Ensure interpreter certified and DBS checked.
- Brief the interpreter beforehand and explain you will be asking sensitive questions.
- Debrief the interpreter afterwards, they may have gathered subtle signs of exploitation or vulnerability through their shared culture / language.
- Sign-post interpreters who may become overwhelmed from the consultation to speak with their GP.
- Stop using an interpreter if they appear to be speaking longer than expected or if you note your patient or the interpreter become distressed.

3 CYP who may require special consideration

3.1 Children of MSHT exploited parents

Many adult (and adolescent) MSHT victims have children. The parent may be the direct MSHT victim, or the family unit may be victimised. CYP may be exposed to high-risk physical, social and emotional living environments. They may have to witness the abuse of their parent(s), suffer abuse and neglect themselves (including exposure to pornography and sexual violence images) and/or be forced to abuse their parent or other CYP. Adult victims may be struggling with mental health, stress, trauma, physical health and/or addiction difficulties. They may be restricted from spending time with their children due to demands by perpetrators, and may be obstructed from engaging with their child in the parent-child activities and events many families would standardly take part in (ie parent and toddler groups). Children may not be registered in school. Families may be restricted in many ways from healthy models of relationship building, fun, nurture, play and rhythms of work and rest.

Children may also be used as a vehicle for the parent to access help or be identified as an MSHT victim. For example, an exploited parent may be allowed by their MSHT perpetrator to take their sick child to see a health professional. The MSHT perpetrator or member of the exploitation network may accompany the parent and child. Similar 'Red Flags' may be present as with presenting CYP victims and health professionals must use their professional curiosity and always consider the child in context.

3.2 Children trafficked for criminal exploitation, such as county lines

Children may be trafficked for criminal exploitation including:

- Forced gang-related criminal activity, commonly related to drug networks including 'County Lines' drug distribution using dedicated phone lines.
- Forced labour for illegal purposes, including cannabis cultivation.
- Forced acquisitive crimes including pickpocketing and shoplifting.
- Forced begging.
- Financial and benefit fraud. Children's bank accounts may also be used for money laundering.
- Trafficking for forced, sham marriage.

Children trafficked for criminal exploitation face major barriers to accessing care and support including:

- Stereotyping and stigma for being 'bad children' and/or from 'bad families'.
- Criminalisation and depiction as independent perpetrators of crime, not victims.
- Dismissal and rejection by professionals as being 'difficult', 'threatening', 'too bad to be a victim' and/or 'hopeless cases'.
- Adultification, and wrong treatment of CYP as if they had adult brains, insight, capacity and consent. CYP can never consent to their exploitation - no matter what they say or do.
- Ignorance from professionals who do not recognise that CYP can be trained to falsify stories to avoid drawing attention to themselves and perpetrators.
- Complexities of grooming and psychological trauma leading CYP to lie about, or state they hate their parents or other genuinely protective adults.
- Paediatricians must be trauma-informed and advocate for the CYP to be recognised as a child throughout, ensuring their child rights are upheld.

3.3 Children within the criminal justice system

The age of criminal responsibility in the UK is 10 years of age, at which point children can be arrested and taken to youth court for sentencing. CYP between 10 and 17 years may be sent to special secure centres for young people for serious crimes. At the age of 18 years, CYP may be sentenced as adults.

CYP who committed crimes under MSHT exploitation are victims and should not be prosecuted, but many children and young adults are not correctly identified as enslaved or trafficked.

Young refugee and migrant MSHT victims may also find themselves in the criminal justice system. This may include accusation of committing immigration offences which could result in deportation. Age assessment is a critical factor but notoriously inaccurate. Paediatricians are not involved in the process of age assessment, as there are no known accurate clinical features to assess a young person's age. Local authorities lead on this process. Paediatricians must be alert to the risks of trafficking in this cohort and use their skills to advocate for the rights of the CYP. Developmental assessment results may be important in age decisions.

Paediatricians must share any concerns about potential trafficking with the appropriate authorities to help safeguard the CYP. Paediatricians who are concerned about a criminalised CYP, should work with other agencies to advocate for that child for them to be considered a victim rather than a criminal.

4. Understanding the referral processes and roles of other agencies.

Please note that there may be variations in practice, policy and availability of Independent Guardian services across the UK nations and changes are ongoing. Up to date information should be reviewed for your region.

4.1 The UK National Referral Mechanism

The National Referral Mechanism (NRM) is the framework and process through which potential adult and child victims of trafficking in the UK are identified, so that they can be supported and protected. Adult and child NRM processes are not the same.

NRM referrals for children can only be done by 'First Responders' (see box below for list) to the Single Competent Authority. Note that healthcare professionals are not first responders, so paediatricians would not be making referrals directly. They would however refer to social care, who would then refer to the NRM. The information contained in those referrals to social care will often be used in the NRM referral.

NRM First Responders

- Local Authorities Children Services and designated persons within Safeguarding
- Children Boards in England and Wales, Child Protection Committees in Scotland,
- Health and Social Care Trusts in Northern Ireland.
- Barnardo's
- CTAC (NSPCC Child Trafficking Advice Centre)
- Police forces
- UK Visas and Immigration, UK Border Force

Decisions about who is a victim of child MSHT are made by trained professionals in the designated 'Single Competent Authority (SCA)' which is part of the UK Home Office. It is good practice for 'First Responders' to consult the CYP in making the NRM referral, explaining the purpose, concerns, benefits and the possible outcomes. Children (including where there is an age dispute but the victim is believed to be a child) do not need to sign the consent form.

The SCA make an initial 'Reasonable Grounds (RG)' decision within 5 days of referral. This means that the SCA considers the statement: "I suspect but cannot prove" that the child is a victim of trafficking to be true. A 'Conclusive Grounds (CG)' decision should then be made in no less than 45 days while the child is provided with support. In practice decisions can take a lot longer, during which time children can feel in limbo.

> If the 'Conclusive Grounds' decision is negative there will be no further trafficking identification decision. Children's Services should ensure a negative NRM decision does not have an adverse impact on the child's care and does not override the statutory duty placed on local authorities by virtue of the Children Act 1989 and 2004; the Children (Scotland) Act 1995; and The Children (NI) Order 1995.

> If the 'conclusive grounds' decision is positive:

- This should affect the way they are treated if they are arrested or facing charges for a crime committed, because the young person was being exploited.
- They should be provided with access to support to help them recover from their experiences, such as therapy. This support should be provided by social services and the NRM decision should be part of their safeguarding decision making.
- If the CYP is seeking asylum or protection in the UK then the NRM decision may be relevant to this. In some cases, a positive NRM decision may lead the Home Office to grant the CYP discretionary leave to remain in the UK.

The government is also running a devolved child decision-making pilot programme in a number of areas, trialling whether child modern slavery decision making is more appropriately made by local multidisciplinary child safeguarding teams within existing safeguarding structures. More details are available here https://www.gov.uk/government/publications/piloting-devolving-decision-making-for-child-victims-of-modern-slavery/devolving-child-decision-making-pilot-programme-general-guidance-accessible-version.

4.2 Roles of other agencies

It is important for Paediatricians to have some knowledge of the roles and responsibilities of various agencies so that they can better advocate for children.

Local authorities: A referral into the NRM does not replace or supersede established child protection processes, which should continue in tandem, such as a Section 47 investigation. All children, irrespective of their immigration status, are entitled to safeguarding and protection under the law.

Police: When a child is found involved in criminal activities such as cannabis cultivation, guidance to law enforcement agencies requires them to follow procedures published by the Association of Chief Police Officers (ACPO) which puts the protection of the child at the forefront.
www.cps.gov.uk/legal/v_to_z/safeguarding_children_as_victims_and_witnesses/

Crown Prosecution Service (CPS): The use of a child in a criminal enterprise is a form of child abuse. Children who may be forced into sexual exploitation, coerced into committing crimes or used by adults to commit offences should be treated by the CPS as victims. In cases where young victims are facing charges for offences committed whilst in a coerced situation, for example when they have been trafficked, the CPS should intervene.

Independent Child Trafficking Guardianship (ICTG) Service: This is a service that is currently being rolled out nationally. The main aim and purpose of the ICTG Direct Worker is to advocate on behalf of the child to ensure the child's best interests are reflected in the decision-making processes undertaken by the public authorities who are involved in the child's care and support.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918466/Interim-Guidance-for-Independent-Child-Trafficking-Guardians-Early-Adopter-Sites.pdf

5. Further Advice

If you have concerns about a CYP or family experiencing MSHT you can contact the following national organisations for advice. Do not share confidential details regarding the CYP via open emails.

NSPCC Child Trafficking Advice Centre (CTAC):
Support line: 0808 800 5000 Monday to Friday 8am to 10pm and 9am to 6pm weekends.
Email: help@nspcc.org.uk
Website: https://learning.nspcc.org.uk/services/child-trafficking-advice

Barnardo's Counter-Trafficking support:
Support line: 0800 043 4303 open 24/7.
Website: https://www.barnardos.org.uk/what-we-do/protecting-children/trafficked-children

Barnardo's Independent Child Trafficking Guardian (ICTG) service referral form and helpline:
https://www.barnardos.org.uk/what-we-do/protecting-children/trafficked-children/ICTG-service-referral-form

Barnardo's leaflet for parents:
https://www.cambornescience.co.uk/wp-content/uploads/the-nrm-a-guide-for-parents.pdf

Modern Slavery Helpline (UK):
Support line: 08000 121 700
Website: https://www.modernslaveryhelpline.org/

6. Additional Resources

UK Government Information & Statistics:

- National Referral Mechanism statistics: https://www.gov.uk/government/collections/national-referral-mechanism-statistics
- The Office for National Statistics: www.ons.gov.uk
- Home Office collection on Modern Slavery: https://www.gov.uk/government/collections/modern-slavery
- Office of the Independent Anti-Slavery Commissioner: https://www.antislaverycommissioner.co.uk/
- Safeguarding Children who may have been Trafficked, Practice Guidance: https://www.gov.uk/government/publications/safeguarding-children-who-may-have-been-trafficked-practice-guidance

National guidance: England and Wales

- National Referral Mechanism Guidance (adult): https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/guidance-on-the-national-referral-mechanism-for-potential-adult-victims-of-modern-slavery-england-and-wales

National guidance and information: Scotland

- Human Trafficking Policy & links to resources, Scotland: https://www.gov.scot/policies/human-trafficking/
- Child Trafficking Strategy Group, Scotland: https://www.gov.scot/groups/child-trafficking-strategy-group/
- Child Trafficking Research, Scotland: https://www.gov.scot/publications/child-trafficking-scotland-research/
- National Referral Mechanism guidance (adult), Northern Ireland and Scotland: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/national-referral-mechanism-guidance-adult-northern-ireland-and-scotland

National guidance and information: Northern Ireland

- Northern Ireland Modern Slavery Strategy 2021-2022: https://www.justice-ni.gov.uk/publications/modern-slavery-and-human-trafficking-strategy-northern-ireland-21-22
- Human Trafficking information: https://www.nidirect.gov.uk/articles/human-trafficking
- National Referral Mechanism guidance (adult), Northern Ireland and Scotland: https://www.gov.uk/government/publications/human-trafficking-victims-referral-and-assessment-forms/national-referral-mechanism-guidance-adult-northern-ireland-and-scotland

Mapping Survivor Services & London Directory

- Human Trafficking Foundation: https://www.humantraffickingfoundation.org/

MSHT and Health Organisations & Networks

- VITA Training Ltd (UK): https://www.vita-training.com/
- VITA Network (UK): https://vita-network.com/
- HEAL Trafficking (USA/global): https://healtrafficking.org/
- Childhood Trauma Recovery Network (CTRN, UK): https://www.traumarecoverynetworkuk.org/

Torture Care Specialist Providers

- Baobab Centre, for young survivors in exile: https://baobabsurvivors.org/
- Helen Bamber Foundation (adults): https://www.helenbamber.org/
- Freedom from Torture (adults): https://www.freedomfromtorture.org/

Survivor Care Standards

- The Slavery and Trafficking Survivor Care Standards 2018: https://www.antislaverycommissioner.co.uk/media/1235/slavery-and-trafficking-survivor-care-standards.pdf

MSHT Further Training & Information

- eLearning for Health child safeguarding modules: https://www.e-lfh.org.uk/programmes/safeguarding-children/
- RCPCH child protection portal: https://childprotection.rcpch.ac.uk/
- NSPCC Protecting Children from trafficking and modern slavery: https://learning.nspcc.org.uk/child-abuse-and-neglect/child-trafficking-and-modern-slavery
- ECPAT UK (Every Child Protected Against Trafficking): https://www.ecpat.org.uk/
- VITA Training Ltd: Advanced training for healthcare professionals safeguarding MSHT victims and survivors, including trauma-informed consultation skills: https://www.vita-training.com/ Many anti-trafficking organisations in the Modern Slavery Helpline provide introductory awareness-raising training.
- Training Framework for the Prevention, Identification, Support and Care of Child Victims and Survivors of Modern Slavery and Human Trafficking and Information and Resources to Support the Training: https://skillsforcareanddevelopment.org.uk/wp-content/uploads/2022/03/2022-CHILDRENS-TRAINING-FRAMEWORK_A4-BOOKLET.pdf

Global Modern Slavery Human Trafficking Information Sources and Organisations

- United Nations: https://www.unodc.org/unodc/en/human-trafficking/human-trafficking.html
- World Health Organisation (Violence against women): https://www.who.int/news-room/fact-sheets/detail/violence-against-women
- International Labour Organisation (ILO): https://www.ilo.org/global/topics/forced-labour/lang--en/index.htm

7. References

1. World Health Organisation, Constitution [Internet]. [cited 2021 Mar 27]. Available from: https://www.who.int/about/governance/constitution.
2. Department for Education, 2018. Working Together to Safeguard Children, Statutory Guidance. [cited 2021 Sep 27]. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
3. Such E, Laurent C, Jaipaul R, Salway S. Modern slavery and public health: a rapid evidence assessment and an emergent public health approach. Public Health [Internet]. 2020 Mar 1 [cited 2021 Mar 20];180:168–79. Available from: https://pubmed.ncbi.nlm.nih.gov/31951910/
4. Oral R, Ramirez M, Coohey C, Nakada S, Walz A, Kuntz A, et al. Adverse childhood experiences and trauma informed care: The future of health care [Internet]. Vol. 79, Pediatric Research. Nature Publishing Group; 2016 [cited 2021 Apr 2]. p. 227–33. Available from: https://pubmed.ncbi.nlm.nih.gov/26460523/
5. International Labour Organisation. Global estimates of modern slavery: Forced labour and forced marriage [Internet]. 2017 [cited 2019 Mar 5]. Available from: http://www.ilo.org/global/topics/forced-labour/publications/WCMS_586127/lang--en/index.htm
6. Home Office, Official Statistics, Modern Slavery: National Referral Mechanism and Duty to Notify statistics UK, end of year summary, 2020 - GOV.UK [Internet]. [cited 2021 Mar 20]. Available from: https://www.gov.uk/government/statistics/modern-slavery-national-referral-mechanism-and-duty-to-notify-statistics-uk-end-of-year-summary-2020/modern-slavery-national-referral-mechanism-and-duty-to-notify-statistics-uk-end-of-year-summary-2020
7. Newson N, 2020. Covid-19: The impact on human trafficking [Internet]. [cited 2021 Mar 29]. Available from: https://lordslibrary.parliament.uk/covid-19-the-impact-on-human-trafficking/
8. United Nations. General Assembly. Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime. 2000. [cited 2021 Sep 27]. Available online at: https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx
9. 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 Paediatr Open [Internet]. 2020 [cited 2021 Apr 2];4:327. Available from: http://bmjpaedsopen.bmj.com/
10. Royal College of Paediatrics and Child Health. Guidance: Rights to access healthcare. Nov 2020. [cited 2022, Feb 4]. Available from: https://www.rcpch.ac.uk/resources/right-access-healthcare
11. UNICEF. A summary of the UN convention on the rights of the child [Internet]. [cited 2020 Aug 20]. Available from: https://downloads.unicef.org.uk/wp-content/uploads/2019/10/UNCRC_summary-1_1.pdf?_adal_sd=www.unicef.org.uk.1597927864109&_adal_

8. Appendix: MSHT Risks to Child Health & Development

The risks to the health and development of CYP MSHT victims should be considered across three critical stages

- Before MSHT exploitation (including health risks relevant to country of origin/travel)
- During MSHT exploitation (physical and social living conditions, direct consequences of abuse)
- After MSHT exploitation (including living environment, independent living skills, high stress assessments including asylum claims).

It is important to consider the contexts of the child or young person's birth, growth, development and the potential impacts of adversity on their physical, mental, emotional, relational and developmental health.

8.1. Before MSHT exploitation

Whilst any child can be at risk of trafficking, certain factors may increase CYP's risk of MSHT (particularly through grooming, manipulation or persuasion) including

- Children with broken social protection networks including family breakdown, removal to foster and adoption care, family and community violence, conflict and war, homelessness. These difficulties may have disrupted the child's development, attachment, social belonging and education. The child may also have experienced anxiety, depression, loneliness, grief and trauma.
- Children who have experienced rejection by their family and/or community on the basis of their identity, appearance or behaviour including gender, LGBTQI+, disability, religion or faith.
- Children living in poverty, economic stress and limited availability of good nutrition, healthcare (including vaccinations and developmental checks), safe housing, education and future opportunities.
- Children who have experienced Adverse Childhood Experiences (ACEs) including forms of abuse or instability at home (including parental mental ill health, substance abuse or parent in prison).
- Children with unmet emotional needs that can be manipulated (i.e. feeling unheard or unloved).
- Children with learning difficulties or extra vulnerabilities such as autism, ADHD, fetal alcohol spectrum disorders, addictions or mental health problems.

8.2. During MSHT exploitation

CYP may face multiple risks to their health and development depending on their MSHT and prior situation. CYP may also appear healthy and well, particularly in early stages of exploitation but information from the CYP and/or carer may suggest a safeguarding concern.

Risks may include, and are not limited to:

Mental and Emotional Health

- Deprivation of safety, nurture and love.
- Psychological violence, threat, manipulation, shaming, humiliation and gaslighting leading to anxiety, fear, depression, low self-esteem and low self-worth.
- Psychological trauma from overwhelming situations of fear and helplessness which can lead to complex coping behaviours and deep sub-conscious changes to what the child believes about themselves, their value, integrity of adults and the safety of the world.
- Non-specific headaches, body aches, pains and functional disorders as physical expressions of psychological distress.
- Addictions, self-harm, eating disorders and other coping mechanisms.
- Sleep disorders secondary to anxiety, trauma and/or night-time exploitation.
- Concentration, memory and education problems.
- Behaviour and personality change including aggression, secrecy, withdrawal, lying, relationship breakdown and new ways of dressing, speaking or behaving.
- Excessive social media or phone use.
- Symptoms of mental health problems such as mood disorders, anxiety disorders, dissociative disorders etc.

Physical Health

- Physical markers of neglect and inadequate care or self-care (ie dental, skin, hair, cleanliness and hygiene, infestations, neglected healthcare, malnutrition).
- Symptoms of chemical exposure (ie pesticides for growing cannabis, cleaning chemicals).
- Physical markers of injury, violence or torture (story may also not match injury well).
- Physical markers of addiction and substance abuse.
- Physical markers of sexual abuse (all ages, all genders, all sexualities) including vaginal, anal, urinary system and oral injuries, including evidence of drug packing/plugging.
- Pregnancy, with the young women either presenting for abortion (potentially multiple times) or with late presentation and little antenatal care.
- Sexual health concerns and/or requesting emergency contraception.
- Dysuria, bedwetting or urinary infections.

8.3. After MSHT exploitation

After exiting exploitation CYP may continue to deal with all the health and developmental problems listed in the sections above. The impact of MSHT on attachment, trust, view of adults, self and the world may be profoundly disrupted. Additional health stressors may be added through the difficult assessment procedures related to the National Referral Mechanism for victims of trafficking, asylum and any upcoming criminal proceedings against them.

For some children, living on 'survival skills' for many years means they have not developed the skills for 'normal life' including managing healthy relationships, rhythms of work, rest, eating and play, shopping and cooking, managing money, using public transport or studying. Adapting to apparent safety can be very challenging, particularly if inadequate support is provided.

9. Acknowledgements

Lead authors
Dr Sarah Boutros, Paediatrician, RCPCH
Dr Laura C N Wood, Paediatrician, RCPCH

Working Group
Dr Geoff Debelle, Designated Doctor for Child Safeguarding, Birmingham & Solihull CCG
Ms Olivia Lam, Policy Lead, RCPCH
Dr Alison Steele, Officer for Child Protection, RCPCH
Dr Vicki Walker, Looked After Children Lead, RCPCH
RCPCH Child Protection Standing Committee

Guidance: child modern slavery and human trafficking
May 2022

Royal College of
Paediatrics and Child Health,
5–11 Theobalds Road,
London, WC1X 8SH

www.rcpch.ac.uk

The Royal College of Paediatrics and Child Health is a registered charity
in England and Wales (1057744)and in Scotland (SCO38299)