

Multisector Community Response to Child Sex Trafficking

TORONTO REGION PROTOCOL AND RESOURCE TOOLKIT
2023

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SickKids[®]



Lotus Health

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EXECUTIVE SUMMARY

All children have the right to live a life free from the harms of sex trafficking. Child sex trafficking is a prevalent form of human trafficking for the purpose of commercial sexual exploitation. It involves the use of a child in a sexual act in exchange for something of perceived value. Toronto is a major urban hub for sex trafficking. Those at greatest risk are young girls with racialized and otherwise marginalized identities and histories of abuse, trauma, and child welfare system involvement. Sex trafficking is an adverse experience in childhood that can have traumatic effects over the lifespan. Through their exploitation and healing journeys, children engage with multiple services and sectors for support and protection, including health care, child welfare, and criminal justice, among others. This calls for a comprehensive and coordinated systems of care approach that is child-centred, rights-based, and trauma-informed.

In response to a growing demand for service and notable gap in specialized care and resources, The Hospital for Sick Children in Toronto embarked on a path to improve the community's response to domestic child sex trafficking. With funding support from Women and Gender Equality Canada and Ontario Ministry of Children, Community and Social Services, we launched Lotus Health, Canada's first pediatric hospital-based specialty program for children exposed to sex trafficking and those at risk. Lotus Health provides a continuum of trauma-informed health care services and works closely with community partners to ensure a holistic approach to care.

Recognizing the lack of an integrated systems of care approach to child sex trafficking resulting in vulnerable children falling through the cracks, we endeavoured to develop a multisector community response protocol to maximize collective impact and guide service delivery in Toronto. Our goal was to build community capacity, strengthen collaboration, coordinate services, and by extension, improve outcomes for children and their families. Community engagement and survivor inclusion were prioritized from the start. We conducted an environmental scan, established partnerships with 18 community organizations and stakeholders across key sectors, formed a multisector community advisory committee and survivor advisory council, and engaged in a series of consultations and interviews with lived experience experts to ensure the work reflected the diverse voices of survivors.

Through this extensive process of consultation, collaboration, and partnership, we developed guiding principles, core competencies, practice approaches, and service pathways. The community response protocol outlines a multisector model of care grounded in the best available empirical and experiential evidence across the pillars of prevention, identification, assessment, and intervention. It provides a comprehensive directory of community resources and supplementary materials to increase awareness, support practice, and guide system navigation.

Multisector Community Response to Child Sex Trafficking: Toronto Region Protocol and Resource Toolkit is a practical resource for multidisciplinary child-serving professionals and organizations, intended to inform practice and policy. It is our hope that it will mobilize a cohesive community response, enhance the full spectrum of care, and ultimately protect and promote child health, safety, justice, and healing.



4

Pillars of Care

- Prevention
- Identification
- Assessment
- Intervention

15

Guiding Principles

- Safety- and rights-based
- Child-centred
- Trauma-informed
- Gender-based violence-informed
- Decolonial lens
- Anti-racism and anti-oppression
- Public health and equity
- Survivor-informed
- Developmentally-sensitive
- Relationship-focused
- Strengths-based
- Harm-reduction
- Evidence-guided
- Forensically-sound
- Collaboration-focused

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Core Competencies

- Competency 1: Use a child-centred, rights-based, trauma-informed approach.
- Competency 2: Apply anti-racist, anti-oppressive, culturally-responsive principles and practices.
- Competency 3: Understand the dynamics, scope, causes, and consequences of child sex trafficking.
- Competency 4: Adopt legal and ethical standards relevant to discipline and setting.
- Competency 5: Collaborate with multidisciplinary service providers across sectors and systems.
- Competency 6: Engage survivors in meaningful input and apply survivor-informed practices.
- Competency 7: Evaluate and identify risk of child sex trafficking.
- Competency 8: Assess multilevel needs and strengths.
- Competency 9: Provide developmentally-sensitive, relationship-focused, evidence-informed interventions.
- Competency 10: Integrate prevention and advocacy strategies into all levels of practice and systems of care.

LAND ACKNOWLEDGMENT



Art by Emily Kewageshig

CONTENT WARNING

This document necessarily contains content of a highly sensitive nature that may be experienced as distressing or traumatic for some individuals. There are references to childhood trauma, physical and sexual violence, exploitation and trafficking, self-harm and suicide, substance use, and racism, among other potentially difficult topics. Readers are encouraged to proceed with caution, engage in self-care, and seek support as needed.

PROJECT BACKGROUND

Human trafficking for the purpose of sexual exploitation is a human rights violation and growing public health concern in Canada, with far-reaching consequences requiring a comprehensive multitiered response. In 2002, Canada became a signatory to the [United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children \(Palermo Protocol\)](#), which was adopted by the United Nations General Assembly in 2000. This legally-binding instrument commits ratified states to prevent and combat human trafficking. Canada has since been at the forefront of addressing human trafficking, with more progress still to be made.

Guided by the Palermo Protocol, the Government of Canada launched its [National Action Plan to Combat Human Trafficking \(2012 - 2016\)](#) and [National Strategy to Combat Human Trafficking \(2019 - 2024\)](#). Using a whole-of-government approach, these efforts focus on four pillars: prevention of human trafficking, protection of victims, prosecution of offenders, and building partnerships domestically and internationally. The current strategy added a new pillar of empowerment to enhance supports and services for victims through a victim-centred, survivor-informed, gender-responsive lens.



Complemented by the National Strategy to Combat Human Trafficking, the Government of Canada launched [It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence \(2017 - 2026\)](#). This federal gender-based violence (GBV) strategy builds on current federal initiatives, coordinates existing programs, fills gaps in support, and lays the foundation for greater action against GBV. The Hospital for Sick Children's Suspected Child Abuse and Neglect Program received grant funding from [Women and Gender Equality Canada's Gender-Based Violence Program](#), which takes action under the federal GBV strategy's pillar of support for survivors and their families. Objectives of our multiyear project are to launch a pediatric health care program for children affected by sex trafficking and to establish a multisector community protocol for responding to child sex trafficking in Toronto.



NATIONAL ACTION PLAN TO END GENDER-BASED VIOLENCE

With the vision of a Canada free of GBV, the Federal-Provincial-Territorial Forum of Ministers Responsible for the Status of Women launched the [National Action Plan to End Gender-Based Violence \(2022 - 2032\)](#). The national action plan builds on existing federal, provincial, and territorial strategies to address GBV. It is a strategic framework for action centred on five pillars and a foundation: support for victims, survivors, and their families; prevention; responsive justice system; implementing Indigenous-led approaches; and social infrastructure and enabling environment.

On a provincial level, [Ontario's Anti-Human Trafficking Strategy \(2020 - 2025\)](#) is a cross-government response which aims to build safer communities by combatting human trafficking and the sexual exploitation of children and youth, with a focus on four areas: raising awareness, protecting victims and intervening early, supporting survivors, and holding offenders accountable. The provincial strategy prioritizes prevention and early intervention initiatives targeted to children and youth, as well as survivor-led and culturally-responsive services and supports for victims and survivors of sex trafficking, including those at risk. Our project received additional grant funding under this mandate.



Raising Awareness



Protecting Victims and Intervening Early



Supporting Survivors



Holding Offenders Accountable

Toronto City Council condemned human trafficking and committed to supporting survivors and preventing human trafficking in Toronto in 2013. In 2019, Council adopted several proposed anti-human trafficking actions under the [End Trafficking TO](#) initiative. Municipal anti-human trafficking efforts focus on public awareness, staff training, community outreach, and support services. In 2021, Council adopted [SafeTO: Toronto's Ten-Year Community Safety and Well-Being Plan \(2021 - 2031\)](#). SafeTO advances 26 priority actions under seven strategic goals: reduce vulnerability, reduce violence, advance truth and reconciliation, promote healing and justice, invest in people, invest in neighbourhoods, and drive collaboration and accountability. It provides a roadmap for how the City and social systems that serve Torontonians can work collaboratively across different sectors and governments to support community safety and well-being. Our project was endorsed by the City of Toronto, represented by the Social Development, Finance, and Administration Division.

At the outset of the project, our environmental scan found the state of anti-human trafficking services in Toronto to be generally adult-focused, fragmented, and lacking a trauma-informed, child development lens. Despite increasing service demand, there were no specialized pediatric health care services or systems-wide response protocols guiding service delivery for children exposed to sex trafficking. Organized under community care, education, and research streams, project objectives were to develop a survivor- and trauma-informed: 1) continuum of pediatric health care services for children impacted by sex trafficking and their families, and 2) multisector community protocol for a collaborative and coordinated response to child sex trafficking in Toronto. This document is the outcome of the second project objective.

This community response protocol was developed in collaboration with anti-human trafficking organizational leaders, frontline service providers, lived experience experts, and other stakeholders. With the main goals of building community capacity and improving service integration, the protocol is intended to be a practical resource for multidisciplinary professionals working across sectors with children of all genders under 18 years of age who are at risk of, transitioning in, entrenched in, transitioning out, or exited from sex trafficking. Its purview is prevention, identification, assessment, and intervention in Toronto.



PROTOCOL STRUCTURE

The contents of this community response protocol are organized under four broad sections:

- Section 1 introduces the protocol rationale and framework for practice and provides an overview of child sex trafficking.
- Section 2 presents the protocol principles and practice model and reviews recommended approaches to identification, assessment, intervention, and prevention.
- Section 3 provides a directory of anti-human trafficking resources and materials.
- Section 4 contains a list of agency acronyms, glossary of terms, and references.

All toolkit hyperlinks to electronic sources are valid at the time of protocol publication. Note that web page links can change or expire over time. Contact the authors for updated or archived URLs if needed.



LANGUAGE NOTE

Language use in this community response protocol is contingent on specific contexts and referenced sources. The terms child sex trafficking (CST) and commercial sexual exploitation of children (CSEC) are commonly used interchangeably in literature and practice settings. CST encompasses CSEC. Sex trafficking is a form of human trafficking for the purpose of commercial sexual exploitation. In this document, CST refers to the use of a child in a sexual act in exchange for something of perceived value, such as money or drugs. Child is defined as an individual under 18 years of age. The term child is inclusive of children and youth. The persons responsible for committing the offence of CST are referred to as traffickers (also known as exploiters, offenders, or perpetrators).

The terms victim and survivor are not mutually exclusive. Victim refers to an individual who is actively being sex trafficked or has suffered harm as a result of trafficking. Victim is used to denote a young person's experience of injustice and need for protection and support. This term is commonly used in child welfare and criminal justice contexts. Survivor refers to an individual who was previously sex trafficked and may be engaged in a healing process. Lived experience expert refers to an individual who has personally experienced sex trafficking and is working in a professional capacity in the anti-human trafficking sector. Experts with lived experience are survivors. These labels do not necessarily reflect how individuals self-identify based on their unique circumstances and preferences. It is important to respect self-naming.

Historically commonly used language, such as child prostitute, teen sex worker, and pimp, should generally not be used in professional practice settings in reference to CST. The terms prostitute and sex worker, in reference to children, do not accurately reflect their incapacity to consent to commercial sex or the power imbalance and absence of choice within exploitative relationships. This implies victim-blaming. The term pimp should be avoided, as it perpetuates stereotypes that glamorize the sex trade and elicits negative racial and cultural connotations.

Refer to section 4.2 of the protocol for a complete glossary of terms.

ABOUT SICKKIDS LOTUS HEALTH

Who We Are

[The Hospital for Sick Children \(SickKids\)](#), in affiliation with the [University of Toronto](#), is Canada's largest and most research-intensive pediatric hospital dedicated to improving child health. SickKids provides child- and family-centred clinical care, ground-breaking clinical and scientific advancements, and interprofessional training for the next generation of child health experts.

This anti-human trafficking project was spearheaded by the [Suspected Child Abuse and Neglect \(SCAN\) Program](#) at SickKids. SCAN provides consultation, assessment, and treatment of child maltreatment concerns. Multidisciplinary services include medical evaluation of suspected child abuse and neglect, sexual assault care, forensic interviewing, psychosocial support, trauma therapy, education, and research. SCAN is a community partner of [Boost Child and Youth Advocacy Centre](#) and member of the [Ontario Network of Sexual Assault/Domestic Violence Treatment Centres](#).



Launched by SCAN in 2019, [Lotus Health](#) is a pediatric health and advocacy program for children who have experienced, or are at risk of, sex trafficking and their families. Lotus Health is a specialty care program comprised of multidisciplinary health care providers who deliver trauma-informed medical, mental health, and peer support services. Lotus Health collaborates with community partners to promote a multipronged and integrated approach to care. Lotus Health also contributes to clinical education and research to advance knowledge and build capacity.

Our Vision

We envision a community where children can live and thrive free from the harms of sex trafficking.

Our Mission

We strive to help keep children healthy and safe from sex trafficking. We work together with community partners to prevent and address the harmful effects of child sex trafficking through a comprehensive, collaborative, and coordinated continuum of child-centred, rights-based, trauma-informed care.



PROTOCOL PARTNERS

SickKids[®]

 **Lotus Health**

 **PROJECT
iRISE**


The Centre
Canadian Centre to
End Human Trafficking.


Ontario
Network
of Sexual Assault/
Domestic Violence
Treatment Centres

BOOST[™]
CHILD & YOUTH ADVOCACY CENTRE
CENTRE D'APPUI AUX ENFANTS ET AUX ADOLESCENTS


CHILDREN'S
AID SOCIETY
of TORONTO
LA SOCIÉTÉ
DE L'AIDE à
L'ENFANCE
DE TORONTO


Catholic
Children's Aid
Society of Toronto

JF&CS
JEWISH FAMILY AND CHILD
SERVICE OF GREATER TORONTO


NCFST


NATIVE WOMEN'S
RESOURCE CENTRE OF TORONTO

BREAKAWAY
REDUCING HARM & ENHANCING HEALTH


FCJ Refugee Centre
Walking With Uprooted People


Strides
TORONTO


**Covenant
House**


Victim
Services
Toronto

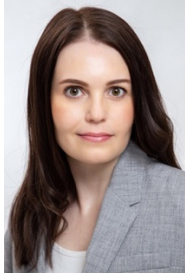

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SECTION I: INTRODUCTION AND BACKGROUND

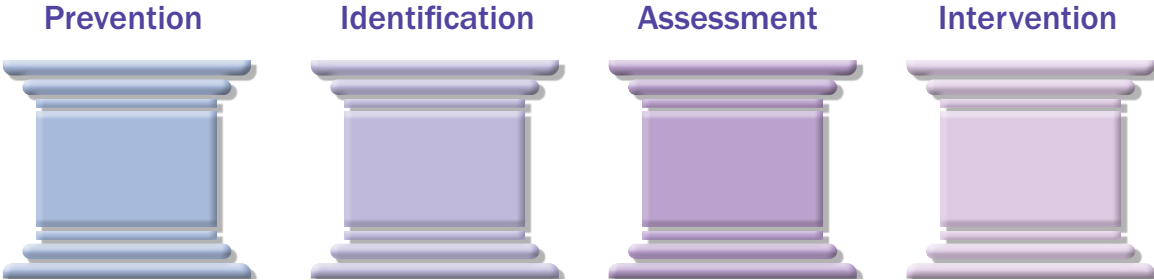
1.1. COMMUNITY RESPONSE PROTOCOL RATIONALE AND CONTEXT

1.1.1. Purpose of the Protocol

This multisector community protocol for responding to child sex trafficking in Toronto aligns itself with broader national, provincial, and municipal government strategies to combat human trafficking and gender-based violence.

- [National Strategy to Combat Human Trafficking \(2019 - 2024\)](#)
- [It's Time: Canada's Strategy to Prevent and Address Gender-Based Violence \(2017 - 2026\)](#)
- [National Action Plan to End Gender-Based Violence \(2022 - 2032\)](#)
- [Ontario's Anti-Human Trafficking Strategy \(2020 - 2025\)](#)
- [City of Toronto's End Trafficking TO \(2019\)](#)
- [SafeTO: Toronto's Ten-Year Community Safety and Well-Being Plan \(2021 - 2031\)](#)

The primary purpose of this community response protocol is to offer guidance to health and social service systems, organizational leaders, and frontline providers for effectively developing and delivering comprehensive and coordinated services to children who have experienced, or are at risk of, sex trafficking and their families. Grounded in guiding principles and core competencies, the protocol intends to formalize and mobilize an integrated multisector, multiagency, multidisciplinary community response to CST in Toronto. The proposed model of care covers four pillars through a trauma-informed, ecosystems lens: prevention, identification, assessment, and intervention. It is meant to be a supplementary resource for child-serving professionals to increase their awareness and use of recommended practice approaches, service pathways, and community resources. The ultimate goal of protocol implementation is to enhance the full spectrum of care and improve outcomes for children impacted by sex trafficking and their affected family members.



This community response protocol is not a standalone resource. It complements existing guidance on the care of children exposed to sex trafficking and other forms of human trafficking and child maltreatment referenced throughout. While evidence-based practices in CST are currently limited, the protocol is informed by the best available research evidence, extant practice guidelines, expert recommendations, and survivor voices. The protocol reflects the state of empirical and experiential knowledge at the current point in time. It is expected to be updated periodically as new trends, literature, interventions, and resources emerge.

This response framework is relevant to all sectors, systems, and providers in Toronto that assume a key role in CST service delivery. This includes, but is not limited to, pediatric health care, mental health and addictions, child welfare, criminal justice, victim services, immigration, education, housing, and survivor-led services. The protocol is not intended to be an authority on CST, nor does it represent all possible perspectives. It is a resource that can supplement and inform organizational policies, procedures, and practices. Degree of relevance of specific protocol content will vary depending on individual agency mandate, case volume, capacity, and resources. Successful adoption of the protocol requires support from leadership. Consistent yet flexible application of recommended practices is encouraged. In addition to those directly tasked with delivering services to children and their families, this protocol will serve as a useful resource for educators, researchers, and policymakers.

Human trafficking characteristics, patterns, and scope vary across geographic and social contexts. This protocol was designed primarily to address domestic CST in Toronto, taking into account the city's urban demographics, population density, and rich access to services in comparison to some rural and remote communities. While it focuses on the unique dynamics of commercial sexual exploitation and service needs of a child population, a holistic community response should be attentive to all forms of domestic and transnational human trafficking, including labour trafficking, among all affected groups, including adults. Many elements of the protocol are relevant and applicable to other forms of human trafficking, older populations, and different jurisdictions. The protocol may be adapted by other organizations and communities in consultation with The Hospital for Sick Children, Lotus Health.

1.1.2. Unique Considerations for Children

Childhood and adolescence are critical stages of human development marked by identity formation, desire for autonomy, sexual development, need for belonging, increased risk-taking, and limited problem-solving skills. Normative developmental behaviours and motivations, coupled with the effects of childhood adversities, render children at heightened risk of coercion and exploitation. Reflective of age-based imbalances of power and societal sexualization of youthful bodies, victims of sex trafficking are usually targeted at a young age. Most are first recruited in their early teens (Baird & Connolly, 2023; Baird et al., 2020).

Children are uniquely impacted by abuse and trauma at this formative stage of development, requiring specialized trauma-informed care plans. In Ontario, special rights and protections are afforded to children under the age of 18 years. This comes with implications for protective recourse, developmental trauma treatment, child-friendly settings, and parent/caregiver engagement, necessitating interventions distinct from adults. Service pathways for children affected by sex trafficking should be appropriately tailored to their chronological age, developmental level, and associated vulnerabilities. This demands a community response protocol that is child-centred and developmentally-sensitive.

1.1.3. Benefits of Adopting a Protocol

The potential benefits of adopting a multisector community response protocol to address CST extend to children and families, service providers and organizations, and broader community and society.

- Community consensus on purpose and principles.
- Consistent aspirational standards of care.
- Promotion of child-centred, rights-based, trauma-informed approaches.



- Guidance on core competencies for practice.
- Clarity on multidisciplinary roles, responsibilities, procedures, and processes.
- Enhanced collaboration and communication.
- Better service integration and coordination across sectors.
- Delineation and streamlining of referral processes and service pathways.
- Consolidation and endorsement of evidence-guided practices.
- Optimized multilevel support for children and their families.
- Improved child safety, health, and well-being.
- Assistance with resource allocation.
- Opportunities for interprofessional education, training, and consultation.
- Opportunities for multisite data collection and research.
- Advocacy for sustainably-funded models of care.

1.1.4. Protocol Development Process

Development and implementation planning for this community response protocol followed a stepwise process over a three-year timeframe.

- Multiyear federal and provincial grant funding was acquired to support the project.
- Support and resources from organizational leaders were obtained.
- Environmental scan and literature review were conducted and updated periodically.
- Key informant interviews with local and global leaders in the field were conducted.
- Regional stakeholders, organizational leaders, service providers, and lived experience experts were identified and engaged.
- Individual and group consultations with lived experience experts were held.
- Interviews with child victims and survivors and parents were conducted.
- Partnerships across key sectors and systems were established.
- Formal partnership agreements between SickKids and community agencies outlining fiscal and human resource contributions to the project and commitment to protocol implementation were executed.
- Multisector community response protocol advisory committee and working groups were formed.
- Committee consensus on shared vision, mission, and principles was reached.
- Roles, responsibilities, referral processes, and service pathways were determined.
- Protocol implementation, monitoring, and evaluation processes were established.
- Toolkit of anti-human trafficking services and resources was compiled and updated periodically.
- Hospital and community education and training needs assessment was conducted.
- Hospital and community education, training, and networking opportunities were provided (ongoing).
- Survivor advisory council for program and protocol review was formed.
- Protocol was reviewed and revised by multisector community advisory committee, survivor advisory council, and external consultants.
- Protocol was disseminated to organizational leaders, service providers, and stakeholders.



Survivor Engagement

Meaningful and ethical survivor engagement was prioritized at all stages of community response protocol development. Protocol partner and co-author, [Rhonelle Bruder](#), uses her lived experience with human trafficking as a leading advocate, educator, and researcher.

Lived experience experts and survivors of sex trafficking were invited to share their experiences, perspectives, and recommendations during a series of group consultations, individual interviews, and advisory committee meetings between 2019 and 2022. They ranged in age from 16 to 36 years, represented diverse ethno-racial and 2SLGBTQI+ identities, and were in various stages of exploitation and recovery. All survivors were financially compensated for contributing their time and expertise to the project. A trauma-informed approach to survivor engagement was followed.

The direct quotations from individuals with lived experience that are included throughout this document were extracted from the recordings of group consultations, individual interviews, and advisory committee meetings and shared with informed consent. Identifying information was removed to honour confidentiality.

Key Reports

Protocol content was informed by our original research findings, stakeholder consultations, survivor voices, lessons from the field, human trafficking literature, and recommended practice models. The following key reports, among others, were reviewed:

- [National Strategy to Combat Human Trafficking \(2019 - 2024\)](#) (Public Safety Canada, 2019)
- [Ontario's Anti-Human Trafficking Strategy \(2020 - 2025\)](#) (Ontario Ministry of Children, Community and Social Services, 2019)
- [Human Trafficking Trends in Canada \(2019 - 2020\)](#) (The Canadian Centre to End Human Trafficking, 2021a)
- [Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#) (Greenbaum & Albright, 2022)

- [Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings](#) (Baldwin et al., 2017)
- [Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems](#) (National Human Trafficking Training and Technical Assistance Center, 2021a)
- [Psychotherapy for Commercially Sexually Exploited Children: A Guide for Community-Based Behavioral Health Practitioners and Agencies](#) (Basson et al., 2018)
- [Getting Out: A National Framework for Escaping Human Trafficking for Sexual Exploitation in Canada](#) (Noble et al., 2020)
- [Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls](#) (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)
- [Journey to Safe Spaces: Indigenous Anti-Human Trafficking Engagement Report \(2017 - 2018\)](#) (Ontario Native Women's Association, 2019)
- [Sexual Exploitation and Trafficking of Aboriginal Women and Girls: Literature Review and Key Informant Interviews](#) (Native Women's Association of Canada, 2014)
- ["NO MORE" Ending Sex-Trafficking in Canada: Report of the National Task Force on Sex Trafficking of Women and Girls in Canada](#) (Canadian Women's Foundation, 2014)

Refer to section 4.3 of the protocol for a complete list of references.

1.1.5. Integration With Existing Laws, Policies, and Procedures

This community response protocol was developed in accordance with existing laws and treaties governing the interrelated domains of human trafficking, sexual exploitation, sexual assault, and child maltreatment. Those with relevance to CST-related matters in Ontario, Canada include the following:

- [United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children \(Palermo Protocol\) \(2000\)](#)
- [Criminal Code of Canada \(1985\)](#)
- [Immigration and Refugee Protection Act \(2001\)](#)
- [Child, Youth and Family Services Act \(2017\)](#)
- [Prevention of and Remedies for Human Trafficking Act \(2017\)](#)
- [Community Safety and Policing Act \(2019\)](#)
- [Anti-Human Trafficking Strategy Act \(2021\)](#)

Refer to section 1.4.2 of the protocol for the most applicable sections of legislation.

Most health and social service organizations in Toronto have internal policies and procedures to inform and direct the identification, reporting, and management of child maltreatment and intimate partner violence. This community response protocol is intended to be integrated within new or existing internal policies and procedures relevant to human trafficking. It is recommended that those in leadership positions be engaged in the process of creating, amending, or updating workplace policies, procedures, and practices to reflect the contents of this protocol.



1.2. OVERARCHING FRAMEWORK FOR PRACTICE

1.2.1. Guiding Principles

The following overlapping principles guided the development of this community response protocol and provide an aspirational framework for professionals, organizations, and systems involved in the delivery of CST services. These fundamental principles reflect the core beliefs and behaviours that should be upheld through their integration in CST policies, procedures, and practices.

Safety- and rights-based:

Sex trafficking is a violation of children’s basic human rights and jeopardizes their safety, health, and well-being. It is a fundamental human right for all children to live free from the harms of commercial sexual exploitation and violence. Embedded in an equity framework, a safety- and rights-based approach considers the restoration and protection of children’s right to safety as paramount.

Child-centred:

Children who have experienced sex trafficking present with unique identities, perspectives, values, strengths, and vulnerabilities. A child-centred approach seeks to empower young victims and survivors by prioritizing their safety, dignity, rights, agency, and needs with a continuum of care that is trauma-informed, developmentally-sensitive, and anti-oppressive. The voices of children should be heard, respected, and centred as they take an active role in their care.

Trauma-informed:

Exposure to sex trafficking in childhood can have pervasive traumatic effects across the lifespan. A universal trauma-informed approach recognizes the presence and impact of trauma and paves pathways for recovery. Underscoring the connections between violence, trauma, and adverse outcomes, trauma-informed care should be violence-informed and healing-focused. Trauma-informed care aims to prevent re-traumatization and promote healing by prioritizing physical and psychological safety, fostering trust and empowerment, encouraging choice and collaboration, building on strengths and skills, and supporting recovery and resilience.

Gender-based violence-informed:

Persons of all genders can be victimized. Young women, girls, and gender-diverse people are at greatest risk of being subjected to sex trafficking, while the majority of those who benefit from their exploitation are men. Risk compounds when gender intersects with other marginalized identities. A gender-based violence-informed approach recognizes child sex trafficking as a form of gender-based violence rooted in gendered power inequality and seeks to transform underlying systems of patriarchal oppression. Exposure to interpersonal and structural gender-based violence is understood as having traumatic impacts requiring gender-responsive, violence- and trauma-informed care.

Decolonial lens:

Disproportionately high rates of child welfare system involvement and sex trafficking among Indigenous children are rooted in historical and contemporary colonialism. A decolonial lens recognizes the individual, collective, and generational harms of colonial-based violence and trauma and the ongoing denial of rights



and protections for First Nations, Métis, and Inuit peoples. This extends to a commitment to working toward reconciliation, creating equitable systems and services, and honouring traditional teachings and healing practices.

Anti-racism and anti-oppression:

Grounded in interpersonal and systemic power imbalances, girls with racialized and otherwise marginalized identities are at heightened risk of experiencing sex trafficking, as well as disparities in service delivery and health and justice outcomes. Through an intersectional lens, interlocking dimensions of diverse identities are understood to uniquely impact life experiences and access to power, opportunities, and resources. An anti-racism and anti-oppression framework strives to dismantle structures that sustain inequities in pursuit of social justice through inclusive, equitable, and culturally-safe practices and policies. This includes intentional, systematic, and proactive courses of action to combat racism and intersecting forms of oppression, beginning with critical self-reflection and commitment to effect change.

Public health and equity:

Public health is an organized approach to protecting and promoting health and health equity in populations and communities. Recognizing child sex trafficking as a public health issue expands how we conceptualize and respond to the problem as it relates to social determinants of health and health inequities. A public health approach addresses the health impacts of exploitation and violence through primary prevention, community action, multidisciplinary collaboration, mitigation of risk using a socioecological model, and generation of evidence to drive public policy and practice.

Survivor-informed:

Survivors of sex trafficking are recognized as having wisdom derived from lived experience. The voices of lived experience experts should be honoured, amplified, and leveraged. A survivor-informed approach seeks and integrates input from a diverse community of survivors on relevant policy, program, and project development, implementation, and evaluation to ensure it accurately reflects the perspectives, interests, and needs of the population served. This should be done in an intentional, meaningful, and ethical way.

Developmentally-sensitive:

Children are at a formative stage of human development, deserving of special rights and protections, balanced with personal autonomy and agency. Children who have experienced sex trafficking present with unique and complex needs requiring specialized plans of care. A developmentally-sensitive approach is considerate of, and responsive to, children's chronological age, developmental level, and related vulnerabilities.

Relationship-focused:

Children exposed to sex trafficking and other relational trauma can experience the world, people, and relationships as inherently unsafe. A relationship-focused approach is grounded in compassion and empathy and seeks to build a strong foundation of trust, connection, and attachment as a core component of the helping relationship.



Strengths-based:

All children affected by sex trafficking possess strengths and capacity to heal and grow. A strengths-based approach shifts the focus from problems and pathologies to strengths and resiliencies. Identifying and mobilizing child, family, and community strengths reduces stigma and shame, rebuilds self-worth, restores identity, supports self-efficacy, and fosters collaborative relationships.

Harm-reduction:

Children are exposed to numerous potential harms through all stages of sex trafficking. Consistent with a rights-based, public health framework, harm-reduction practice aims to minimize risks to health and well-being by maximizing safety behaviours. Rooted in the principles of acceptance, empowerment, and self-determination, a harm-reduction approach meets individuals where they are at and uses realistic, nonjudgmental, non-coercive strategies to promote safety and self-efficacy by enhancing knowledge, skills, resources, and support to increase motivation and commitment to change.

Evidence-guided:

Children impacted by sex trafficking have a right to receive high-quality services that are informed by the best available evidence to promote optimal health and safety outcomes across the developmental trajectory. Barrier-free access to evidence-guided care should be available to all children. Evidence may be empirical or experiential and should reflect diverse ways of knowing, being, and doing.

Forensically-sound:

Child sex trafficking is grounds for child welfare and criminal justice system intervention. A forensically-sound approach recognizes children's rights to protection and justice. This requires caution in the collection and management of forensic evidence in a manner that will not compromise potential legal proceedings.

Collaboration-focused:

Single organizations and providers cannot combat child sex trafficking alone. A shared commitment, common agenda, and collective action are required for substantive change. A collaboration-focused approach seeks to enhance community partnerships and service coordination for a unified response across sectors and systems with a key role in anti-human trafficking efforts.

1.2.2. Core Competencies

Mapped from guiding principles, core competencies encompass the foundational values, knowledge, and skills that professionals should acquire to effectively and ethically deliver CST services. The following competencies have been adapted from the [Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems](#), expanded upon, and tailored to our local multisector community response strategy.

Having a shared set of minimum standards promotes clarity and consistency in the quality of evidence-guided care that is expected. This community response protocol integrates basic information on each competency, intended to be augmented with more in-depth education and training in specialized areas of practice. These core competencies can help to identify gaps in knowledge and skill, as well as inform learning objectives and curriculum development. They can be integrated into job descriptions, supervision agendas, and performance



evaluations. Our guiding principles and core competencies are fluid. They may be periodically reviewed and revised to reflect the evolving state of human trafficking trends and evidence-based practices over time.

Our guiding principles and core competencies are grounded in a public health approach that centres on understanding and responding to root causes of CST, with the ultimate goal of prevention. The first two competencies, focused on trauma-informed and anti-oppressive practices, are universal competencies that provide the foundation for all other competencies.

Competency 1: Use a child-centred, rights-based, trauma-informed approach.

Competency 2: Apply anti-racist, anti-oppressive, culturally-responsive principles and practices.

Competency 3: Understand the dynamics, scope, causes, and consequences of child sex trafficking.

Competency 4: Adopt legal and ethical standards relevant to discipline and setting.

Competency 5: Collaborate with multidisciplinary service providers across sectors and systems.

Competency 6: Engage survivors in meaningful input and apply survivor-informed practices.

Competency 7: Evaluate and identify risk of child sex trafficking.

Competency 8: Assess multilevel needs and strengths.

Competency 9: Provide developmentally-sensitive, relationship-focused, evidence-informed interventions.

Competency 10: Integrate prevention and advocacy strategies into all levels of practice and systems of care.

1.3. UNDERSTANDING CHILD SEX TRAFFICKING

1.3.1. Defining the Problem

Definitions of human trafficking, child sex trafficking, and commercial sexual exploitation of children overlap and vary by context. The terms are often used interchangeably in literature and practice settings but have distinct meanings. Reaching a shared understanding of the problem using common language is an important first step to being able to effectively address the problem together as a community.

The Palermo Protocol provides an internationally recognized definition of human trafficking that classifies trafficking in persons as 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”* (United Nations Office on Drugs and Crime, 2000).

The Government of Canada’s National Strategy to Combat Human Trafficking similarly defines trafficking in persons as *“recruiting, transporting, transferring, receiving, holding, concealing, harbouring, or exercising control, direction or influence over that person, for the purpose of exploitation, generally for sexual exploitation or forced labour”* (Public Safety Canada, 2019).



A form of human trafficking for the purpose of commercial sexual exploitation, CST involves the actual or attempted use of a person under 18 years of age in any sexual act in exchange for something of perceived value. CST is recognized as a human rights violation and public health problem with harmful effects across the lifespan. All CST constitutes child maltreatment. It is associated with high rates of psychological, physical, and sexual violence. While persons of all genders can be subjected to CST, the majority of known child victims are female, and the majority of known traffickers are adult males. It is therefore considered a form of gender-based violence rooted in gendered imbalances of power.

A commercial sex act is any type of sexual conduct for which something of perceived value is given, promised, or received, directly or indirectly. This includes contact (e.g., in-person sex acts, escort services, illicit massage services) and non-contact (e.g., virtual sex acts, production of sexual photos or videos, exotic dancing/stripping) commercial sex conduct. It is usually repeated or chronic. Payment may come in the form of money, food, drugs, alcohol, shelter, clothing, transportation, protection, social status, or any other valued item or entity.

CST can happen in-person and online. It can occur in urban and rural areas. It can transpire with or without a third-party in control. There is always an exploitative element to transactional sex acts with children. For persons under 18 years of age, sex trafficking does not require the use of force, fraud, or coercion to be considered a crime given their inability to consent to commercial sex by law, although these dynamics are often present. CST does not always involve the movement or smuggling of a person from one location to another. This is a common misconception. Human trafficking can be domestic (trafficking of individuals within their own national borders) or transnational (trafficking of individuals across national borders). Domestic sex trafficking is the form of human trafficking that is most prevalent in Canada (Conroy & Sutton, 2022) and most frequently comes to the attention of service providers in Toronto.

Commonly known as “pimps” (third-party sellers) and “johns” or “tricks” (buyers), the persons responsible for committing the offence of CST, whether as individuals or groups, are referred to in this protocol as traffickers (also known as exploiters, offenders, or perpetrators). Traffickers can be anyone from any cultural background, socioeconomic status, age, and gender, though the vast majority are men. They can be intimate partners, family members, friends, acquaintances, or strangers to the victims. CST may occur within the context of large organized domestic or international networks, small businesses, family operations, street gangs, or lone perpetrators. The primary motivation of most traffickers is money and power. Persons in subordinate roles, such as recruiters, assist with the identification, luring, and grooming of potential victims. They are often similar to the victim in age, gender, and circumstance. Some recruiters are simultaneously being exploited by traffickers.

Human trafficking is a criminal offence in Canada under sections 279.01 and 279.011 of the Criminal Code of Canada (1985) and section 118 of the Immigration and Refugee Protection Act (2001). There are other Criminal Code offences that may apply in CST situations. Refer to section 1.4.2 of the protocol for relevant legislation related to human trafficking, sexual offences, and sexual services.

In Canada, it is a criminal offence for anyone to obtain, or communicate with anyone for the purpose of obtaining, the sexual services of a person under the age of 18 years in exchange for money or something else of value. Purchasers of sexual services, and those who communicate for the purpose of obtaining the sexual services of a person under the age of 18 years in exchange for money or something else of value, can be charged with a criminal offence, but the young person cannot because they are immune from prosecution for offering or selling their own sexual services.



Persons under 18 years of age in Canada cannot legally agree to sexual activity with a partner who is in a position of trust or authority toward them, or upon whom the young person is dependent, or where the relationship between the young person and their partner is exploitative, or where the young person's sexual services are exchanged for something of value. Where a young person agrees to participate in sexual activity in any of these circumstances, the young person does not commit a criminal offence and their agreement to participate in the sexual activity will not provide a defence to the offence(s) committed by the other person involved.

Some children, particularly those with housing insecurity or substance dependence, engage in survival sex with no third-party involvement. They may feel they have no other option but to self-initiate commercial sex to meet subsistence needs. Those who participate in sexual activity, knowing it is with a child, and provide money or something else of value in exchange, are committing a criminal offence. The child's vulnerabilities are being exploited by someone with greater power. This is different from consensual adult sex work. There is a clear distinction, though it is also currently illegal to obtain, or communicate for the purpose of obtaining, the sexual services of a person over the age of 18 years in exchange for money or something else of value. Regardless of the age of the person who exchanges their own sexual services for something of value, that person cannot be charged with a criminal offence for selling their own sexual services because the Criminal Code provides them immunity from prosecution.

1.3.2. Landscape and Scope

Reliable CST incidence and prevalence data do not currently exist in Canada. Identifying victims and accurately quantifying rates of trafficking are difficult tasks given its criminal nature, dynamics of secrecy and stigma, definitional discrepancies, surveillance and measurement challenges, under-recognition by providers, and under-reporting by victims due to fear of retribution from traffickers, distrust of authorities, or lack of faith in the justice system. Moreover, many children exposed to sex trafficking do not recognize that they are being exploited and therefore do not self-identify as victims.

"I still didn't actually know what the term was for what was happening to me. I had no idea that was my experience. I didn't know this was a thing." (Survivor)

While the true magnitude of the problem is unknown, global prevalence rates suggest that more than one million children were victims of commercial sexual exploitation, excluding forced marriage, in 2016 (International Labour Organization & Walk Free Foundation, 2017). The majority of victims are girls and young women, which aligns with age- and gender-based power inequalities and consumer preferences.

North American population-based studies estimate that 3% to 4% of children in grades 7 to 12 report having exchanged sex for drugs or money (Barnert et al., 2022; Edwards et al., 2006; Homma et al., 2012). Among children screened in health settings serving children at risk, prevalence of CST was found to be 11% (Greenbaum et al., 2018b). Rates increase substantially for Black and Indigenous girls, racialized and sexual/gender-diverse children with housing insecurity, and children with disabilities (Chisolm-Straker et al., 2017; Franchino-Olsen et al., 2020; Greeson et al., 2019).

Police-reported incidence rates of human trafficking in Canada have generally trended upward year-over-year, with a slight dip in 2020 (Conroy & Sutton, 2022; Cotter, 2020; Ibrahim, 2021). There were 1.4 police-reported incidents of human trafficking per 100,000 population in 2020 (Conroy & Sutton, 2022),

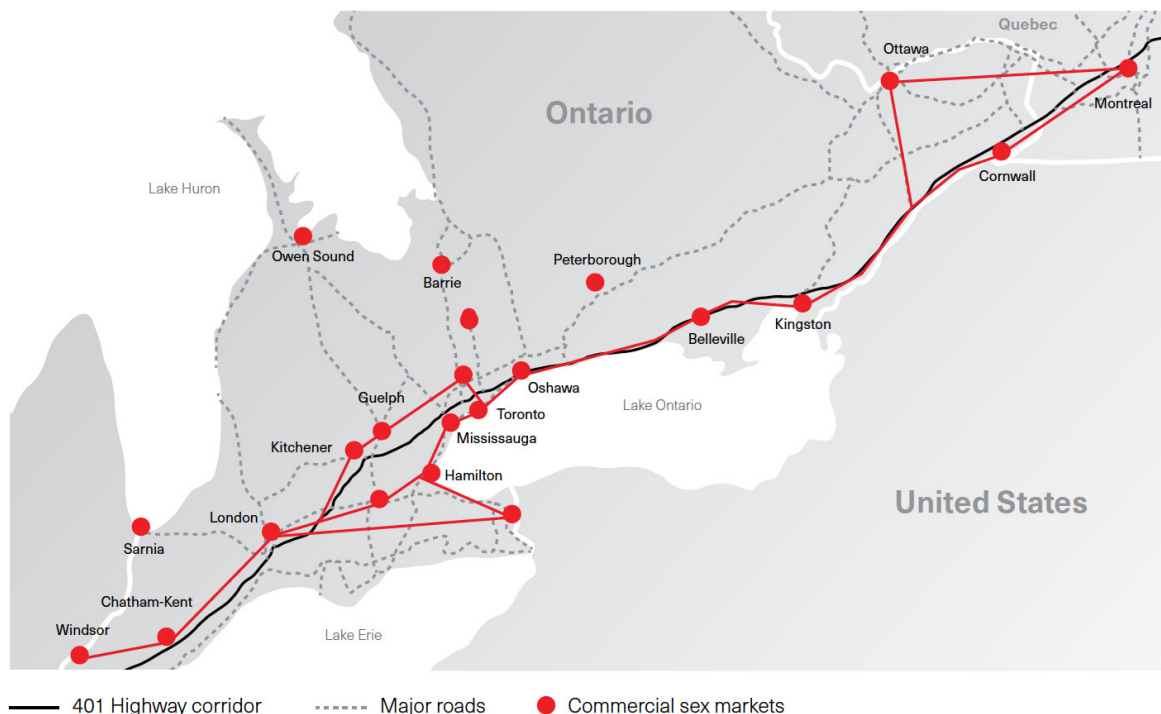
representing the tip of the iceberg as most goes undetected. Ontario reports the highest number of police-reported human trafficking incidents in all of Canada. The majority are domestic.

- 96% of victims in police-reported human trafficking incidents are women and girls.
- 25% of victims in police-reported human trafficking incidents are under 18 years.
- 81% of persons accused in police-reported human trafficking incidents are men and boys.
- 91% of detected victims are trafficked by someone known to them.
- 31% of detected victims are trafficked by a current or former intimate partner.

Source: [Trafficking in Persons in Canada, 2020](#) (Conroy & Sutton, 2022)

Human trafficking operates under a business model driven by financial profit. It is among the world's most economically lucrative, low-risk crimes, generating high profits for organized criminal groups and smaller-scale individual and opportunistic traffickers (United Nations Office on Drugs and Crime, 2023). Victims are treated as disposable since there is a seemingly endless supply and demand, often facilitated by the internet. There is overlap between human trafficking offences and other illicit activities related to drugs, weapons, and gangs. In Canada, close to half of police-reported incidents of human trafficking in 2020 involved at least one other violation (Conroy & Sutton, 2022), highlighting the interconnected nature of crimes.

Human trafficking does not always involve the movement and transportation of persons. Domestic human trafficking corridors are, however, systematically used to transport victims to different commercial sex markets within and across provinces in Canada. Corridors are a means to maximizing profits, minimizing risk of detection and prosecution, and maintaining control over victims (The Canadian Centre to End Human Trafficking, 2021b). Ontario's intra-provincial corridor connects commercial sex markets within large cities and small towns via Highway 401. Toronto is recognized as a major urban hub for commercial sex in Ontario.



Source: [Human Trafficking Corridors in Canada](#) (The Canadian Centre to End Human Trafficking, 2021b)

1.3.3. Colonialism, Racism, and Gender Inequality

Cultural oppression is a fundamental root cause of human trafficking (Bryant-Davis & Tummala-Narra, 2017). Implementing an effective community response to CST requires critical examination of Canada's history of state-sanctioned violence and continuing systems of oppression that underpin its proliferation. Situating the problem within a broader historical, sociocultural, and structural context helps us to better understand and address the disproportionate rates of sex trafficking experienced by Black and Indigenous girls and women, 2SLGBTQI+ people, and those with disabilities.

Intersectionality

Intersectionality offers a power-based analysis of how various forms of inequality operate together and exacerbate each other (Crenshaw, 1989). Social aspects of individual identities (including but not limited to Indigeneity, race, ethnicity, gender, age, socioeconomics, 2SLGBTQI+ status, religion, (dis)ability, family status, education, geography, and immigration status) represent overlapping sources of privilege and oppression. The ways in which diverse social locations intersect impact how one is seen, heard, and treated by society. This results in outcome disparities for groups who face marginalization and discrimination across multiple axes of social inequality (Jackson et al., 2016).

This framework augments our understanding of [Trafficking at the Intersections](#). The social structures that shape the practice of human trafficking are rooted in interconnected systems of colonialism, racism, and sexism (Nonomura, 2020). Through an intersectional lens, the multiple marginalized identities of children, particularly Black and Indigenous girls living in poverty, compound risk of being sex trafficked, as well as likelihood of being denied equitable access to protection, care, and justice. Community responses to CST must include an intersectional analysis that centres lived experiences and interrogates the interactional effects of socially-constructed identities and related power, privilege, and oppression.

Colonial Legacy

“Canada’s colonial legacy has forced Indigenous women and girls into dangerous and precarious social and economic conditions, which in turn has made them more vulnerable to different kinds of violence. This includes situations of exploitation and human trafficking, a prevailing concern that has yet to be properly addressed and recognized.” (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)



The legacy of settler colonialism continues to be complicit in the sexual exploitation and trafficking of Indigenous girls, women, and Two-Spirit people in Canada (Sethi, 2007). Trafficking of Indigenous people was an essential tool for the colonization of Turtle Island historically. It provided Indigenous bodies for labour and sex under the pretext of civilizing Indigenous communities, while securing their lands for occupier settlement to enrich imperial powers. Traditional Indigenous cultures, territories, economies, and families were eradicated over centuries of institutionalized genocide, slavery, reservations, and residential schools. Pathways to contemporary manifestations of colonial violence include generational trauma, social and economic marginalization, lack of institutional and political will, and failure to recognize

the agency and expertise of Indigenous women, girls, and 2SLGBTQI+ people (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019).

Underscoring the gendered dimension of colonialism, the bodies of Indigenous girls and women have been dehumanized and devalued, positioned as inherently hypersexual, and controlled with sexual violence. These attitudes and violations continue today. Indigenous girls and women comprise a disproportionately high rate of those sexually exploited through human trafficking in Canada (Ontario Native Women's Association, 2019). They are groomed for exploitation across the [Human Trafficking Lifecycle](#). Systemic racism, poverty, unemployment, housing insecurity, substance use, mental health conditions, family violence, child welfare system involvement, and other interlocking effects of trauma and identity loss contribute to the ongoing vulnerability of Indigenous girls (Native Women's Association of Canada, 2014). Microlevel manifestations of macrolevel injustices are used to justify perceptions of Indigenous victims and survivors as blameworthy.

Colonialism created the conditions for sex trafficking of Indigenous children and continues to shape modern-day exploitation methods and responses. The control tactics of traffickers mirror the policies and practices of governments that subjugate Indigenous people, marked by possession, displacement, relocation, commoditization, and exploitation (Bourgeois, 2015). Institutional approaches to protection and support continue to rely on colonial state structures and systems of oppression (Roxburgh & Shaw, 2022). Despite the inextricable link between colonial violence and human trafficking, the invisibility of Indigenous experiences in anti-human trafficking discourse persists.

Anti-Black Racism

Black communities have endured centuries of colonial violence and racism, dating back to Canada's role in chattel slavery justified by white supremacy ideology. The slave trade objectified and exploited Black bodies for the purposes of labour and sex. The slavery-era Jezebel stereotype, a construction of white society, framed Black girls and women as innately sexually promiscuous and immoral (Butler, 2015). This form of dehumanization and hypersexualization legitimized the pervasive use of sexual violence against them. Against this historical backdrop, these racist and sexist connotations continue to shape contemporary manifestations of sexual exploitation and trafficking.

Black girls are over-represented among victims of sex trafficking, while simultaneously overlooked as victims (Cook et al., 2022). They are more likely to be blamed and criminalized, particularly when attention shifts to behavioural responses to trauma that are often misunderstood. As their victimization is minimized, their vulnerabilities and needs are obscured. The invisibility of Black children as victims can be explained, in part, by the theory of adultification, whereby Black girls are perceived as more adult-like and less innocent than white girls of the same age (Epstein et al., 2017). They tend to be viewed by adults as needing less nurturing, protection, support, and comfort, while being more independent and knowing more about adult topics and sex. They are under-protected, over-policed, and over-disciplined, which pushes them out of school and down a path of dead-end streets (Crenshaw, 2015).

Anti-Black racism underpins the social context that contributes to greater risk of CST and poorer trajectories for Black girls across a range of social systems. The adverse effects of internalized, interpersonal, and systemic racism on health and well-being have been well-documented (Priest et al., 2013; Trent et al., 2019). A function of ongoing colonial and racial violence and reluctance to engage the justice system, the lived realities of Black communities have, for the most part, been erased from anti-human trafficking dialogue, data collection, and policymaking (Bruder, 2022).



Gender-Based Power

Sex trafficking is a form of gender-based violence deeply rooted in gender inequality. Canada, like all Western societies, is a patriarchal nation wherein men hold privilege and power over women. Patriarchy is maintained through sexism and misogyny and manifests across political, legal, economic, social, and familial realms. This intersects with racism, the feminization of poverty, and other institutionalized oppressions to intensify effects. Violence, and the threat of violence, against girls and women by men is a means of enacting and upholding male dominance and superiority, and by extension, subordination and oppression of girls and women.

Physical and sexual violence against girls, women, and gender-diverse people are pervasive and sustained through patriarchy. In Canada, 30% of girls and women aged 15 years and older report being a victim of sexual assault at least once since the age of 15 (Cotter & Savage, 2019). Sex trafficking is a gendered crime. While 96% of police-reported human trafficking victims are women and girls, 81% of accused traffickers are men and boys (Conroy & Sutton, 2022). These figures reflect longstanding ideologies and behaviours wherein girls and women are devalued, sexualized, objectified, and commodified. This points to the need for a gender-based analysis and response.

A gender-based lens also recognizes the power dynamics underlying sex trafficking of boys and gender-diverse young people perpetrated primarily by older males. Their exploitation often goes unreported due to shame rooted in sexual orientation and gender stereotypes. In the context of heterosexism, homophobia, and transphobia, 2SLGBTQI+ children are vulnerable to experiencing rejection by families, ostracization by peers, and discrimination by society. This contributes to low self-worth, substance use, and homelessness, all of which increase risk of CST stemming from unmet needs (Chisolm-Straker et al., 2017; Hogan & Roe-Sepowitz, 2020). Gender-affirming and inclusive CST services for 2SLGBTQI+ people are vital but lacking (Gerassi & Pederson, 2022).

1.3.4. Dynamics and Stages

Understanding the nature, dynamics, and process of CST is essential for being able to accurately identify patterns and effectively respond. The elements of coercive control and exploitation are complicated and can be subtle at the outset, progressing over days, weeks, months, or years. While the experience differs for each individual, CST is typically facilitated by entrapment and enmeshment schemes (Baird & Connolly, 2023; Reid, 2016), and it occurs in somewhat predictable stages: luring, grooming and gaming, coercion and manipulation, exploitation, and recruitment (Kalish & Lagios, 2013).



Luring and Grooming

Traffickers and their associates strategically target young people with vulnerabilities, such as unsupportive families, abuse and trauma histories, low socioeconomic status, and mental health or substance use problems. They use a variety of surveillance and recruitment methods. Traffickers pursue children in spaces where they are known to frequent and spend time unsupervised. This happens in-person (e.g.,

schools, malls, group homes, youth shelters, bus terminals, clubs), as well as online (e.g., social media, dating applications). The internet is increasingly being used to facilitate CST, while providing a means to evade detection. Some young people are entrapped for commercial sex using physical force and confinement. Most, however, experience a gradual process of luring and grooming by someone they know using relational tactics (Baird & Connolly, 2023).

Traffickers exploit children's basic needs and leverage their vulnerabilities and insecurities to gain power, control, and trust. They may promise a better life, job opportunities, money, gifts, housing, safety, protection, or romantic love under false pretenses. A sense of security, love, and belonging can be especially enticing for children exposed to abuse or neglect by their family, particularly those involved with the child welfare system and placed in out-of-home care settings (Baird et al., 2020; Reid, 2016). The grooming process may involve love bombing, whereby traffickers, in the role of romantic partner or "boyfriend," intentionally make their victims feel special, shower them with affection, compliment their appearance, and spend money on them. As trust develops, personal information about past experiences, hopes, and dreams is shared and later used against them. For those with neurodevelopmental disabilities, relational manipulation can be particularly challenging to decipher.

Physical intimacy is engaged and paired with rewards. Sexual boundaries are gradually tested and pushed. Traffickers will sometimes encourage substance use and supply drugs or alcohol to victims to lower inhibitions and build dependence as an entrapment strategy. Substances, intimacy, gifts, and basic necessities are eventually withheld as traffickers become increasingly controlling and isolating. As the dynamics change, victims seek to return the relationship to the honeymoon phase. This tends to be met with a cycle of calm and affection followed by aggression and violence.

"This is the first step in getting her to totally depend on you. You'll start to dress her, think for her, own her. Her family will become her No. 1 enemy and she'll attack them with all she has because they are trying to keep her from that which brings her joy – You. If you and your victim are sexually active, then slow it down. Once a week is fine. After sex, take her shopping for one item. Hair and/or nails are fine. She will develop a feeling of accomplishment. The shopping after a month will be replaced with cash. The love making turns into raw sex. She'll start to crave the intimacy and be willing to get back into your good graces. After you have broken her spirit, she has no sense of self-value. Now pimp, put a price tag on the item you have manufactured." (The Pimp Game: Instructional Guide by Royal, 2018)

Coercion and Exploitation

Traffickers use psychological and financial manipulation and coercion to fulfil their victims' unmet needs, gain their trust, and reinforce physical and emotional dependence and dominance. The commercial sex industry is normalized and glamorized to reduce inhibitions and desensitize them to uncomfortable sex acts. A common tactic used by traffickers is to manipulate their victims into believing they owe them for their new lifestyle, using forced or coerced commercial sex as repayment. This is referred to as debt bondage. This occurs within relationships where there are imbalances of power and authority between traffickers and victims (e.g., gender, age, size, race, money). Children are always in the subordinate role, with coercion and manipulation used to blur the lines between free choice and exploitation.



Coercive control is the patterned use of physical and non-physical behaviours to control, dominate, and hold power over another person, wherein noncompliance is punished and chronic fear is the by-product. Traffickers may exert and maintain control with sexual and physical violence, or threats of violence, against victims directly and/or those they care about. Means of non-physical coercive control include intimidation, isolation, degradation, humiliation, gaslighting, deprivation, extortion, exhaustion, reproductive coercion, and physiological dependency on drugs or alcohol. Access to substances, food, sleep, and money may be micromanaged or denied, with occasional indulgences to maintain motivation for compliance. Some are branded with tattoos or carvings as signs of ownership and surveilled with electronic tracking devices. Some are enlisted to participate in illegal activities, such as drug offences, and then threatened to be turned in to the police for their involvement in crime.

Traffickers will often incite victims' distrust of authorities and drive a wedge between them and their social support networks to increase isolation and reliance. With prolonged trauma exposure, victims' sense of self-worth and self-esteem gradually diminish and decision-making becomes distorted. As they become more distanced from family and friends and disengaged from school and hobbies, they become more deeply entrenched in the life. Survival mode takes over.

"You're just trying to live. Focused on today, right now in the moment. Worried about how people will look at you. Worried about how you're going eat. It sounds crazy, but in the moment, you have no capacity to think about anything else. You're in survival mode." (Survivor)

Traffickers sometimes instill rivalry among victims with ranks and rewards. Some victims are instructed or coerced by traffickers to become recruiters, whereby they facilitate the luring and grooming of other potential victims. For those entrenched in the life, this may offer a sense of reclaimed power, higher status, or self-protection, including avoiding violence or having a lower quota for commercial sex themselves. CST victim-offender intersectionality should be understood in the context of coercive control, trauma bonding, and trauma survival, as well as neurodevelopmental disabilities, mental illness, and substance use that may increase susceptibility to manipulation and dependence.

Barriers to Exiting

Transitioning out of sex trafficking can be a lengthy and difficult process requiring extensive support and time. Multiple overlapping and mutually reinforcing psychological, relational, financial, and structural barriers operate to prevent victims from exiting and contribute to re-entry (Baird & Connolly, 2023; Hammond & McGlone, 2014; Noble et al., 2020). Awareness of the impediments to escaping and strategies for overcoming them is integral to formulating safe and effective service plans.

"It takes a long time to leave and a lot of help to leave. People act like it's just picking up the phone. But emotionally, physically, and financially, it's a lot." (Survivor)

Many children do not recognize that they are being commercially sexually exploited at the outset. They often do not perceive themselves as victims. They may genuinely believe they are in a real romantic relationship or friendship with their trafficker, who makes them feel loved and protected. They may think they are helping their trafficker or proving loyalty by engaging in commercial sex, without fully understanding that consent is not possible under coercion. For children with a history of maltreatment by



family members they trusted and consequent altered worldview, being mistreated by traffickers can feel normal and expected. Some prefer this life over the abusive or impoverished homes they left. They may feel unworthy of anything better.

Traffickers can become attachment figures to whom children turn to fulfil their basic human need for connection and protection, especially those with disrupted attachment histories. Some children form trauma bonds with their trafficker that are very difficult to sever. This occurs when acts of love, kindness, and affection are interspersed with acts of betrayal, aggression, and violence. Patterns of coercive control leave room for hope that caring behaviours will return. There may be a sense of loyalty to the trafficker, obligation to protect them, and guilt for leaving them. The threat of losing an important attachment figure can evoke memories of earlier abuses and abandonments. These emotional attachments and dependencies are strong and challenging to overcome, often resulting in victims staying with, or repeatedly returning to, their trafficker. They may experience cognitive dissonance, attempting to make sense of the situation by minimizing and rationalizing the harm and directing blame inward.

These complicated attachments can extend to the living situation and peer victims. Forming close relationships with other young trafficking victims within their network can add to the challenges of exiting due to feelings of guilt for leaving them behind and ongoing concern for their safety.

“When I was younger, I would actually get quite defensive of my pimp when friends would make comments about him. I think it was a bit of Stockholm syndrome. In my younger eyes, he protected me against bad Johns by vetting them and attacking the bad ones who’d hurt me, so I thought he had my back. At that time, he was really the only person I had in my life that I could talk to about what was going on and help me if I got hurt. So even though he was the one putting me in those situations, my brain was wired to think he was my guardian. It might be good for providers to know that the kids going through this may be protective or defensive of their pimps.” (Survivor)

Exiting CST generally means leaving one life to start a new life with a different culture and expectations. The compounding effects of psychological manipulation, physical and sexual violence, and substance use can influence victims’ decision-making and coping capacity, readiness to leave their trafficker, and ability to adapt to life outside of trafficking. With their self-worth and self-efficacy chipped away, many victims are conditioned to believe they will not survive on their own and no one cares. Some fear they will never belong or fit in with “mainstream” society again. They may feel a sense of hopelessness or apathy, which tends to intensify over time. Internalized stigma, blame, and shame play a powerful role in preventing victims from seeking help and returning to the families and communities from which they were isolated.

Fear is a powerful method of control. Feeling stripped of their power, victims can become overwhelmed by fear of the many unknowns associated with exiting and starting over. They may fear reprisals by traffickers against them and/or their loved ones should they attempt to leave. This is reinforced with direct or indirect intimidation and threats of physical or sexual violence. Groomed to be distrustful of authorities, victims may worry about getting into trouble with the police, not being believed, losing their immigration status, being placed in state care, or losing custody of children.

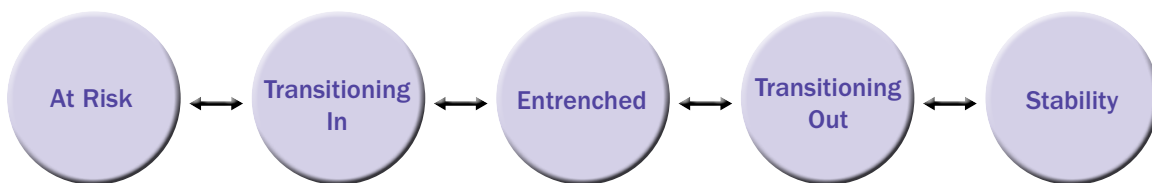
Once estranged from family and friends, many victims lack the necessary financial and social supports to exit. They may be told they are financially indebted to their trafficker and therefore forced to stay.



Sometimes there are dollar-figure quotas or exit fees that victims are coerced into believing they have to pay. They may have their passports, identification, and money taken away, leaving them trapped in the situation. For those with precarious immigration status, threats of deportation may impede help-seeking. Language barriers contribute further to isolation. Unaware of their rights and denied access to resources, staying may appear to be the only viable option.

“If I leave, then I’m completely alone. There’s no one else who will do what he was doing for me. I can’t provide myself those things. They’ll tell you, oh it’s not that bad. But what if I leave and I don’t know what I’m doing. I can’t manage this, can’t manage my money, don’t know what to do. They might have things you need, things that hold significance. There’s no leaving that.” (Survivor)

These psychological, relational, and financial barriers are reinforced by structural and systemic barriers to successfully exiting and integrating into a new life. The broader context of stigmatization and discrimination based on race and gender influences access to resources and opportunities, as well as perceived value and worth. With no guarantee of basic income support or stable housing upon exiting, the harsh realities of returning to a life of poverty can strengthen victims’ ties to traffickers. For those who do seek help to transition out, a lack of specialized services and adequate training among providers to respond sensitively and effectively can further obstruct the exit and recovery process. These dynamics contribute to victims returning to their trafficker, often several times, before reaching a place of stability. It can become more difficult to exit as children transition into older adolescence and adulthood, underscoring the importance of prevention and early intervention efforts.



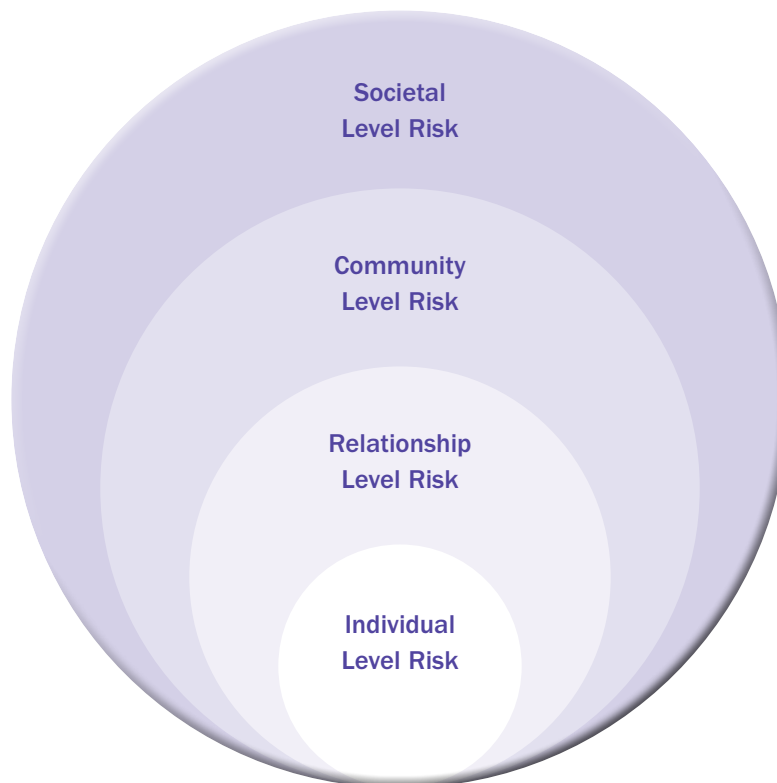
1.3.5. Risk Factors and Vulnerabilities

Sex trafficking can happen to anyone, regardless of age, gender, race, religion, sexual orientation, socioeconomic status, ability, education level, citizenship, family type, neighbourhood, or other social location. However, some groups are more likely to be victimized and less likely to be protected than others. Understanding the social circumstances and personal vulnerabilities underlying CST is critical for effective prevention and early intervention strategies.

There are individual, interpersonal, and environmental risk factors associated with greater likelihood of exposure to CST (Barnert et al., 2017; Choi, 2015; Fedina et al., 2019; O'Brien et al., 2017). Risk and protective factors for CST are best conceptualized using an ecological systems framework (Finigan-Carr et al., 2019; Greenbaum, 2020). They intersect across individual, relational, community, and societal levels of the ecosystem to increase or decrease risk. Structural and systemic inequities are at the core of most personal vulnerabilities. Risk factors may or may not have a causal relationship to CST. Causal factors may play a direct or indirect role. It is difficult to differentiate risk factors for CST from the effects of CST. There is also overlap with risk factors for, and effects of, other co-occurring adverse childhood experiences.

Children are inherently more vulnerable to sex trafficking than adults. Seeking personal autonomy and exploring sexuality are normative parts of child and adolescent development which can be taken advantage of. Children generally have limited life experiences, restricted options and resources, and brains that have not fully developed. This leaves them susceptible to impulsivity and risk-taking without critical analysis of consequences. They are less capable of defending themselves against coercion and manipulation, rendering them prone to exploitation by adults.

Age-based risk is compounded by gender, socioeconomic status, race, disability, 2SLGBTQI+ identity, immigration status, and other intersecting marginalized identities and adverse experiences. Indigenous and Black children are over-represented in Ontario's child welfare system (Ontario Human Rights Commission, 2018). Children with histories of child maltreatment and child welfare system involvement, particularly those entering or leaving care with limited social support, are at heightened risk of CST (Baird et al., 2020; O'Brien et al., 2017). These children tend to be targeted by traffickers due to their poor family connections, lack of adult supervision, effects of abuse and trauma, desire for love and belonging, and need for money and housing. Prior childhood sexual abuse is among the strongest risk factors for CST, especially for girls (Choi, 2015; De Vries & Goggin, 2018).



For an overview of risk factors using an ecological systems framework, see [Child Sex Trafficking: Who is Vulnerable to Being Trafficked?](#)

Individual-level risk factors:

- Young age (childhood and adolescence)
- Female gender
- Adverse childhood experiences (e.g., child abuse and neglect, exposure to intimate partner violence)
- Abandoned or unhoused
- Runaway behaviour
- Substance use and addiction
- Behavioural and mental health conditions
- Neurodevelopmental and physical disabilities
- Low self-esteem and self-worth
- Attachment insecurity
- Poor sense of belonging
- Racialized and marginalized identities
- Precarious immigration status
- Multisystem involvement
- Placement in care and placement breakdown
- Low socioeconomic status
- Limited education and unemployment
- School disengagement

Relationship-level risk factors:

- Family fragmentation and separation
- Family violence and dysfunction
- Household poverty
- Parent/caregiver substance use
- Parent/caregiver death or incarceration
- Family or friend involvement in sex trade
- Intolerance of 2SLGBTQI+ identity
- Family rejection and abandonment
- Social isolation and ostracism
- Peer pressure and bullying
- Gang affiliation
- Unsupportive and unstable relationships
- Intimate partner violence

Community-level risk factors:

- Under-resourced schools, community programs, and neighbourhoods
- Lack of trauma-informed schools
- Poverty and lack of employment opportunities
- Community housing insecurity
- High crime neighbourhoods
- Illegal drug trade
- Gang activity
- Adult sex work nearby
- Transient populations (e.g., sporting events)
- Over-policing and over-disciplining of Black and Indigenous girls
- Corrupt authorities
- Poor service coordination

Societal-level risk factors:

- Structural and systemic inequities (rooted in colonialism, racism, patriarchy, sexism, heterosexism, classism, ageism, ableism, and other oppressions)
- Cultural norms promoting gender roles and gender-based violence
- Policies and practices contributing to socioeconomic and health disparities
- Feminization of poverty
- Generational, colonial, and racial trauma
- Societal undervaluing of children
- Sexualization and commodification of children
- Hypersexualization and adultification of Black and Indigenous girls
- Glamorization of sex trade and pimp culture
- Child welfare, criminal justice, and education system weaknesses
- Ineffective CST laws and policies
- Natural disasters, disease pandemics, and geopolitical conflicts
- Mass migration

“There are a lot of things that happen in your early life that determine the rest of the things that happen afterwards. Things could have gone very differently too, if I had been given the right supports then, when I was just left to fend for myself and had to get in dangerous situations to survive.” (Survivor)

“No one just wakes up one day and this happens to them. There are things leading up. People don’t just take someone who’s in a good place in their life. You have to be like, broken. That’s what they look for. All these things that lead you to a place where you’re vulnerable enough to get into this situation. So if that person’s not given adequate support before it happens, it can lead to it happening. There are preventive measures too that can take place.” (Survivor)

Responsibility for CST lies firmly with the individuals and groups perpetrating it for personal power, sexual gratification, and financial gain, in the context of sociocultural ideologies and institutions that enable it. Anti-human trafficking efforts should work toward transforming the social injustices at the core of the problem and proactively mitigating risk factors amenable to change. Refer to sections 2.9 and 3.2.1 of the protocol for multilevel prevention strategies and resources.

1.3.6. Protective Factors and Resiliencies

Prevention and intervention strategies should not only aim to identify and mitigate risk factors for CST but also to recognize and strengthen protective influences at individual, interpersonal, and environmental levels. Protective factors provide buffers against CST from happening and harmful effects from developing. They can change with developmental stages and life conditions. It should be noted that many protective characteristics and circumstances are associated with privileged social status. Removing barriers and creating equitable opportunities to bolster resiliencies in marginalized groups should be infused in anti-human trafficking work.

Protective factors:

- Financial security
- Safe and secure housing
- Stable and supportive family connections
- Secure attachments
- Positive peer relationships
- Supportive communities
- Safe neighbourhoods
- Constructive coping strategies
- Sense of belonging
- Connection to culture
- Connection to land
- Religious or spiritual beliefs
- Positive school experiences
- Academic achievement and employment
- Emotional, behavioural, and social competence
- Healthy self-esteem and self-worth
- Talents and skills
- Prosocial activities and hobbies
- Routine and structure
- Access to effective mental health services
- Responsive and just child welfare and criminal justice systems



1.3.7. Traumatic Effects and Outcomes

[Adverse Childhood Experiences](#) are potentially traumatic events occurring in childhood that can undermine one's sense of safety, stability, and bonding and impact lifelong health and opportunity (Felitti et al., 1998). Adverse experiences include various forms of abuse, neglect, and household dysfunction, as well as system-induced and identity-based traumas. Sex trafficking is an adverse experience in childhood, frequently coinciding with other childhood adversities. Children who have been commercially sexually exploited have been found to have a history of five other trauma types, on average, mostly within the caregiving environment, including sexual abuse, emotional abuse, neglect, domestic violence, and traumatic loss (Cole et al., 2016). CST also generates secondary adversities, such as social stigma, arduous legal proceedings, and institutional betrayal.

Exposure to CST can lead to toxic stress and trauma responses. Trauma is the lasting adverse effects of a distressing event, or series of events or circumstances, experienced as frightening, harmful, or life-threatening. Complex trauma (or developmental trauma) is interpersonal, repeated or prolonged, involves direct harm due to various forms of abuse, and occurs during developmentally vulnerable periods in life (Briere & Lanktree, 2012; Ford & Courtois, 2013). Complex trauma is associated with impairment across the domains of attachment, biology, affect regulation, dissociation, behavioural control, cognition, and self-concept (Cook et al., 2005). For many children, CST can be characterized as complex trauma involving multiple enduring interpersonal abuses (physical, sexual, psychological) at a critical period of development. Elements of coercive control, relational betrayal, and shame add to the complexity.

Traumatic experiences can evoke strong neurobiological responses and impact physiological systems responsible for regulating stress. The nervous system's automatic defence against real or perceived danger is to fight, flee, freeze, or shut down. Service providers working with children subjected to exploitation and violence should have an understanding of [What Happens in the Brain During a Potentially Traumatic Event](#) and the adaptive ways in which the brain and body respond to trauma. Frequent and prolonged activation of stress response systems can interfere with development of the brain and other bodily systems, leading to developmental delay and other health problems over the life course.



CST and related trauma can impact physical, psychological, emotional, social, and spiritual well-being, altering a child's life trajectory. Children exposed to sex trafficking are at increased risk of experiencing a range of physical and mental health challenges (Barnert et al., 2017, 2022; Cole et al., 2016; Le et al., 2018; Lederer & Wetzel, 2014; Oram et al., 2012, 2015; Ottisova et al., 2016, 2018; Varma et al., 2015). There is a disproportionately high prevalence of post-traumatic stress symptoms (PTSS), post-traumatic stress disorder (PTSD), and complex post-traumatic stress disorder (C-PTSD) among young people who have been commercially sexually exploited (Evans et al., 2022; Ottisova et al., 2018; Perry et al., 2022). In addition to the core PTSD symptoms of re-experiencing, avoidance, and hyperarousal, C-PTSD involves affect dysregulation, negative self-concept, and relational difficulties. Trauma responses are adaptive attempts at surviving adversity that can become maladaptive. While serving the purpose of self-preservation, this can interfere with one's ability to control emotions, cope with stress, feel safe and secure, form trusting relationships, make good decisions, set healthy boundaries, develop a sense of self-worth, perform well in school, hold a job, and find stability in life.

Children are uniquely impacted by sex trafficking and traumatic stress. Sequelae should be understood in the context of stage of exploitation and recovery. Severity, duration, and proximity of CST-related abuses affect

levels of PTSD, depression, and anxiety (Hossain et al., 2010). Pre-existing conditions can be exacerbated by CST, as well as contribute to risk of CST. Coping with trauma through numbing behaviours (e.g., substance use), while offering temporary relief of symptom intensity, can ultimately worsen symptoms. Symptom onset and severity are influenced by several intrinsic and extrinsic factors, including developmental stage, prior trauma exposure, psychological resources, material circumstances, marginalized status, and social supports. Supportive and protective relationships with caring adults can prevent, reduce, or reverse damaging effects.

There are social, cultural, and historical dimensions of personal trauma. Racial stress and racial trauma can result from the cumulative impacts of interpersonal and systemic racism experienced by individuals and communities who are Black, Indigenous, and people of colour in Canada (Williams et al., 2022). Moving beyond the Eurocentric medicalization of trauma, Indigenous conceptions of health, harm, and healing recognize individual, collective, and generational soul wounds. A decolonizing approach centres the soul wounds of colonization and imbalances that arise across the four spheres of health and wellness: mental, physical, emotional, and spiritual (Linklater, 2014).

Neurobiological, psychological, and emotional effects:

- Structural and functional brain changes
- Changes to physiological system regulating stress
- Emotional dysregulation
- Altered states of consciousness and detachment (e.g., dissociation, disorientation)
- Psychosis and prodromal symptoms
- Intrusive thoughts and re-experiencing (e.g., nightmares, flashbacks)
- Negative cognitive appraisals
- Altered self-concept and body image
- Diminished self-belief, shame, and guilt
- Memory impairment
- Inattention and poor concentration
- Learning difficulties
- Communication challenges
- Avoidance of trauma-related stimuli
- Anxiety, panic, and fear
- Hypervigilance
- Irritability and anger
- Depression
- Suicidal thoughts

Physical and behavioural effects:

- Disordered eating
- Sleep disturbances
- Substance use and related complications
- Traumatic physical injuries
- Sexually transmitted infections
- Pregnancy and related complications
- Lasting reproductive issues
- Sexualized behaviour
- Sexual dysfunction
- Self-injury and suicide
- Malnutrition
- Weakened immunity
- Skin conditions
- Gastrointestinal problems
- Weight loss
- Headaches and dizziness
- Back pain
- Dental injuries and decay
- Somatic symptoms
- Toileting-related challenges
- Oppositional behaviour
- Impulsivity
- Physical aggression
- Excessive compliance

Interpersonal, social, and spiritual effects:

- Attachment problems
- Difficulty sustaining relationships
- Family estrangement
- Disengagement from friends and hobbies
- Impaired social skills
- Distrust of others
- Social isolation
- School disengagement
- Disconnection from culture and community
- Altered sense of identity and belonging
- Loss of faith and hope
- Existential stress
- Trauma bonding

For an overview of common youth experiences before being, while being, and after being sex trafficked, see [Child Sex Trafficking: Experiences of Youth Who Have Been Trafficked](#).

The effects of CST extend to the entire family system. Parents/caregivers commonly experience a wide range of reactions and impacts, including traumatic stress, shame, guilt, anxiety, depression, anger, grief, and despair. This may compromise their ability to keep up with household and employment responsibilities, place a strain on intimate relationships, interfere with parenting other children, and lead to family breakdown. These secondary effects of trafficking can undermine a child's post-trauma adjustment, highlighting the need for family-centred supports and services.

Even in the face of adversity, many children and families impacted by sex trafficking demonstrate remarkable resilience, hope, recovery, and post-traumatic growth (Knight et al., 2021; Volgin et al., 2019). Strengths should be recognized and reinforced.

Traumatic stress resources:

- [What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them](#)
- [The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families](#)
- [The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families Adapted for Youth Who Are Trafficked](#)
- [Impact of Trauma on Youth With Intellectual and Developmental Disabilities: A Fact Sheet for Providers](#)
- [Cultural Responsiveness to Racial Trauma](#)
- [A Guide to Toxic Stress](#)
- [Adverse Childhood Experiences](#)
- [National Child Traumatic Stress Network](#)
- [Canadian Consortium on Child and Youth Trauma](#)
- [Academy on Violence and Abuse](#)
- [International Society for Traumatic Stress Studies](#)



1.4. COMMUNITY RESPONSES

1.4.1. Multisector, Multiagency, Multidisciplinary Approach

Children affected by sex trafficking present with a multitude of needs, often requiring service plans spanning several organizations at various stages of their exploitation and recovery. Effectively preventing, identifying, assessing, and intervening in CST therefore requires a multifaceted, community-wide, systems of care approach. A comprehensive community response calls for multiagency, multidisciplinary collaboration, communication, and coordination across key sectors and systems, including health care, child welfare, and criminal justice, among others. There is a tendency for organizations to work in silos, with a separation of programs, expertise, training, and funding, despite having similar mandates. This results in the compartmentalization and fragmentation of service delivery, ultimately contributing to some children and families falling through the cracks.



Single organizations and providers cannot effectively combat CST alone.

Embracing a collaborative community network is required for optimal outcomes (Greenbaum & Albright, 2022). Strategic partnerships are fundamental to holistic responses that best meet the needs of children and their families.

Jurisdictions with joint anti-human trafficking efforts are more likely to identify victims and achieve successful results (Farrell et al., 2008). A multidisciplinary team approach has been associated with improved criminal justice and mental health responses, as well as increased caregiver and staff satisfaction (Herbert & Bromfield, 2019). Developing cohesive working relationships should be the goal for maximum impact. With a shared body of knowledge and pooling of resources, collective efforts are fortified.

Principal Actors and Coalitions

Building organized systems of care can be set in motion by forming anti-human trafficking coalitions, task forces, and advisory committees to develop a shared philosophy and language, establish community standards of practice, and strengthen the support network for victims and survivors. Clearly articulating the purpose of the group is important to ensure it is filling an identified need, avoiding duplication, and making the best use of time and resources. Leadership structure, diverse representation, roles and responsibilities, and decision-making processes should be well-defined. When collective objectives and cohesive relationships have been established, it is important to maintain the momentum of collaborative efforts. Progress toward goals should be regularly evaluated. Membership, objectives, and action plans should be modified as needed.

Coinciding with national, provincial, and municipal anti-human trafficking strategies, many anti-human trafficking networks and joint initiatives have emerged in Toronto and Greater Toronto Area in recent years to create a unified local response (including the multisector community advisory committee convened to establish this community response protocol). Committees with a human trafficking focus that are currently operational locally include the following, among others:

- Child Sex Trafficking Community Response Protocol Advisory Committee, The Hospital for Sick Children, Lotus Health
- Toronto Region Anti-Human Trafficking Service Providers Table, Ontario Ministry of Children, Community and Social Services
- Human Trafficking Intervention Prevention Strategy, Strides Toronto

- Toronto Counter-Human Trafficking Network, FCJ Refugee Centre
- Collaborative Network to End Exploitation, Sisters of St. Joseph of Toronto
- Human Trafficking Provincial Workgroup, Ontario Association of Children's Aid Societies
- Sex Trafficking Network, Covenant House Toronto
- Anti-Sex Trafficking Collaboration, Toronto District School Board
- Human Trafficking and Modern Slavery Response Council, Salvation Army

The principal actors involved in the identification, assessment, intervention, and prevention of CST will vary by geography, jurisdiction, and resources available. Core sectors and services generally include health, protection, justice, housing, and education, among others. The child's best interests should always be placed at the centre of the multisystem care model.

Health and mental health care sectors:

- Pediatric and adult hospitals
- Primary health care clinics
- Community health centres
- Mental health organizations
- Substance use and addictions services
- Public health units
- Dental services

Child welfare, justice, and legal sectors:

- Child protection services
- Municipal, provincial, and federal law enforcement
- Crown prosecution
- Youth justice
- Victim services
- Immigration and refugee legal services

Housing and social service sectors:

- Foster homes and congregate care settings
- Emergency shelters
- Intermediate, transitional, and permanent housing
- Financial assistance programs
- Immigration and refugee support services
- Translation and interpretation services

Employment and education sectors:

- Elementary, secondary, and post-secondary schools
- Job skills training programs
- Life skills mentorship programs

Culture-based and survivor-led services and advocacy:

- Culturally-relevant services
- Traditional healing and faith-based programs
- Survivor leadership programs
- Peer support and mentorship programs
- Grassroots consciousness-raising and advocacy efforts

Government:

- Municipal, provincial, and federal governments
- Policymakers and advisors
- Government taskforces and partnerships



Academia and research:

- University-hospital-community research collaborations and knowledge hubs

Commercial industries:

- Hospitality and tourism
- Transportation and trucking
- Branding tattoo removal
- Telecommunications
- Banking and financial intelligence

Response Continuum

A multisystem community response to CST exists along a non-linear continuum, from preventive outreach to ongoing support, with multidisciplinary trauma-informed care integrated at each point to meet victims and survivors wherever they are at in their process of exploitation and recovery.



1.4.2. Relevant Legislation

Laws recognize and protect individual rights and freedoms and provide rules of conduct. Human trafficking and sexual offence laws shape how the best interests of victims and survivors are protected, how traffickers and purchasers of child sex are held responsible for their actions, and how service providers should respond. Awareness of international protocols and federal, provincial, and municipal laws governing all aspects of human trafficking, sexual exploitation, sexual assault, and child maltreatment is an important component of a community response protocol concerned with protection and justice. Refer to section 1.1.5 of the protocol for those most relevant to CST-related matters.

Alternative approaches to law and justice, such as restorative justice, offer holistic means to repair harm caused to people, relationships, and communities through collective engagement in resolutions and healing. See Department of Justice Canada's [Indigenous Justice Program](#) and City of Toronto's [Restorative Justice Programs](#).

Criminal Code of Canada

[Criminal Code of Canada \(1985\)](#) is a federal law that defines criminal offences enacted by Parliament of Canada and sets out procedures related to investigation, defences, prosecution, and sentencing.

Age of consent for sexual activity:

Sexual activity without consent is a criminal offence, regardless of age. Age of consent is the age at which a young person can legally agree to sexual activity with another person. Age of consent for sexual activity in Canada is 16 years. Age of consent is higher (18 years) when there is a relationship of trust, authority, dependency, or exploitation. There are close-in-age exceptions for 12- to 15-year-olds.

Age of Consent for Sexual Activity in Canada*

<12 years	Cannot consent to any sexual activity.
12-13 years	Can consent to sexual activity with a partner who is less than two years older if the partner is not in a position of trust or authority, there is no relationship of dependency, and the relationship is not exploitative of the young person. If the partner is two years or older than the 12- or 13-year-old, any sexual activity is a criminal offence (if it can be established that the accused did not believe the young person was of an age to legally consent and did not take all reasonable steps to ascertain their age).
14-15 years	Can consent to sexual activity with a partner who is less than five years older if the partner is not in a position of trust or authority, there is no relationship of dependency, and the relationship is not exploitative of the young person. Can also consent to sexual activity with a partner who is five or more years older if they are in a common law relationship or cohabiting in a conjugal relationship, and they have had or are expecting a child together, as long as there is no relationship of trust, authority, dependency, or exploitation.
16-17 years	Can consent to sexual activity if the partner is not in a position of trust or authority, there is no relationship of dependency, and the relationship is not exploitative of the young person.
<18 years	Cannot consent to sexual activity with a person in a position of trust or authority toward the young person, or upon whom the young person is dependent. Cannot consent to sexual activity when the relationship is exploitative of the young person, which arguably includes any commercial sex transaction.

*Note that the consent of someone under 16 years is not a defence to any sexual activity that would satisfy section 272 or 273 of the Criminal Code. This includes sexual activity that involves bodily harm, use of a weapon, choking or strangulation, or multiple partners at once. Consent of someone under 18 years is not a defence against a trafficking charge under section 279.

Human trafficking of persons under 18 years:

Human trafficking has been a crime under the Criminal Code since 2005. The Criminal Code contains three indictable offences related to human trafficking of persons under the age of 18 years.



Trafficking of a person under the age of eighteen years

279.011 (1) Every person who recruits, transports, transfers, receives, holds, conceals or harbours a person under the age of eighteen years, or exercises control, direction or influence over the movements of a person under the age of eighteen years, for the purpose of exploiting them or facilitating their exploitation is guilty of an indictable offence and liable

(a) to imprisonment for life and to a minimum punishment of imprisonment for a term of six years if they kidnap, commit an aggravated assault or aggravated sexual assault against, or cause death to, the victim during the commission of the offence; or

(b) to imprisonment for a term of not more than fourteen years and to a minimum punishment of imprisonment for a term of five years, in any other case.

Consent

(2) No consent to the activity that forms the subject-matter of a charge under subsection (1) is valid.

Material benefit — trafficking of person under 18 years

279.02 (2) Everyone who receives a financial or other material benefit, knowing that it is obtained by or derived directly or indirectly from the commission of an offence under subsection 279.011(1), is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of two years.

Withholding or destroying documents — trafficking of person under 18 years

279.03 (2) Everyone who, for the purpose of committing or facilitating an offence under subsection 279.011(1), conceals, removes, withholds or destroys any travel document that belongs to another person or any document that establishes or purports to establish another person's identity or immigration status — whether or not the document is of Canadian origin or is authentic — is guilty of an indictable offence and liable to imprisonment for a term of not more than 10 years and to a minimum punishment of imprisonment for a term of one year.

Exploitation

279.04 (1) For the purposes of sections 279.01 to 279.03, a person exploits another person if they cause them to provide, or offer to provide, labour or a service by engaging in conduct that, in all the circumstances, could reasonably be expected to cause the other person to believe that their safety or the safety of a person known to them would be threatened if they failed to provide, or offer to provide, the labour or service.

Factors

(2) In determining whether an accused exploits another person under subsection (1), the Court may consider, among other factors, whether the accused

(a) used or threatened to use force or another form of coercion;

(b) used deception; or

(c) abused a position of trust, power or authority.

There are other offences in the Criminal Code that are routinely laid in CST situations, depending on whether the evidence establishes each of the essential elements of the offence. The most common of these other offences are the child sexual offences (sexual interference, invitation to sexual touching, sexual exploitation) and the sexual services offences (receiving material benefit from sexual services, procuring, advertising sexual services).

Sexual interference

151 Every person who, for a sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of a person under the age of 16 years

(a) is guilty of an indictable offence and is liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year; or

(b) is guilty of an offence punishable on summary conviction and is liable to imprisonment for a term of not more than two years less a day and to a minimum punishment of imprisonment for a term of 90 days.



Invitation to sexual touching

152 Every person who, for a sexual purpose, invites, counsels or incites a person under the age of 16 years to touch, directly or indirectly, with a part of the body or with an object, the body of any person, including the body of the person who so invites, counsels or incites and the body of the person under the age of 16 years,

(a) is guilty of an indictable offence and is liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year; or

(b) is guilty of an offence punishable on summary conviction and is liable to imprisonment for a term of not more than two years less a day and to a minimum punishment of imprisonment for a term of 90 days.

Sexual exploitation

153 (1) Every person commits an offence who is in a position of trust or authority towards a young person, who is a person with whom the young person is in a relationship of dependency or who is in a relationship with a young person that is exploitative of the young person, and who

(a) for a sexual purpose, touches, directly or indirectly, with a part of the body or with an object, any part of the body of the young person; or

(b) for a sexual purpose, invites, counsels or incites a young person to touch, directly or indirectly, with a part of the body or with an object, the body of any person, including the body of the person who so invites, counsels or incites and the body of the young person.

Inference of sexual exploitation

(1.2) A judge may infer that a person is in a relationship with a young person that is exploitative of the young person from the nature and circumstances of the relationship, including

(a) the age of the young person;

(b) the age difference between the person and the young person;

(c) the evolution of the relationship; and

(d) the degree of control or influence by the person over the young person.

Definition of young person

(2) In this section, young person means a person 16 years of age or more but under the age of eighteen years.

Parent or guardian procuring sexual activity

170 Every parent or guardian of a person under the age of 18 years who procures the person for the purpose of engaging in any sexual activity prohibited by this Act with a person other than the parent or guardian is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year.

Householder permitting prohibited sexual activity

171 Every owner, occupier or manager of premises, or any other person who has control of premises or assists in the management or control of premises, who knowingly permits a person under the age of 18 years to resort to or to be in or on the premises for the purpose of engaging in any sexual activity prohibited by this Act is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year.

Luring a child

172.1 (1) Every person commits an offence who, by a means of telecommunication, communicates with

(a) a person who is, or who the accused believes is, under the age of 18 years, for the purpose of facilitating the commission of an offence with respect to that person under subsection 153(1), section 155, 163.1, 170, 171 or 279.011 or subsection 279.02(2), 279.03(2), 286.1(2), 286.2(2) or 286.3(2);

(b) a person who is, or who the accused believes is, under the age of 16 years, for the purpose of facilitating the commission of an offence under section 151 or 152, subsection 160(3) or 173(2) or section 271, 272, 273 or 280 with respect to that person; or

(c) a person who is, or who the accused believes is, under the age of 14 years, for the purpose of facilitating the commission of an offence under section 281 with respect to that person.



Presumption re age

(3) Evidence that the person referred to in paragraph (1)(a), (b) or (c) was represented to the accused as being under the age of eighteen years, sixteen years or fourteen years, as the case may be, is, in the absence of evidence to the contrary, proof that the accused believed that the person was under that age.

No defence

(4) It is not a defence to a charge under paragraph (1)(a), (b) or (c) that the accused believed that the person referred to in that paragraph was at least eighteen years of age, sixteen years or fourteen years of age, as the case may be, unless the accused took reasonable steps to ascertain the age of the person.

Agreement or arrangement — sexual offence against child

172.2 (1) Every person commits an offence who, by a means of telecommunication, agrees with a person, or makes an arrangement with a person, to commit an offence

(a) under subsection 153(1), section 155, 163.1, 170, 171 or 279.011 or subsection 279.02(2), 279.03(2), 286.1(2), 286.2(2) or 286.3(2) with respect to another person who is, or who the accused believes is, under the age of 18 years;

(b) under section 151 or 152, subsection 160(3) or 173(2) or section 271, 272, 273 or 280 with respect to another person who is, or who the accused believes is, under the age of 16 years; or

(c) under section 281 with respect to another person who is, or who the accused believes is, under the age of 14 years.

Presumption

(3) Evidence that the person referred to in paragraph (1)(a), (b) or (c) was represented to the accused as being under the age of 18, 16 or 14 years, as the case may be, is, in the absence of evidence to the contrary, proof that the accused believed that the person was under that age.

No defence

(4) It is not a defence to a charge under paragraph (1)(a), (b) or (c) that the accused believed that the person referred to in that paragraph was at least 18, 16 or 14 years of age, as the case may be, unless the accused took reasonable steps to ascertain the age of the person.

No defence

(5) It is not a defence to a charge under paragraph (1)(a), (b) or (c)

(a) that the person with whom the accused agreed or made an arrangement was a peace officer or a person acting under the direction of a peace officer; or

(b) that, if the person with whom the accused agreed or made an arrangement was a peace officer or a person acting under the direction of a peace officer, the person referred to in paragraph (1)(a), (b) or (c) did not exist.

Obtaining sexual services for consideration from person under 18 years

286.1 (2) Everyone who, in any place, obtains for consideration, or communicates with anyone for the purpose of obtaining for consideration, the sexual services of a person under the age of 18 years is guilty of an indictable offence and liable to imprisonment for a term of not more than 10 years and to a minimum punishment of imprisonment for a term of

(a) for a first offence, six months; and

(b) for each subsequent offence, one year.

Material benefit from sexual services from a person under 18 years

286.2 (2) Everyone who receives a financial or other material benefit, knowing that it is obtained by or derived directly or indirectly from the commission of an offence under subsection 286.1(2), is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of two years.

Presumption

(3) For the purposes of subsections (1) and (2), evidence that a person lives with or is habitually in the company of a person who offers or provides sexual services for consideration is, in the absence of evidence to the contrary, proof that the person received a financial or other material benefit from those services.



Exception

- (4) Subject to subsection (5), subsections (1) and (2) do not apply to a person who receives the benefit
- (a) in the context of a legitimate living arrangement with the person from whose sexual services the benefit is derived;
 - (b) as a result of a legal or moral obligation of the person from whose sexual services the benefit is derived;
 - (c) in consideration for a service or good that they offer, on the same terms and conditions, to the general public; or
 - (d) in consideration for a service or good that they do not offer to the general public but that they offered or provided to the person from whose sexual services the benefit is derived, if they did not counsel or encourage that person to provide sexual services and the benefit is proportionate to the value of the service or good.

No exception

- (5) Subsection (4) does not apply to a person who commits an offence under subsection (1) or (2) if that person
- (a) used, threatened to use or attempted to use violence, intimidation or coercion in relation to the person from whose sexual services the benefit is derived;
 - (b) abused a position of trust, power or authority in relation to the person from whose sexual services the benefit is derived;
 - (c) provided a drug, alcohol or any other intoxicating substance to the person from whose sexual services the benefit is derived for the purpose of aiding or abetting that person to offer or provide sexual services for consideration;
 - (d) engaged in conduct, in relation to any person, that would constitute an offence under section 286.3; or
 - (e) received the benefit in the context of a commercial enterprise that offers sexual services for consideration.

Procuring a person under 18 years

286.3 (2) Everyone who procures a person under the age of 18 years to offer or provide sexual services for consideration or, for the purpose of facilitating an offence under subsection 286.1(2), recruits, holds, conceals or harbours a person under the age of 18 who offers or provides sexual services for consideration, or exercises control, direction or influence over the movements of that person, is guilty of an indictable offence and liable to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of five years.

Advertising sexual services

286.4 Everyone who knowingly advertises an offer to provide sexual services for consideration is guilty of

- (a) an indictable offence and liable to imprisonment for a term of not more than five years; or
- (b) an offence punishable on summary conviction.

Immunity — material benefit and advertising

286.5 (1) No person shall be prosecuted for

- (a) an offence under section 286.2 if the benefit is derived from the provision of their own sexual services; or
- (b) an offence under section 286.4 in relation to the advertisement of their own sexual services.

Immunity — aiding, abetting, etc.

(2) No person shall be prosecuted for aiding, abetting, conspiring or attempting to commit an offence under any of sections 286.1 to 286.4 or being an accessory after the fact or counselling a person to be a party to such an offence, if the offence relates to the offering or provision of their own sexual services.

Sexual assault

271 Everyone who commits a sexual assault is guilty of

- (a) an indictable offence and is liable to imprisonment for a term of not more than 10 years or, if the complainant is under the age of 16 years, to imprisonment for a term of not more than 14 years and to a minimum punishment of imprisonment for a term of one year; or
- (b) an offence punishable on summary conviction and is liable to imprisonment for a term of not more than 18 months or, if the complainant is under the age of 16 years, to imprisonment for a term of not more than two years less a day and to a minimum punishment of imprisonment for a term of six months.

Assault

265 (1) A person commits an assault when

- (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;
- (b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe on reasonable grounds that he has, present ability to effect his purpose; or
- (c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs.

Application

(2) This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault.

Consent

(3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of

- (a) the application of force to the complainant or to a person other than the complainant;
- (b) threats or fear of the application of force to the complainant or to a person other than the complainant;
- (c) fraud; or
- (d) the exercise of authority.

Accused's belief as to consent

(4) Where an accused alleges that he believed that the complainant consented to the conduct that is the subject-matter of the charge, a judge, if satisfied that there is sufficient evidence and that, if believed by the jury, the evidence would constitute a defence, shall instruct the jury, when reviewing all the evidence relating to the determination of the honesty of the accused's belief, to consider the presence or absence of reasonable grounds for that belief.

Meaning of consent

273.1 (1) Subject to subsection (2) and subsection 265(3), consent means, for the purposes of sections 271, 272 and 273, the voluntary agreement of the complainant to engage in the sexual activity in question.

Consent

(1.1) Consent must be present at the time the sexual activity in question takes place.

Question of law

(1.2) The question of whether no consent is obtained under subsection 265(3) or subsection (2) or (3) is a question of law.

No consent obtained

(2) For the purpose of subsection (1), no consent is obtained if

- (a) the agreement is expressed by the words or conduct of a person other than the complainant;
 - (a.1) the complainant is unconscious;
- (b) the complainant is incapable of consenting to the activity for any reason other than the one referred to in paragraph (a.1);
- (c) the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority;
- (d) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or
- (e) the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity.

Subsection (2) not limiting

(3) Nothing in subsection (2) shall be construed as limiting the circumstances in which no consent is obtained.

Where belief in consent not a defence

273.2 It is not a defence to a charge under section 271, 272 or 273 that the accused believed that the complainant consented to the activity that forms the subject-matter of the charge, where



- (a) the accused's belief arose from
 - (i) the accused's self-induced intoxication,
 - (ii) the accused's recklessness or wilful blindness, or
 - (iii) any circumstance referred to in subsection 265(3) or 273.1(2) or (3) in which no consent is obtained;
- (b) the accused did not take reasonable steps, in the circumstances known to the accused at the time, to ascertain that the complainant was consenting; or
- (c) there is no evidence that the complainant's voluntary agreement to the activity was affirmatively expressed by words or actively expressed by conduct.

Immigration and Refugee Protection Act

[Immigration and Refugee Protection Act \(2001\)](#) contains a provision prohibiting the trafficking of persons into Canada. This applies to circumstances of cross-border trafficking.

Offence — trafficking in persons

118 (1) No person shall knowingly organize the coming into Canada of one or more persons by means of abduction, fraud, deception or use or threat of force or coercion.

Definition of organize

(2) For the purpose of subsection (1), organize, with respect to persons, includes their recruitment or transportation and, after their entry into Canada, the receipt or harbouring of those persons.

Child, Youth and Family Services Act

[Child, Youth and Family Services Act \(2017\)](#) governs child welfare matters in the province of Ontario. The paramount purpose of the Act is to promote the best interests, protection, and well-being of children. CST for the purposes of sexual exploitation is recognized as grounds for a child to be deemed in need of protection.

Child sex trafficking

74 (1.1) A child is subjected to child sex trafficking for the purposes of this Part where another person does any of the following for the purposes of sexually exploiting the child:

1. Recruits, transports, transfers, receives, holds, conceals or harbours the child.
2. Exercises control, direction or influence over the movements of the child.

Child in need of protection

74 (2) A child is in need of protection where,

(c) the child has been sexually abused or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual abuse or sexual exploitation and fails to protect the child;

(d) there is a risk that the child is likely to be sexually abused or sexually exploited as described in clause (c);

(d.1) the child has been sexually exploited as a result of being subjected to child sex trafficking;

(d.2) there is a risk that the child is likely to be sexually exploited as a result of being subjected to child sex trafficking;



Removal to offer services, children 16 or 17

77.1 (1) A child protection worker or a peace officer may bring a child who is 16 or 17 to another location for up to 12 hours for the purpose of offering services and supports to the child, including the possibility of entering into an agreement under section 77, if the child protection worker or the peace officer has reasonable and probable grounds to believe that the child is in need of protection within the meaning of clause 74 (2) (d.1) and that,

(a) the child has suffered physical harm inflicted by a person involved in subjecting the child to child sex trafficking or received threats of physical harm by such a person;

(b) the child is dependent on alcohol or controlled substances as defined in the Controlled Drugs and Substances Act (Canada) or is being provided with alcohol or such controlled substances by another person in order to facilitate the sexual exploitation of the child;

(c) the child has a disorder of emotional processes, thought or cognition, a developmental disability or a brain injury and the disorder, disability or injury significantly impairs the child's capacity to make reasoned judgements regarding the circumstances surrounding their sexual exploitation;

(d) the child does not have access to housing other than as provided by a person involved in subjecting the child to child sex trafficking;

(e) the child's finances are being controlled by a person involved in subjecting the child to child sex trafficking or such a person is threatening to control their finances;

(f) the child's personal effects or identification documents are under the control of a person involved in subjecting the child to child sex trafficking;

(g) the child does not have Canadian citizenship and information about their immigration status is being used by another person in order to coerce the child into being sexually exploited; or

(h) the child is otherwise unable to exercise mature and independent judgement regarding the circumstances of their sexual exploitation because the child is being coerced, manipulated or unduly influenced by a person involved in subjecting the child to child sex trafficking.

Offences re interfering, etc. with child in society supervision or care

140 If a child is the subject of a temporary order for care and custody made under clause 94 (2) (b), (c) or (d) or an order for society supervision, interim society care or extended society care made under paragraph 1, 2 or 3 of subsection 101 (1) or clause 116 (1) (a) or (c), no person shall,

(a) induce or attempt to induce the child to leave the care of the person with whom the child is placed by the court or by the society, as the case may be;

(b) detain or harbour the child after the person or society referred to in clause (a) requires that the child be returned;

(c) interfere with the child or remove or attempt to remove the child from any place; or

(d) for the purpose of interfering with the child, visit or communicate with the person referred to in clause (a).

Offences re false information, obstruction, etc.

141 No person shall,

(a) knowingly give false information in an application under this Part; or

(b) obstruct, interfere with or attempt to obstruct or interfere with a child protection worker or a peace officer who is acting under section 77.1, 81, 83, 84, 85 or 86.



SECTION 2: PROTOCOL COMPONENTS

2.1. PROTOCOL PRINCIPLES AND PRACTICE MODEL

2.1.1. Decolonial, Anti-Racism, Anti-Oppression, Rights-Based Framework

Historical and contemporary systems of intersecting oppressions and inequalities create the underlying conditions for sex trafficking to exist in Canada, as reviewed in section 1.3.3 of the protocol. This community response protocol advocates for a decolonial, anti-racism, anti-oppression, rights-based approach to policies, procedures, and practices related to CST. This overarching framework guides the protocol's model of care for CST prevention, identification, assessment, and intervention with children and families from equity-deserving groups in Toronto.

Rights-based care should be at the core of CST service delivery (Muraya & Fry, 2016). Sexual exploitation and violence are a violation of children's fundamental human rights to safety, health, and protection. A rights-based approach recognizes young people's developmental vulnerabilities and centres all children as inherently worthy of rights and protections. The civil, political, economic, social, and cultural rights of children in Canada are ratified under the [United Nations Convention on the Rights of the Child \(1989\)](#). According to the Convention, all parties shall take measures to protect the child from all forms of violence, abuse, exploitation, and trafficking.

Special rights for victims of crime are codified in [Ontario Victims Bill of Rights \(1995\)](#) and [Canadian Victims Bill of Rights \(2015\)](#), both of which recognize that every victim of crime deserves to be treated with courtesy, compassion, and respect for their personal dignity. The Canadian Victims Bill of Rights sets out victims' rights to information, participation, protection, and restitution.

This protocol aligns itself with these basic rights and protections. Victims and survivors of CST should be made aware of their rights and responsibilities in their encounters with providers and systems, including [Child Welfare](#), [Youth Justice](#), and [Health Care](#).

All child victims and survivors of CST have a right to:

- Safety, security, and protection
- Be treated with dignity and respect
- Be seen, heard, and believed
- Be informed of rights and options
- Privacy and confidentiality within limits of the law
- Care that is free of bias and discrimination
- Equitable access to resources
- Fair protection and justice system responses
- Restitution, reparation, and rehabilitation
- Anti-racist, anti-oppressive, culturally-safe services
- Developmentally-appropriate, trauma-informed care
- Timely access to information and services
- Specialized legal counsel
- Assistance with navigating systems
- Participate in their own care plans when capable
- Freely express views and wishes
- Meaningful engagement in policy and program development



Source: [United Nations Convention on the Rights of the Child \(1989\)](#)

[United Nations Declaration on the Rights of Indigenous Peoples \(2007\)](#) establishes universal human rights standards and fundamental freedoms of Indigenous people. This community response protocol acknowledges and honours Indigenous people as holders of rights to culture, health, safety, and justice (as per the National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Government responses to human trafficking in Canada are inherently colonial. A decolonial approach is sensitive to the destructive legacy of settler colonialism and continued abuses of Indigenous people, while committed to working toward healing relationships and creating systems and services that are safe, respectful, and equitable. Reconciliation is an ongoing individual and collective journey requiring awareness of the past, acknowledgment of inflicted harms, atonement for the causes, and commitment to change (Truth and Reconciliation Commission of Canada, 2015).

Strategies for working toward decolonizing services:

- Support Indigenous people's right and ability to practice self-determination.
- Foster mutually respectful and trusting relationships between Indigenous and non-Indigenous organizations, service providers, and service users.
- Engage with First Nations, Métis, and Inuit communities. Support and partner with Indigenous-led organizations. Advance meaningful dialogue and collaboration with Indigenous Elders, traditional healers, and knowledge keepers. Move beyond tokenism.
- Provide education on the history of Indigenous communities, colonization, and the intersection between colonial violence and present-day sex trafficking of Indigenous women, girls, and Two-Spirit people.
- Authentically incorporate Indigenous land acknowledgments, followed by commitment to tangible actions.
- Advocate for fair and sustainable funding for Indigenous healing centres to address the individual and generational impacts of colonialism underlying sex trafficking.
- Facilitate access to culturally-grounded support for Indigenous victims and survivors of CST.
- Examine mainstream education and service models for Eurocentric, colonial influences that may cause harm. Restructure approaches to integrate traditional Indigenous teachings and healing practices (e.g., smudging, sharing circles).
- Broaden understanding of health and wellness to include connection and balance across mental, physical, emotional, and spiritual parts of self.
- Create culturally-affirming and welcoming spaces. Provide onsite access to Indigenous foods, places for healing and reflection, and natural elements for balancing effects (e.g., moving water, fresh air).
- Support Indigenous cultural events and gatherings that foster identity, connection, and belonging.
- Bring awareness to disproportionate representation of Indigenous children in child welfare and youth justice systems and support action for reform.
- Increase the number of Indigenous leaders and providers proportionate to the population served.
- Work to dismantle the structures of white supremacy and racism through advocacy and education.
- Adopt anti-oppressive principles and practices across all levels of the organization. Provide cultural safety training followed by evaluation of learning application.
- Anchor practice in [Truth and Reconciliation Commission of Canada: Calls to Action](#) and [Journey to Safe Spaces: Indigenous Anti-Human Trafficking Engagement Report \(2017 - 2018\)](#) recommendations.
- Uphold the principles of [OCAP](#) (ownership, control, access, possession) for First Nations data governance.
- Regularly renew personal and organizational commitments to practice through a decolonial lens and critically evaluate progress.



Art by Richard Shorty

Institutionalized cultural oppression is a cause of human trafficking, justifies victim-blaming, and exacerbates trauma (Bryant-Davis & Tummala-Narra, 2017). Oppression is a system of power that denies individuals of human rights and dignity, and equitable access to resources and opportunities, based on their social identities. Black, Indigenous, and people of colour, girls and women, 2SLGBTQI+ people, people living in poverty, immigrants and refugees, people with disabilities, and other marginalized groups face discrimination and exclusion across social, political, and economic dimensions. Experiences of racism, sexism, heterosexism, trans/homophobia, classism, ageism, ableism, and other oppressions intersect to shape the everyday life experiences of those at greatest risk of sex trafficking. Many victims and survivors of CST encounter discrimination and judgment in their interactions with providers and systems (Garg et al., 2020). This influences their decisions to access services and negatively affects health and safety outcomes.

"I was very stigmatized because I was this punk ass queer kid. I fell through the gaps as this angry teenager. It was hard to decipher if it was a stigma against my queerness or my anger. I literally showed every single sign and nobody did anything." (Survivor)

"In most settings asking pronouns has become common, but not so much in the human trafficking sector. I think there's a lot of assumptions that of course you're a girl or woman. It can be an uncomfortable question, especially if the person doesn't know the answer. I felt like I lost a lot of my identity after I was trafficked. Don't make assumptions about a person's gender. Give space for that conversation, but don't push. Listen and accept whatever answer they provide." (Survivor)

"I felt like an animal, like they [police] made me feel like a stereotype of Black kids, even though I know I wasn't. It made me feel like there's no hope, like race is still an issue in 2022. Just made me feel like there's honestly no hope for one day just being like everybody else. I had gotten so used to the police encounters, I don't even feel anything anymore. I have no anger to even put out, if that makes sense. I'm just so used to it." (Survivor)

Systems, organizations, and providers have a responsibility to ensure service environments are safe for everyone, regardless of cultural identity. Cultural safety is embedded in anti-oppressive practice. Informed by a systemic analysis of power, anti-oppressive practice acknowledges and challenges oppression at individual and structural levels in pursuit of social justice (Dominelli, 1998). An anti-oppressive, critical consciousness lens is fundamental to effective cross-cultural practice (Azzopardi, 2020; Azzopardi & McNeill, 2016) and necessary for anti-human trafficking work (Gerassi et al., 2022). This approach extends the focus beyond individual risk factors for CST to include strategic efforts to tackle root causes and enable self-empowerment in interpersonal and institutional realms.

In line with this protocol's ethical framework, anti-oppressive principles and practices are anti-racist, anti-sexist, gender-affirming, and disability justice-based. Anti-racism is a systematic process of actively seeking to identify, remove, and prevent racially inequitable outcomes and power imbalances that sustain inequities within institutions and systems. This is grounded in a commitment to upholding the interconnected values of equity, diversity, inclusion, impartiality, fairness, and justice.



Anti-racist, anti-oppressive, culturally-responsive principles and practices:

- Develop, implement, and evaluate equity, diversity, and inclusion strategies in organizational structures, systems, and policies (e.g., [SickKids EDI Strategy](#)). Commit to equity-based governance, power redistribution, and shared decision-making.
- Identify and challenge oppressive policies, procedures, and practices in the workplace. Create and enforce anti-oppression and anti-racism policies and codes of conduct, including mechanisms for safely and confidentially reporting violations.
- Recognize and work to transform structural and systemic injustices based on gender, race, class, age, and other social categories.
- Provide anti-racism, anti-oppression, and cultural safety training periodically. Implement frameworks for measuring cultural safety in systems of care.
- Recognize the inherent power and privilege service providers hold. Minimize power imbalances between service providers and service users through anti-oppressive practice.
- Link personal problems to broader social, political, and economic conditions. Critically analyze the connections between structural inequalities and sex trafficking.
- Centre, amplify, and learn from the voices of those most directly impacted. Engage lived experience experts in program and policy development.
- Collaborate and partner with Black- and Indigenous-led organizations and other culture-based services in meaningful, responsible, and equitable ways.
- Be an ally. Use your power and privilege to support equity-deserving group caucuses, including anti-Indigenous and anti-Black racism, 2SLGBTQI+ and gender equity, and disability justice efforts.
- Advocate for equitable and timely access to resources. Ensure spaces and services are accessible and non-discriminatory.
- Advance access and inclusion of people with disabilities through a disability justice lens.
- Provide gender-affirming care. Recognize the spectrum of gender identity. Use chosen names and correct pronouns. Use gender-inclusive language and provide access to gender-inclusive spaces (e.g., washrooms).
- Use a reproductive justice approach to advance sexual and reproductive rights and health.
- Build support networks that uphold cultural identities. Integrate culture-based and 2SLGBTQI+-affirming programming into service plans.
- Acknowledge, validate, and address system-induced and identity-based trauma and injustice, including past and present racial discrimination, stress, and trauma.
- Avoid replicating oppressive interactions. Intervene in the least intrusive and least disruptive manner possible.
- Promote self-determination, self-empowerment, and self-advocacy. Collaborate with victims and survivors in their care using a child-centred, rights-based framework. Ensure their views are heard and incorporated into decision-making processes. Use consciousness-raising as a form of empowerment.
- Work within a healing-centred, strengths-based model. Restore cultural identity as a resilience-building asset for healing.
- Be mindful of language used in the framing of people and problems. Challenge language that is stigmatizing and disempowering.
- Facilitate access to providers of choice when possible, including preferred cultural identities.
- Offer services in the preferred language when possible. Provide professional, trauma-informed interpreters if needed. Consider use of cultural mediators to facilitate understanding. Ensure there is no conflict of interest with interpreters and mediators.

- Ensure written materials are easy to understand and culturally-appropriate. Provide materials in the language of choice when possible. Do not assume literacy.
- Practice cultural humility. Approach cultural differences from a place of genuine curiosity and respect. Recognize and appreciate differences between and within cultural groups. Refrain from generalizing, stereotyping, and assuming.
- Honour and affirm each person’s intrinsic value and lived experience. Respect different worldviews, beliefs, norms, and values. Do not impose your own.
- Pursue diversity in the workplace. Recruitment and retention practices should seek staffing at levels representative of the population served.
- Create culturally-safer spaces by offering ethnically diverse foods, providing places for prayer and meditation, and displaying visual images and objects signalling inclusion (e.g., Positive Space symbol, Indigenous and Africentric artwork).
- Build an anti-racism, anti-oppression framework into research, with mechanisms to establish community engagement, accountability, and transparency.
- Uphold the principles of [OCAP](#) (ownership, control, access, possession) and [EGAP](#) (engagement, governance, access, protection) for data governance in First Nations and Black communities.
- Cultivate brave and accountable workspaces. Engage in deliberate and ongoing critical reflection on self, organization, and system. Confront biases and acknowledge mistakes as opportunities for learning.

“Being African Caribbean first generation made it difficult to access services. Most service providers are European descent. There’s too much to explain. You shouldn’t have to because it’s common sense to you, but not to other people. We’re loud and straightforward. They think it’s rude. They just don’t understand the cultural differences. That’s the most difficult part. Constantly seeing people that don’t look like you. They can’t relate. You feel lower on the hierarchy. I need stuff from you. I need guidance and support. When it’s a lot of people you can’t relate to, you don’t get the care you need.” (Survivor)

Gaining the knowledge, skills, and values required to work effectively and ethically across differences is a lifelong journey. All service providers bring their own lived experiences, values, viewpoints, and preconceptions to the helping relationship. Conscious and unconscious biases and assumptions influence how we perceive, relate to, and intervene with victims and survivors of CST. Anti-oppressive practice begins with thoughtful and honest examination of one’s own social locations, sources of power and privilege, and role in perpetuating oppression and marginalization of others. Developing self-awareness demands a continual and intentional process of critical self-reflection. Commitment to action toward improvement should follow.

Critical self-reflection questions:

- *What aspects of my identity are privileged? How do I benefit from the privileged parts of my identity?*
- *What aspects of my identity are subjugated? How am I disadvantaged by the subjugated parts of my identity?*
- *How do settler colonialism and racism affect my day-to-day life?*
- *What biases do I hold? How do I contribute to the oppression of others, intentionally or unintentionally?*
- *How do I feel when I think about child sex trafficking?*
- *How might victims of sex trafficking perceive me based on my social location?*
- *What comes to mind when I think about what a victim looks like? What comes to mind when I think about what a trafficker looks like?*



- *Where do my beliefs about sex trafficking come from? How do they affect my work?*
- *How does my lived experience shape my views of sex trafficking? How does my lived experience shape my approach to supporting victims?*
- *What happens in my mind/body when I interact with victims? How do I react when victims engage in behaviours I do not agree with?*
- *How do I react when my ideas about sex trafficking or assumptions about people different from me are challenged?*
- *How do I react when others say or do things that could be perceived as microaggressions? How do I engage in allyship?*
- *How comfortable am I talking about race? How comfortable am I talking about sex?*
- *How open am I to new or different perspectives?*
- *How does engaging in critical self-reflection make me feel? How do I react when undesirable parts of myself surface?*
- *What motivates me to do this work? What makes me feel hopeful?*
- *How do I cope with difficult feelings and experiences at work?*
- *What challenges exist for me to continue this work? What can I do to address those challenges?*
- *How committed am I to anti-oppressive practice? What is my responsibility for action? Where can I start?*

Culture-based and anti-oppressive practice resources:

- [Trafficking at the Intersections: Racism, Colonialism, Sexism, and Exploitation in Canada](#)
- [Truth and Reconciliation Commission of Canada: Calls to Action](#)
- [Journey to Safe Spaces: Indigenous Anti-Human Trafficking Engagement Report \(2017 - 2018\)](#)
- [Being Anti-Racist is Central to Trauma-Informed Care: Principles of an Anti-Racist, Trauma-Informed Organization](#)
- [Cultural Responsiveness to Racial Trauma](#)
- [Standards of Care for the Health of Transgender and Gender Diverse People, Version 8](#)
- [Tips on How to Practice 2SLGBTQI Allyship](#)
- [LGBTQ2S Toolkit](#)
- [Gender-Affirming Care is Trauma-Informed Care](#)
- [SickKids, About Kids Health, Gender and Identity Learning Hub](#)
- [Canadian Centre for Gender and Sexual Diversity](#)
- [Canadian Centre for Diversity and Inclusion](#)

Examples of cultural safety and self-assessment tools:

- [Self-Assessment of Culture in Regard to Privilege: Hot Spots, Hidden Spots, and Soft Spots](#)
- [Measuring Cultural Safety in Health Systems](#)

Refer to sections 2.8.6 and 3.2.9 of the protocol for additional cultural safety and anti-oppressive practice considerations and resources.



2.1.2. Child-Centred, Trauma-Informed Care

This community response protocol is grounded in a shared understanding of the connection between violence and trauma and the widespread implications for individuals, families, organizations, and communities. CST is an adverse experience in childhood that generally involves exposure to multiple traumas of an interpersonal, severe, and prolonged nature at a formative stage of development, overwhelming usual coping capacities. As outlined in section 1.3.7 of the protocol, trauma responses manifest in distinct ways and can negatively affect physical, mental, emotional, social, and spiritual parts of self. It can change a person's concept of self and others, sense of safety, ability to regulate emotions, and ways of relating to others. Trauma, identity, and healing are interrelated and should be understood in the context of unique life circumstances, diverse cultural backgrounds, and systemic influences such as racism.

Children can work toward overcoming their trauma history and rebuilding their lives with appropriate supports. Service provider and system responses can, however, be inadvertently re-traumatizing, interfere with recovery, and cause further harm. A trauma-informed approach can mitigate this potential. Trauma-informed care is recommended for all aspects of CST work (Barnert et al., 2017). While specific interventions should be individualized, the use of trauma-informed care should be universal. Universal application operates from the assumption that trauma is present and precautions are needed. Underscoring the connections between interpersonal and structural violence, trauma, and adverse outcomes, trauma-informed care should be violence-informed and healing-focused. A healing-focused approach moves away from the pathology of trauma, recognizes that trauma and healing occur collectively, and emphasizes holistic, strengths-based, culturally-rooted care.

Healing-focused, trauma- and violence-informed tenets should be infused throughout policies, procedures, and practices for prevention, identification, assessment, and intervention at the level of the provider, organization, and system. Professionals in every part of an organization, from administrative to executive personnel, should have an understanding of the prevalence and effects of violence and trauma, as well as the principles and practices of trauma-informed care. This can be achieved through education, training, and mentorship and should be embedded in organizational governance, standards of care, and performance measures. This requires sustained commitment from leaders and funders.

*"A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist** re-traumatization."* (Substance Abuse and Mental Health Services Administration, 2014)



Source: [Six Key Principles of a Trauma-Informed Approach](#) (Substance Abuse and Mental Health Services Administration, 2014)

“Many service providers aren’t trained in trafficking and trauma-informed care. It’s hard to get through your trauma when there’s not people there to support you and help you move on with your life. Service providers need training. They can’t just work with the same habits. When service providers don’t have good boundaries or don’t respond in a trauma-informed way, it’s not a safe space.” (Survivor)

For any organization to be truly trauma-informed, it must be anti-racist (Powell et al., 2022). A radical healing framework focuses on identity-based trauma wounds resulting from racism (Ballentine, 1999). Through this lens, an organizational culture that leans into radical healing is anchored in collectivism, critical consciousness, strength and resistance, cultural authenticity and self-knowledge, radical hope, and restorative self-care (French et al., 2020).

Healing from trauma requires safe and supportive human connection. Trauma-informed care goes hand-in-hand with child-centred, rights-based, anti-oppressive, and strengths-based care. It involves fostering mutual trust, imparting a sense of safety and security, showing respect and sensitivity to diversity, maintaining transparency, ensuring privacy and confidentiality, promoting self-determination and empowerment, offering choice and collaborative decision-making, responding sensitively to trauma reactions, and minimizing risk of re-traumatization throughout the service plan (Greenbaum & Albright, 2022). Trauma-informed principles should be demonstrated in the physical setting, language, behaviour, and interactions.

For some children, particularly those who have been, or are being, silenced and controlled by traffickers, it can be challenging to voice their own needs and make their own decisions. Many have had their personal power taken away throughout their lives. It is important for trauma-informed service providers to restore agency and not overwhelm victims and survivors with too much too soon. This can be done by taking small steps, building trust, providing options, and offering guidance when needed. Mandated child welfare system involvement, wherein some choices are removed, can emulate exploitative experiences and exacerbate trauma. Implementing measures to minimize the potential harms associated with child protection and criminal justice responses is essential.

“When you’re just re-traumatizing them in different ways, someone is at risk of stepping back into the life.” (Survivor)

“You can’t always be there, but I think one of the things that they [service providers] can do is put some flexibility into their schedule so that if a kid needs to cancel at the last minute, it’s not like the child is penalized, because they know that kids have changes in schedules and kids who’ve been traumatized may have something come up quite suddenly, with their mood or their mobility or whatever.” (Parent of Child Victim)



Trauma-informed care principles and practices:

- Provide organization-wide training in trauma-informed care. Evaluate the degree to which providers and organizations apply trauma-informed care principles and practice competencies.
- Apply trauma-informed care universally.
- Strive for equity-oriented and culturally-safe care as the foundation for trauma-informed care.
- Level power in the helping relationship. Apply anti-oppressive principles and practices.
- Acknowledge individual, collective, and generational trauma. Help clients understand their trauma. Recognize that traumatic experiences are not always understood or processed as traumas and may be minimized or denied.
- Provide a safe, comfortable, private place to talk. Minimize interruptions.
- Introduce yourself by name, explain your role, and explain the roles of each service involved in simple terms. Remember and use the child's correct name (chosen name may be different from the name on file).
- Respect privacy. Be transparent about confidentiality limits and mandatory reporting requirements before discussing sensitive topics.
- Clearly communicate client rights. Seek informed consent. Explain what you want to do using plain language and ask for permission before doing it.
- Check in for understanding. Repeat information as needed. Allow time for questions without interjections.
- Promote self-determination and self-assertion. Encourage shared decision-making and partnership in service plans. Respect views and wishes. This includes the decision to not report victimization and decline services (excluding exceptions in medical emergencies and mandatory reporting scenarios).
- Respect physical space and boundaries. Seek permission before any physical contact. Be cognizant of the physical setting. Maximize meeting room space, and offer choice in seating arrangements and proximity to exits to promote a sense of safety.
- Take time to build rapport and gain trust. Maintain a respectful and nonjudgmental attitude. Listen actively and demonstrate genuine concern and compassion.
- Communicate a sense of calm with measured voice tone, facial expressions, and body language. Keep a relaxed, open body posture and use gentle eye contact.
- Adapt communication style and pacing to the child's presentation and needs. Avoid technical or clinical language that labels or pathologizes individuals or experiences.
- Attend to emergency and basic needs first. Offer water, food, and washroom.
- Assess and address current and future safety and risk of harm. Ask if they feel safe in the moment and what is needed for them to feel safer and more comfortable.
- Meet where they are at, even if their choices do not align with your views.
- Do not impose an agenda. Take their lead and prioritize their priorities (if safe).
- Offer choice in provider gender, language, and cultural background when possible.
- Provide services with no or as few barriers as possible. Refrain from enforcing abstinence- or compliance-oriented criteria for care. Simplify intake processes. Be flexible with schedules and provide appointment reminders. Refrain from shaming for late arrivals or missed appointments.
- Minimize the number of times they have to retell their story. Minimize the number of providers directly involved when possible. Maintain continuity of care.
- Be judicious with questioning. Avoid continuous lines of intrusive questions. Only ask for information that is essential for determining next steps.

- Validate experiences, reactions, and worth. Shift the narrative from “*What’s wrong with you?*” to “*What happened to you?*”
- Recognize and validate traumatic stress responses to racism and other forms of identity-based discrimination and marginalization. Acknowledge and apologize for prior system-induced stress or trauma.
- Be aware of potential trauma triggers, including sensorial reminders. Monitor for signs of traumatic stress reactions (e.g., rapid breathing, zoning out). Check in regularly, regardless of visible signs of distress.
- Use grounding techniques and return focus to the here-and-now if they become overwhelmed. Ensure safe crisis de-escalation procedures are in place.
- Apply a holistic, healing-focused approach that is culturally-grounded. Understand how trauma affects identity development and work toward restoring individual and shared identity.
- Emphasize strengths, resilience, and empowerment. Recognize potential to survive and grow from adversity.
- Offer thanks for sharing trauma stories and honour them.
- Create opportunities for client feedback on trauma-informed services using safe and confidential procedures. Integrate feedback in meaningful ways.
- Monitor and mitigate the effects of secondary traumatic stress on providers and organizations.

A trauma-informed approach also recognizes the inevitable and pervasive impact of secondary traumatic stress and vicarious trauma on providers and organizations. A parallel process for staff health and wellness should be implemented. Refer to sections 2.10.2, 3.2.7, and 3.2.10 of the protocol for secondary traumatic stress management strategies, resources, and tools.

Trauma-informed care resources:

- [SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#)
- [The Trauma-Informed Code of Conduct: For All Professionals Working With Survivors of Human Trafficking and Slavery](#)
- [PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings](#)
- [A Trauma-Informed Guide for Working With Youth Involved in Multiple Systems](#)
- [Being Anti-Racist is Central to Trauma-Informed Care: Principles of an Anti-Racist, Trauma-Informed Organization](#)
- [Trauma- and Violence-Informed Approaches to Policy and Practice](#)
- [Trauma- and Violence-Informed Care: A Tool for Health and Social Service Organizations and Providers](#)
- [Trauma-Informed Care Implementation Resource Center](#)

Examples of trauma-informed care assessment tools:

- [Trauma-Informed Organizational Assessment \(TIOA\) Informational Packet](#)
- [Trauma-Informed Care in Youth Serving Settings: Organizational Self-Assessment](#)
- [Trauma-Informed Workplace Assessment](#)
- [Trauma-Informed Organizational Capacity \(TIC\) Scale](#)

Refer to sections 3.2.4 and 3.2.10 of the protocol for additional trauma-informed care resources and tools.



2.1.3. Physical and Psychological Safety Considerations

A universal violence- and trauma-informed approach recognizes the experience of violence and trauma and seeks to prevent re-traumatization by prioritizing physical and psychological safety and security. There may be ongoing threats to child and staff safety during the help-seeking process. Anti-human trafficking organizations should be prepared to identify and respond to potential dangers within the service setting with policies and procedures for safety and risk management. Emergency protocols should be established proactively with internal protection services and local law enforcement in the event of escalation. Implications for privacy and confidentiality should be carefully considered.

Individual threat appraisals and safety plans with risk mitigation strategies should be done for every child accessing CST services. The nature and extent of appraisals and plans will vary depending on stage of exploitation and unique circumstances. They should be continuously reviewed and reformulated as situations and risk level change.

In their quest to maintain control, traffickers or their associates may accompany victims for services, such as medical appointments, or they may wait offsite but close by. This could be used as an opportunity to control the narrative or recruit others inside or outside the building. Organizations should have a vetting process for accompanying persons to ensure safety. The true nature of the relationship may not be apparent. Traffickers may identify themselves to service providers as a family member, friend, or boyfriend. There should be a clear response plan in place should suspected traffickers or recruiters present onsite, with impact on child safety at the forefront. Specific approaches will vary case-by-case.

Service providers should explain to the accompanying person that it is standard practice to speak with clients alone. If they allow separation, assess the child's safety in private, without raising the other person's suspicions. Ask about the relationship and explore what they believe will happen if they do or do not leave with the person. If they refuse to separate, consider the potential benefits versus harms of enforcing separation. In rare circumstances, it may be safer to allow them to remain together. Factors to consider include the accompanying person's demeanour and level of aggression, the child's ability and desire to speak freely in their presence, and the consequences of losing the opportunity to provide service.

Service providers should also be mindful of potential risks to their own personal safety. While the level of threat to staff is generally low, some traffickers target those who could jeopardize profit with their child protection efforts. This should be a consideration in organizational safety and risk management plans. Extra precautions should be taken if meeting clients in public or private spaces offsite.

Strategies for risk reduction and safety planning:

- Identify current and future risks of harm. Explore clients' safety needs, security concerns, and strategies for protection from their perspective.
- Co-create individualized safety and risk management plans.
- Implement onsite security measures (e.g., secure entrances and exits, monitor premises with security cameras and personnel, develop an alert system, flag potentially violent persons).
- Document any threats of harm made against clients, their families and friends, or staff.
- Document all possible methods of contact in the event of an emergency, including primary and secondary phone numbers, email addresses, and guardian information. Regularly update preferred and alternate contact information in the file.



- Ask for the safest way to communicate. Document it in the file and ensure all team members are aware. Offer text options when possible. Avoid relaying sensitive information via text, email, or voicemail. Be aware that privacy is not guaranteed.
- Refrain from distributing written materials about CST. This may place children in a difficult position should traffickers find the materials.
- Be discreet with how provider contact information is shared. Suggest memorizing phone numbers or saving information in a phone under a pseudonym.
- Refrain from publishing exact program location with a detailed description of services.
- Be cognizant of the potential for onsite recruitment by clients seeking services or by traffickers accompanying clients to appointments. Provide separate waiting areas to limit contact.
- Screen companions before permitting access to premises. Avoid asking sensitive questions in the presence of an accompanying person. Document descriptions of accompanying persons if concerns arise.
- Consider proximity of seating to doors. Sense of safety may increase with a clear view and path to exits.
- Minimize barriers to attending appointments safely. Offer public transit passes, taxi vouchers, volunteer drivers, or staff accompaniment when possible.
- Educate about tracking applications and other risks associated with electronic devices and social media accounts. Recommend disabling location settings, deleting search histories, changing passwords, and replacing SIM cards when safety is at risk.
- Provide safety planning resources for exiting CST situations. Exit strategies include planning escape routes, carrying a bag with essential supplies (e.g., important documents and phone numbers, communication device, transit fare, medication, clothing), and contacting a trusted person or emergency service.
- Post emergency helplines in common areas, such as washrooms and waiting rooms (e.g., [Canadian Human Trafficking Hotline](#), [Kids Help Phone](#)).
- Involve security, child welfare, and police services as needed.

Refer to sections 2.8.2, 3.1.3, and 3.2.8 of the protocol for additional safety planning considerations and resources.

Trauma-informed, anti-oppressive practices promote physical and psychological safety and security. The impact of race, gender, 2SLGBTQI+ status, disability, and other marginalized identities on children's sense of safety and worth should be considered. Victims and survivors of CST are often the best source of information about their own safety. Their sense of safety and comfort can be reinforced by demonstrating genuine care and concern for their immediate needs and well-being.

Questions to enhance sense of safety and care:

- *Is it safe for you to meet and talk to me right now?*
- *What would help you feel most safe right now?*
- *What would help you feel more comfortable?*
- *Do you need something to eat or drink?*
- *When did you last sleep? Do you need to sleep?*
- *Do you need to take a shower? Do you need hygiene supplies or clean clothes?*
- *Do you need to see a doctor?*
- *Do you need the washroom before we begin?*



2.1.4. Strengths-Based, Relationship-Focused Practice

This community response protocol promotes a strengths-based, relationship-focused approach espousing compassion, empathy, and genuine interpersonal connection. Relationships have the power to heal or harm. For many children exposed to sex trafficking and other traumas, the world, people, and relationships are experienced as inherently unsafe. Developing trust and forming healthy attachments can be difficult. Fear of being hurt, left, judged, blamed, or not believed can activate strong defences. Deep distrust of, and lack of confidence in, providers and systems are common among victims and survivors. This may be a response to prior unsupportive system interactions and/or the result of conditioning by traffickers as a control tactic. Some children are told, and come to believe, that no one other than their trafficker cares about them or will keep them safe.

Given the relational consequences of CST, including traumatic bonding, stigma, shame, and distrust, it is essential to focus on building trusting relationships that are consistent, predictable, and sustained (Contreras et al., 2017). Many children come to the helping relationship with histories of ruptured relationships with caregivers and attachment insecurities. This may show up as emotional dysregulation, abrupt shifts from openness to rejection, avoidance of emotional intimacy, anxious preoccupation with the relationship, need for validation and reassurance, fear of abandonment, and boundaries being challenged. This can be taxing on the therapeutic relationship. Fostering a sense of safety and security, while maintaining healthy boundaries, are fundamental goals of the helping relationship. As a consistent and reliable source of support, service providers have an opportunity to provide a secure attachment base from which children can begin to heal. This functions as a reparative model of a healthy attachment relationship.

Relationships are a primary instrument for healing from trafficking experiences (Evans, 2020). Positive interpersonal connections can be a powerful driver of change for CST victims and survivors (O'Brien, 2018). Meaningful encounters wherein they feel seen, heard, and understood can make a significant difference in children's lives. Service providers should be intentional and persistent in their efforts to create a nurturing environment and centre the therapeutic relationship. Strategies for fostering engagement and trust overlap with the trauma-informed care approaches reviewed in section 2.1.2 of the protocol.

Strategies for engagement and building supportive relationships:

- Engage in reflective practice and gain self-awareness. Monitor transference and countertransference reactions.
- Recognize inherent power imbalances and how they impact the helping relationship. Be mindful of how power and control are exercised.
- Be authentic. Demonstrate warmth, empathy, and compassion in every encounter through body language, tone of voice, and caring words. Show and tell them that they matter and belong.
- Reinforce that their safety and well-being are your priority. Demonstrate care by attending to basic needs (e.g., offer food and water).
- Take time to foster the alliance. Build trust through consistency, genuineness, dependability, transparency, and patience.
- Be fully present and tuned in. Listen actively without judgment. Attend to verbal and nonverbal cues.
- Validate feelings, struggles, and worth. Explicitly honour diverse cultural identities, beliefs, and practices.
- Work through mistrust in an intentional, open, and respectful way.
- Take their lead while setting physical and emotional boundaries. Respect the need for space. Allow for silence.



- Be transparent about professional limitations and boundaries. Avoid making false promises and setting unrealistic goals. Set achievable goals collaboratively.
- Resist the urge to “fix” the problem. Refrain from imposing solutions. Embrace partnership.
- Be flexible with service plans. Move at their pace. Expect interruptions and adjust expectations for attendance and progress.
- Expect relationship ruptures and work to repair them. Continue support when boundaries are tested.
- Take the initiative to reach out and follow up. Always follow through with commitments.
- Show interest and develop relationships with the significant people in their life when possible.
- Be mindful to not convey blame or reinforce shame. Avoid why questions. Do not judge choices or question motivations. Do not criticize the people in their life.
- Refrain from focusing on inconsistencies and disputing facts. Gently challenge when indicated.
- Identify, mobilize, and build upon strengths. Praise and positively reinforce help-seeking, prosocial activities, and adaptive behaviour (e.g., attending appointments, making it to class).
- Instill hope and encouragement. Recognize and celebrate big and small achievements.

“Compassion and empathy go a long way. Continuing to encourage me and tell me I’m doing really well. That really helped.” (Survivor)

Anti-human trafficking efforts have traditionally been deficit-based. A strengths-based perspective shifts the focus from problems, pathologies, and needs to strengths, competencies, and resources (Saleebey, 1996). It is rooted in the assumption that individuals have the capacity to learn, grow, and change. A strengths-based approach reframes the narrative from shame and despair to hope and empowerment. This facilitates engagement, fosters trust, and builds the alliance.

Sex trafficking can alter children’s worldviews, reinforce their internalized stigma and shame, and diminish their self-esteem and self-worth. Strengths-based practice helps to restore self-concept and self-efficacy by intentionally identifying and building on strengths, such as healthy coping strategies, support systems, skills, and interests. Focusing on strengths and resources should not equate to disregarding or downplaying challenges and needs. Refer to section 2.4.1 of the protocol for strengths-based assessment strategies.

Strengths-Based Practice Application to Child Sex Trafficking	
Problem-Focused	Strengths-Focused
<ul style="list-style-type: none"> • Persons are defined by their problems, needs, and diagnoses. • Assessments and interventions are problem-focused. • Focus is on failures and mistakes. • Service providers are the experts. • Service providers set goals for the work. • Language is stigmatizing, pathologizing, and deficit-based. 	<ul style="list-style-type: none"> • Persons are unique and possess strengths, capabilities, and aspirations. • Assessments and interventions are possibility-focused. • Focus is on successes and progress. • Clients are their own experts. • Helping relationships and goal setting are collaborative. • Language is destigmatizing, empowering, and affirming.

2.1.5. Harm-Reduction Approach

Children are exposed to a number of potential harms throughout the various stages of exploitation and recovery. They may continue to engage in unsafe behaviours, such as high-risk sex practices, substance use, and running away, while simultaneously accessing services. They may be willing to accept some help but not yet ready to fully acknowledge the problem or make substantial changes. Without requiring cessation of the behaviour as a condition for care, a harm-reduction approach seeks to minimize inherent risks to health and well-being and maximize safety behaviours of young people in sexually exploitative relationships (Hickie & Hallett, 2016). Harm reduction is grounded in a commitment to human rights and public health, consistent with the guiding principles of this protocol. It centres on victim and survivor empowerment, self-determination, and acceptance. Through a harm-reduction lens, services are provided along the continuum of harm and healing in a manner that is pragmatic, nonjudgmental, equitable, accessible, and non-coercive. See [Harm Reduction International](#).

“Don’t judge and stigmatize us. Accept us where we are at.” (Survivor)

Using the stages of change model, a harm-reduction approach meets individuals where they are at, thus demonstrating unconditional acceptance and combatting stigma and shame. Affirming a person’s intrinsic value regardless of undesirable behaviour and acknowledging small behavioural shifts and incremental gains builds self-efficacy and fosters hope for healing. This paves the way for continued help-seeking and more substantial change moving forward. Applying evidence-based harm-reduction principles and practices with clients who engage in high-risk behaviours promotes safety, health, and wellness by enhancing knowledge, skills, resources, and support for reducing risk. This should be done without disregarding or enabling harmful behaviours and used in combination with other interventions that address underlying trauma, mental health, and social determinants of health. A harm-reduction approach should only be used with clients who are developmentally capable of understanding and appreciating the reasoning and ramifications of harm-reduction strategies.

A harm-reduction model does not seek to condone or prolong commercial sexual exploitation, risky sex practices, or substance use. Rather, it recognizes children’s agency and right to receive care while living in unsafe situations or engaging in harmful behaviours. This represents a departure from the traditional rescue mentality, forced removal of children, and abstinence-based approaches, which have proven to be less effective. Such tactics run the risk of increasing risk-taking behaviours and disengagement from services. There are, however, occasions where involuntary removal from dangerous situations may be necessary to prevent imminent risk of serious harm. For a review of tensions and practical uses of a harm-reduction approach in cases of commercial sexual exploitation, see [Harm Reduction Series](#).

“When they asked what was happening, I said that there were drugs involved and they were like, maybe if you weren’t using drugs then this wouldn’t happen. I felt really shameful. I just think people should care a bit more.” (Survivor)

“If I didn’t have workers that worked from a harm-reduction capacity, I don’t know where I’d be.” (Survivor)



Harm-Reduction Strategies Application to Child Sex Trafficking

Substance Use	Sex Practices
<ul style="list-style-type: none"> • Affirm the person’s inherent worth and demonstrate respect and acceptance. Use nonjudgmental language. • Educate about the harms of substance use and healthy replacement behaviours. • Teach safer substance use and overdose prevention strategies (e.g., reduce amounts, avoid mixing, refrain from using alone). • Facilitate convenient access to spaces and supplies for safer use. • Provide overdose reversal training and access to naloxone kits. • Refer for vaccinations to reduce risk of infections. • Give out healthy snacks and water. • Offer low-barrier services (e.g., flexible intake, transportation to appointments). Remove abstinence-based criteria for service. • Help to navigate services and schedule appointments. Send appointment reminders. • Refrain from shaming about substance use and relapse. Normalize relapse as part of recovery. • Continue acceptance and nonjudgment when they do not show for appointments or return from long absences. • Be consistent and reliable. Reach out and maintain contact. • Provide encouragement and strategies for reducing or abstaining from using for important events (e.g., court date). • Connect with peer support. • Foster hope. Use motivational interviewing. 	<ul style="list-style-type: none"> • Affirm the person’s inherent worth and demonstrate respect and acceptance. Use nonjudgmental language. • Educate about sexually transmitted infections, pregnancy, and contraception. • Teach safer sex practices (e.g., lubrication use, safe condom removal). • Refer for vaccinations to reduce risk of infections. • Offer testing and treatment for sexually transmitted infections and pregnancy. • Provide nonjudgmental options counselling if they become pregnant. • Help to navigate services and schedule appointments. Send appointment reminders. • Provide free access to safer sex supplies and contraception. • Give out hygiene and sanitizing products. • Discuss ways to stay safer through CST (e.g., share location with a trusted person, be aware of surroundings, write down licence plate numbers). • Teach about healthy relationships and consent using a sex-positive approach. • Refrain from shaming about sex and unsafe sex practices. • Continue acceptance and nonjudgment when they do not show for appointments or return from long absences. • Be consistent and reliable. Reach out and maintain contact. • Foster hope. Use motivational interviewing.

Refer to section 2.4.3 of the protocol for stages of change and motivational interviewing strategies.

2.2. SYSTEMS OF CARE FRAMEWORK

2.2.1. Collaboration and Coordination

This community response protocol supports a multidisciplinary approach embedded within a systems of care framework. A main premise is that effective collaboration, coordination, and communication among cross-sector anti-human trafficking organizations are key to achieving seamless service delivery, positive work experiences for staff, and better outcomes for children and their families. No single provider or program can sufficiently address the wide-ranging needs associated with CST, rendering cohesive



partnerships and service integration essential. Establishing a coordinated network of trauma-informed, interdisciplinary, interagency care is a recommended practice for anti-human trafficking work (Baldwin et al., 2017, 2023; Greenbaum & Albright, 2022; Hemmings et al., 2016; Institute of Medicine & National Research Council, 2014) and work with multisystem-involved youth (Fehrenbach et al., 2022).

Agency mandates should make collaborative practice a strategic priority to minimize fragmentation and maximize resources and collective impact. Effective communication and coordination will help to ensure gaps in service are filled, avoid duplication and unnecessary burdening of children and families with repeat assessments and interventions, and use provider time and program resources wisely. Collaborative efforts must be deliberate and meaningful, focused on a common mission, and guided by shared principles. Working together across diverse settings and disciplines can present challenges, though not insurmountable.

Types of collaborative practice:

- Multisector community response protocol development and application
- Multidisciplinary consultation, assessment, and intervention
- Multiagency case review meetings
- Joint forensic investigations
- Co-location of services
- Wraparound programming
- Joint efforts on task forces, coalitions, and committees
- Interprofessional education and training
- Multisite data collection and research

Elements of successful collaboration:

- Shared purpose and principles
- Multidisciplinary team approach
- Understanding of different roles and responsibilities
- Intentional and meaningful engagement
- Open and consistent communication
- Transparency in decision-making
- Mutual respect for varying perspectives
- Appreciation for different roles and expertise
- Recognition of roles complementing rather than competing with one another
- Trust and confidence in one another's abilities
- Reliable peer support
- Flexibility to change and adapt
- Willingness to compromise
- Commitment to sustainability
- Effective conflict resolution strategies

Obstacles to effective collaboration:

- Differences in organizational culture, priorities, and practices
- Lack of buy-in from leaders
- Ambiguous agendas
- Role and process confusion
- Insufficient time and resources
- Overstretched schedules
- History of tenuous relationships
- Territorialism
- High staff turnover
- Information-sharing without breaching confidentiality
- Gaps in communication
- Failure to acknowledge and work through differences and conflicts
- Lack of strategies to manage emotional complexity of cases
- Training and funding silos
- Lack of sustainable funding
- Changing governments and political platforms



Strategies for working through interagency and interdisciplinary conflict:

- Focus on common purpose and shared goals. Prioritize the rights and needs of victims and survivors over all else.
- Adhere to a community response protocol. Operate under a memorandum of understanding. Establish a joint code of conduct.
- Use group exercises to build alliances, cohesion, and trust. Offer networking opportunities to enhance relationships.
- Increase awareness of organizational mandates and philosophies. Ensure understanding of different roles and responsibilities. Emphasize complementary areas of expertise and interest.
- Release “ownership” over cases. Embrace collaboration.
- Set specific objectives and action plans. Clarify expectations and avenues for communication.
- Be transparent about differences in opinions and approaches. Address problems as they arise to prevent escalation. Refrain from finger-pointing and blaming.
- Provide training on interprofessional collaboration and conflict resolution strategies.
- Actively listen to one another with open minds. Maintain a calm and respectful tone. Be mindful of body language. Use humour when appropriate.
- Show a willingness to compromise and accommodate. Acknowledge limitations and mistakes.
- Be mindful of the effects of secondary traumatic stress on interpersonal conflict in teams.
- Consult leadership. Involve independent mediators. Engage lived experience experts to offer insights.
- Engage in continual critical self-reflection and personal and professional development.

Collaborative care resources:

- [Multidisciplinary Collaborative Model for Anti-Human Trafficking Task Forces: Development and Operations Roadmap](#)
- [A Trauma-Informed Guide for Working With Youth Involved in Multiple Systems](#)
- [Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings](#)
- [Improving Physical and Mental Health Care for Those at Risk of, and Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#)

2.2.2. Core Sectors and Roles

Anti-human trafficking service providers across various sectors and systems share the common goal of keeping children safe from the harms of commercial sexual exploitation and violence. Joining forces, drawing on specialized expertise, and capitalizing on pooled resources has the greatest impact on collective efforts to combat CST. To that end, this community response protocol engages organizations, networks, and authorities from the sectors and systems most directly involved in CST prevention, identification, assessment, and intervention in Toronto.



Protocol Partners

The following organizations are the main collaborators and partners on this community response protocol. Section 3.1 of the protocol provides a directory of additional anti-human trafficking services in Toronto and Greater Toronto Area.



SickKids



Lotus Health

[The Hospital for Sick Children \(SickKids\)](#), [Lotus Health](#) is a pediatric health and advocacy program for children under the age of 18 years who have experienced, or are at risk of, sex trafficking and their families. The multidisciplinary team consists of a peer support worker with lived experience, program coordinator, social worker, registered nurse, nurse practitioners, psychologists, pediatricians, and clinical researchers. Lotus Health provides a continuum of specialized medical care (health assessment and management, sexual and reproductive health care, physical and sexual assault forensic evaluation), mental health care (crisis support and safety planning, substance use screening and intervention, trauma assessment and treatment, family support), and peer support services (psychoeducation, mentorship, resource referrals, system navigation). Lotus Health uses a trauma-informed, systems of care approach in collaboration with community partners and is actively engaged in clinical consultation, capacity building, education, and research.



BOOST
CHILD & YOUTH ADVOCACY CENTRE
CENTRE D'APPUI AUX ENFANTS ET AUX ADOLESCENTS

[Boost Child and Youth Advocacy Centre \(CYAC\)](#) is a community-based organization that provides programs and services for children, youth, and families after abuse or violence has occurred. The CYAC model brings together police, child protection, medical and mental health professionals, and dedicated advocates to work under one roof to provide a coordinated response. Boost CYAC provides advocacy, therapy, and court support to victims of human trafficking and their caregivers. Boost CYAC is also involved in community consultation, prevention, and education.

Boost CYAC community partners include The Hospital for Sick Children, Children's Aid Society of Toronto, Catholic Children's Aid Society of Toronto, Native Child and Family Services of Toronto, Jewish Family and Child Service of Greater Toronto, Toronto Police Service, and Radius Child and Youth Services.



Ontario
Network
of Sexual Assault/
Domestic Violence
Treatment Centres

[Ontario Network of Sexual Assault/Domestic Violence Treatment Centres \(ONSADVTC\)](#) provides leadership, education, and research support to 37 hospital-based Sexual Assault/Domestic Violence Treatment Centres (SA/DVTCs) across Ontario. SA/DVTCs provide 24/7 trauma-informed care to all persons across the lifespan who have experienced sexual violence and/or domestic violence. Services include emergency medical and nursing care, testing and treatment for sexually transmitted infections and pregnancy, crisis intervention, safety planning, documentation of injuries, collection and storage of forensic evidence, arrangement of health care follow-up, counselling, support in reporting to the police, and referrals to community resources.



[Children's Aid Society of Toronto \(CAST\)](#), [Catholic Children's Aid Society \(CCAS\) of Toronto](#), [Jewish Family and Child Service \(JFCS\) of Greater Toronto](#), and [Native Child and Family Services of Toronto \(NCFST\)](#) are the child welfare agencies for Toronto Region. The role of Children's Aid Societies and Indigenous Child and Family Well-Being Agencies in Ontario is to promote the best interests, protection, and well-being of children through a broad range of child welfare services and supports. All four agencies have a specialized response to child sex trafficking concerns.



Under NCFST, the Bekaadendang (Being Peaceful) Team provides holistic supports to Indigenous community members of all ages who are survivors of, or at risk of, experiencing exploitation. These supports include case management, counselling, Children at Risk of Exploitation team support, education and outreach, specialized programming for survivors, and prevention- and empowerment-focused groups. Bekaadendang provides support at all NCFST hubs, including Mount Dennis, Scarborough, Malvern, and downtown Toronto. The goal of all Bekaadendang services is to support community to find peace and balance within themselves, so they can heal in ways that are the most meaningful to them.



[Toronto Police Service \(TPS\)](#), [Human Trafficking Enforcement Team \(HTET\)](#) is a subsection of the Sex Crimes Unit. Its mandate is multijurisdictional investigation, enforcement, and prosecution of human trafficking. HTET is responsible for:

- Investigations of persons where human trafficking for a sexual purpose and/or forced labour purpose is alleged or suspected.
- Apprehension and taking to a place of safety persons under the age of 16 years, where human trafficking for a sexual and/or forced labour purpose is alleged or suspected.
- Assisting with providing victim support services and management when required.
- Arrest and prosecution of offenders involved in human trafficking for a sexual purpose and/or forced labour purpose.

Children at Risk of Exploitation (CARE) Unit is a specialized team of child protection workers and police officers that work together to identify, engage, and support children who are being, or are at risk of being, sexually exploited or trafficked and their families. The role of the CARE Unit is to:

- Identify and locate children aged 12 to 17 years who are repeatedly missing and at high risk of being sexually exploited and trafficked.
- Prevent high-risk children from being sexually exploited and trafficked.
- Intervene and provide support and resources to children who are being sexually exploited and trafficked.
- Help to hold offenders accountable by providing intelligence that leads to charges against traffickers.



Ontario [Ministry of the Attorney General \(MAG\)](#), Human Trafficking Prosecution Team (HTPT) is composed of dedicated Crown prosecutors who are responsible for handling human trafficking cases, providing legal advice to police and prosecutors, and delivering education and training within the justice sector. HTPT has specialized knowledge to vigorously prosecute human trafficking cases using a trauma-informed and survivor-centred approach, with the ultimate goal of holding offenders accountable and supporting survivors. HTPT works closely with the police, Victim/Witness Assistance Program (V/WAP), and community service providers, providing support and information to victims and witnesses of crime throughout the court process.



[Victim Services Toronto \(VST\)](#) provides immediate crisis response, intervention, and prevention services to individuals, families, and communities affected by crime and sudden tragedies. Services include Human Trafficking Prevention and Intervention, Project Recover, 24/7 Victim Crisis Response Program, Trauma Dog Program, Teens Ending Abusive Relationships Program, Neighbourhood Victim Advocacy Program, and Case Management Services. VST administers emergency support through the Victim Quick Response Program (VQRP), designed to assist victims of violent crime with immediate financial assistance. VST support is not contingent on criminal justice system involvement.



[Covenant House Toronto \(CHT\)](#) serves youth who are homeless, trafficked, or at risk. CHT supports individuals who have experienced sexual exploitation or sex trafficking and/or have been engaging in sex work or survival sex. The Urban Response Model was created to address sex trafficking and sexual exploitation in three key ways:

- Prevention and early intervention: school presentations, staff training sessions, awareness campaigns, and survivor leadership.
- Direct services to survivors: trauma therapy for individuals aged 14 to 18 years and their families/supports, two unique crisis shelter beds, and two specialized housing programs. *Avdell Home* (intermediate housing, short-term stay) and *Rogers Home* (transitional housing, two-year stay) provide 24/7 care, health care services, therapeutic supports, safety planning, goal navigation, income supports, education and employment resources, court and legal supports, and mentoring and coaching.
- Learning and knowledge transfer: customized training, research and evaluation, and campaign findings.



[Breakaway Community Services](#) provides comprehensive harm-reduction services and a full range of substance use and addiction treatment services that are amenable to an individual's needs and goals. Services are offered through community-based facilities with a focus on street and community outreach.



[Strides Toronto](#) is a multiservice agency that offers a variety of programs and services for children, youth, and families. The Gender-Based Violence Program provides free support to individuals aged 12 to 29 years who are at risk of sexual exploitation or involved in the sex trade by choice, circumstance, or coercion. The program is grounded in treating trauma, client-centred approaches, and addressing human rights. The team works from a strengths-based, sex-positive, harm-reduction, and trauma-informed approach and is made up of therapists, community outreach workers, and peer navigators. Survivors are empowered to have self-worth and build healthy support systems. The program is goal-oriented and participants are encouraged to be engaged in working toward self-identified service goals. Service planning is individualized to meet participants where they are at.



[FCJ Refugee Centre](#) is a non-profit agency that offers settlement support for uprooted people navigating their new lives in Canada. FCJ serves refugees and others at risk due to their immigration status through an anti-oppressive and holistic approach. The anti-human trafficking team provides direct services to precarious-status migrants at risk, in conditions, or with lived experience of, sexual or labour exploitation. FCJ primarily offers immigration support to gain status in Canada, while working collaboratively with internal services and external organizations. Projects and services include:

- Youth Alliance Against Human Trafficking.
- Migrant Women's Counter-Human Trafficking Alliance.
- Migrant Workers Mobile Program.
- Toronto Counter-Human Trafficking Network.
- Immigration support and case management.
- Mobile clinics to support victims outside of Toronto.
- Information sessions and awareness-raising.
- Referrals for food security, health care, legal assistance, and other resources.
- Advocacy work within partnering networks.



[Native Women's Resource Centre of Toronto \(NWRCT\)](#) provides a safe and welcoming environment for Indigenous women and children in Toronto and Greater Toronto Area. NWRCT offers wraparound blanket services to address basic needs, healing from trauma, and access to ceremonies and traditional practitioners/healers. Survivors of sexual violence and human trafficking are supported through the Trauma Support Program. NWRCT aims to build confidence and capacity in the community and hosts a variety of cultural activities. Work is guided by the Seven Sacred Teachings: Wisdom, Love, Respect, Bravery, Honesty, Humility, and Truth.



[Project iRISE](#) is a survivor-led anti-human trafficking organization with a mission to empower and educate survivors of human trafficking and those at risk. Initiatives include survivor leadership programming and branding tattoo removal. Project iRISE closed operations in 2022 but continues as an online hub.



[The Canadian Centre to End Human Trafficking \(CCEHT\)](#) is a national charity dedicated to ending all types of human trafficking in Canada. Operated by CCEHT, the [Canadian Human Trafficking Hotline](#) is a confidential, multilingual service operating 24/7 to connect victims and survivors of human trafficking with support. The Hotline maintains a directory of 900+ social service agencies across Canada and provides referrals to social service supports and law enforcement (when requested or mandated by law). The Hotline can provide safety planning to callers and family members of trafficked persons; provide trauma-informed, person-centred support; and share educational/awareness resources about the issue of trafficking.



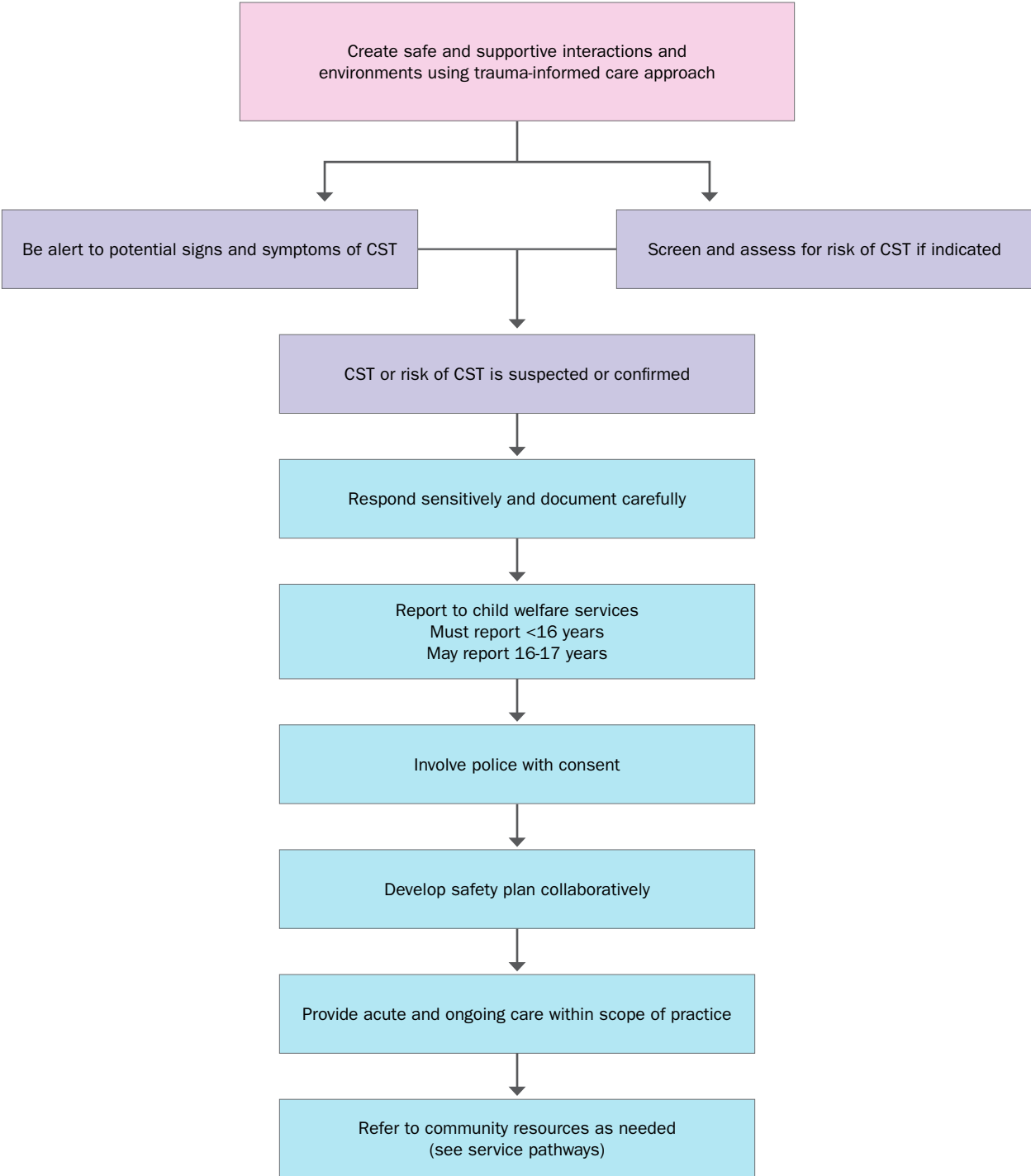
City of Toronto's [Social Development, Finance, and Administration Division](#) provides leadership and support in the areas of social inclusion, community safety, community engagement, and life skills opportunities for youth. The Division identifies and responds to community social needs, undertaking social planning and trend analysis, and developing social policy responses. This includes the City of Toronto's actions to address human trafficking.

2.2.3. Service Integration and Care Pathways

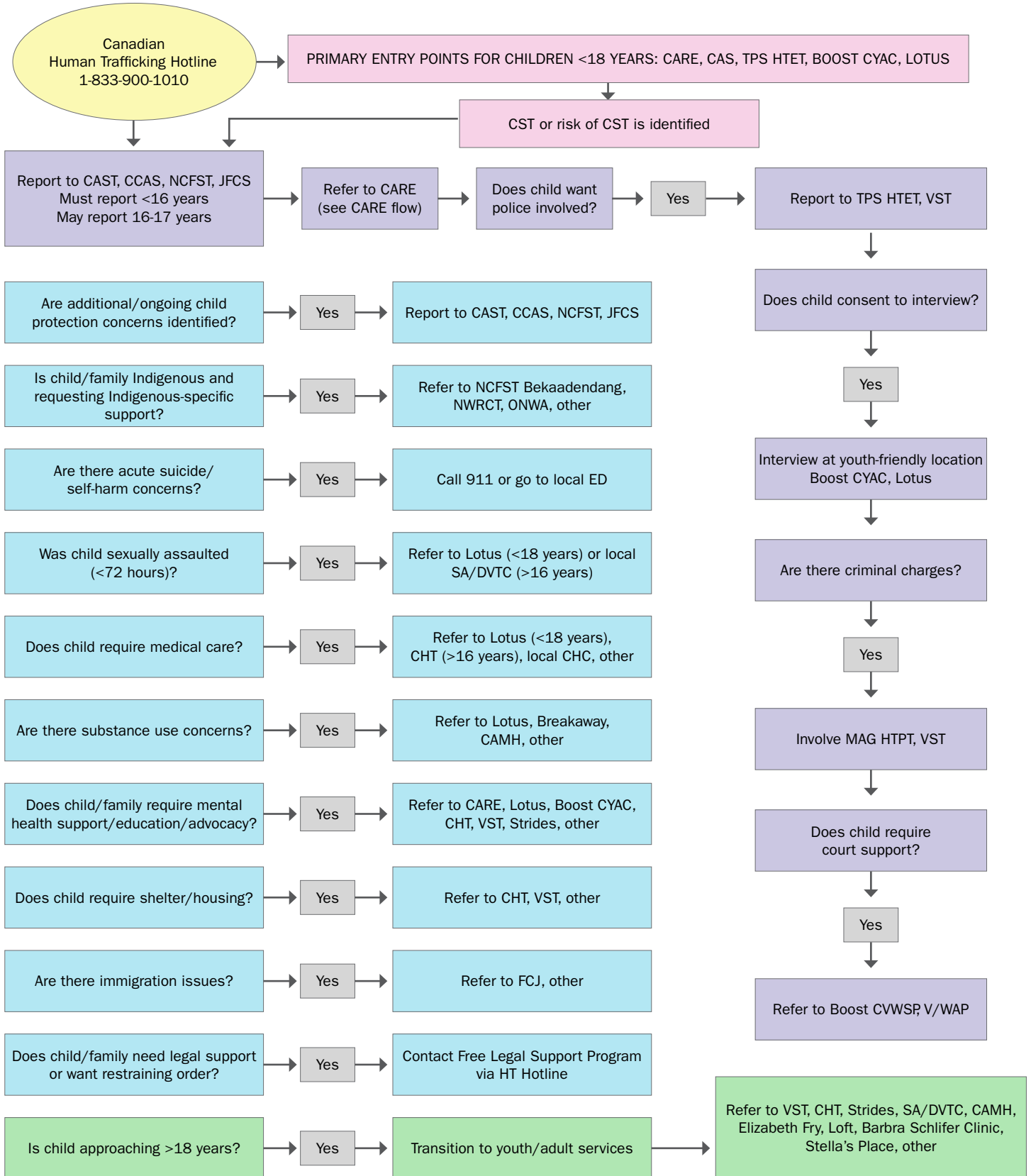
A fundamental objective of this community response protocol is to establish a collaborative and coordinated network of care for children who are at risk of, transitioning in, entrenched in, transitioning out, and stable after exiting from sex trafficking. To that end, multisector, multiagency, multidisciplinary roles and care pathways were developed. Mapping an integrated flow of service from the initial point of entry promotes seamless movement through systems and organizations. This aids providers and clients in the navigation of services, facilitates access to support, and strengthens the safety net.



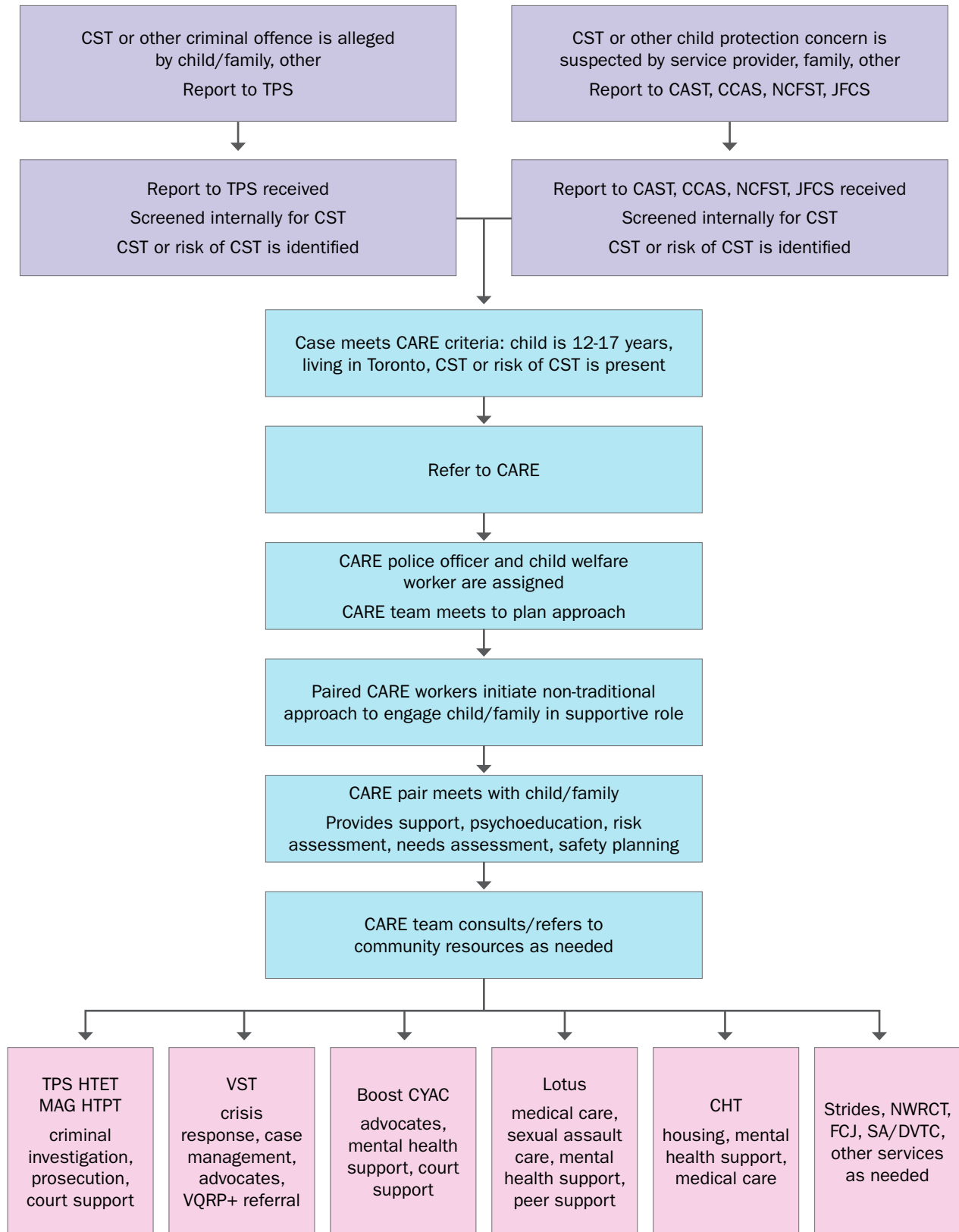
Child Sex Trafficking Risk Identification and Response Pathway



Child Sex Trafficking Service Pathways for Toronto Region



Children at Risk of Exploitation Unit Flow



Points of Entry

Children who have experienced, or are at risk of, sex trafficking may be identified anywhere by anyone, including emergency department personnel, primary care providers, teachers, helpline operators, counsellors, shelter workers, and family members, among others. Determining a centralized point of access to CST services is feasible for some communities. Given Toronto's large geographic scope, number of organizations, and case volumes, there are multiple potential entry points where children under 18 years of age first present for specialized CST services.

Primary entry points in Toronto Region:

- Children's Aid Societies and Indigenous Child and Family Well-Being Agency
- Toronto Police Service, Human Trafficking Enforcement Team
- Children at Risk of Exploitation Unit
- Boost Child and Youth Advocacy Centre
- The Hospital for Sick Children, Lotus Health

Intake and Triage

At the initial point of entry, there should be a flexible intake process to gather sufficient information from the referral source to determine next steps. This is typically completed for all new clients and those returning after an extended time away. Level of detail available at this point will vary case-by-case. Standard intake data include client demographics, brief CST/trauma history, safety concerns, symptoms, strengths, and services requested. Some organizations incorporate routine screening and assessment procedures at the intake level. Refer to sections 2.3.2, 2.4.1, and 3.2.10 of the protocol for screening and assessment components and tools.

This community response protocol promotes the principle of immediacy in the provision of care. Information obtained at intake should be used to triage referrals according to type and urgency of need. Physical and psychological safety is the highest priority. Referrals deemed urgent should be responded to on the same day. Given the nature and acuity of CST, waitlists for urgent and non-urgent care should be avoided.

Intake and triage are the launching points of an integrated service pathway. Anti-human trafficking organizations generally provide some services onsite and refer offsite for other services. Connecting children and their families with external service providers should be a collaborative, fully-informed, coordinated process of helping them move through the multisystem service flow.

Case Management and Service Navigation

Implementing multiagency, multidisciplinary service plans, while essential to a holistic response, can be complicated and confusing with the number of providers involved. Intensive case management is a recommended practice for child victims of sex trafficking (Muraya & Fry, 2016). Identifying a single provider or program to assume case flow management responsibilities can improve streamlining of services and continuity of care. Case managers (also referred to as navigators or advocates in some settings) serve as a consistent point of contact and source of support for children and their families from initial entry into the system until services are no longer required.



There are therapeutic, administrative, coordination, and advocacy functions to case management. In partnership with multidisciplinary teams and clients, case managers play a pivotal role in helping to meet basic client needs, bridge service gaps, navigate systems, liaise among providers, coordinate services, facilitate referrals, assist with warm handovers, accompany to appointments, monitor care plans, track goal attainment, and transition from child to adult systems. Advocating on behalf of, and with, clients and educating other providers are also key to the position. This requires transparency about systems limitations.

In Toronto, components of this role are assumed by Boost CYAC advocates, CARE team workers, Lotus intake nurse and peer support worker, and VST case managers, among others. At Boost CYAC, for example, the anti-human trafficking advocate provides support to children and their families from the beginning of an investigation to the conclusion of the criminal justice process. During the investigation at the CYAC, the advocate meets with children and families to orient them to the CYAC, introduces them to the investigative team, remains with them while investigative interviews take place to provide emotional support and psychoeducation, answers questions and addresses concerns related to the process, and provides information on next steps and services available. Following the investigation, the advocate remains in contact with them on a regular basis to offer support, updates, and referrals, which may include needs assessments, counselling, psychoeducation, medical services, court support, and other supports as required.

Transitioning to Adult-Centred Care

Transitions from child-centred to adult-centred systems of care should be approached thoughtfully using a trauma-informed, attachment-based framework. Age mandates for most child- and youth-serving anti-human trafficking organizations end at 18 years, with some extending to 21 years up to 29 years. Aging out of child-focused programs marks the onset of new responsibilities and uncertainties, sometimes with little or no family support and less system support available. While some young people develop precociously and take on adult responsibilities prematurely out of necessity, others experience trauma-related developmental delay or regression, making it challenging to independently manage tasks, problem solve, and make good choices. Those with neurodevelopmental disabilities may face added difficulties, requiring more intensive support.

Transitioning away from child-centred systems may be met with excitement, indifference, or anxiety. For some, it can be a scary experience, especially when trusting relationships have been formed with children's service providers over time. Sense of danger and insecurity can become heightened during this time for those with prior trauma, abandonment, and loss. Preparing for the transition can help to reduce anxiety and attachment trauma. Transition planning is an individualized, collaborative process that should begin well in advance to build independence and competencies and to ensure uninterrupted and coordinated care into adulthood.

Strategies for successful transitions to adult systems:

- Approach transitions in a trauma-informed, attachment-sensitive manner.
- Develop collaborative relationships between child-centred and adult-centred organizations and providers to promote seamless transitions.
- Involve anti-human trafficking youth-in-transition workers. This can be facilitated by local child welfare services or anti-human trafficking service providers.
- Be flexible with the timing of transitions. Consider safety, development, and capacity.



- Be proactive. Start the transition process at least six months before the child's aging-out birthday.
- Provide developmentally-appropriate information about transitioning. Be transparent about changing family and provider roles.
- Empower clients to co-create transition plans that reflect their perspectives, goals, and needs.
- Explore and validate concerns and worries. Address gaps in preparedness and confidence.
- Gradually promote independence, build self-sufficiency, and teach self-advocacy skills. Focus on strengths, resilience, and courage.
- Build a strong support system. Enhance physical and psychological safety strategies and coping skills. Emphasize the importance of continued use to support growth and development into adulthood.
- Ensure they understand and can articulate their ongoing service needs, diagnoses and medications, and adult drug benefit plans (if relevant).
- Encourage transparency with new providers. Foster confidence to openly communicate needs and views.
- Ensure timely referrals are made to adult-serving, trauma-informed organizations and providers with specialization in human trafficking. Anticipate waiting lists.
- Schedule transition visits to meet new providers. Accompany and facilitate introductions. Warm handovers are important for building trust and confidence.
- Seek informed consent to release relevant personal information to new providers. Provide a written transfer summary and pertinent reports with consent.
- Advocate for continuity of integrated trauma-informed care plans.
- Mark the transition with a graduation celebration.
- Check in occasionally post-transition. This demonstrates ongoing care and helps with feelings of abandonment.

Transition resources:

- [SickKids, About Kids Health, Transition to Adult Health Care Learning Hub](#)
- [Youth in Transition: Pathways to Independence – A Resource Guide for Youth and Workers](#)
- [Trauma-Informed Guiding Principles for Working With Transition Age Youth: Provider Fact Sheet](#)
- [Jewish Child and Family Service of Greater Toronto, The Pearl Project](#)
- [Children's Healthcare Canada, Child Health Hub in Transition to Adult Healthcare](#)

Anti-human trafficking services for youth over 18 years and adults in Toronto Region:

- [Strides Toronto](#)
- [Covenant House Toronto](#)
- [Victim Services Toronto](#)
- [Loft Community Services](#)
- [Stella's Place](#)
- [Elizabeth Fry Toronto](#)
- [Barbra Schlifer Commemorative Clinic](#)
- [Women's College Hospital, Sexual Assault/Domestic Violence Care Centre](#)
- [Scarborough Health Network, Sexual Assault/Domestic Violence Care Centre](#)

2.2.4. Informed Consent, Information-Sharing, and Record-Keeping

Experiences of coercive control, exploitation, and violence can leave young people feeling powerless. This community response protocol promotes trauma-informed, rights-based practices, procedures, and policies for consent, information-sharing, and record-keeping that recognize children's rights to self-determination, privacy, and non-coercive service delivery.

Consent

Assistance provided to victims and survivors of CST should proceed on the basis of full, voluntary, and informed consent. Exceptions include when there is imminent risk of harm or incapacity to consent. Clients should be afforded as much knowledge and control as possible in the collection, use, disclosure, and disposal of their personal information. It is the responsibility of service providers to explain programs and services in such a way that could be reasonably understood by the child, including risks and benefits of consenting to or declining intervention. Consent should be freely obtained prior to collecting personal information to provide a service (including conducting an interview, video-recording or photographing for evidentiary purposes, and assessing medical or mental health status) and prior to releasing personal information to a third-party, unless permitted or required by law.

Legislation guiding terms of consent, capacity, and disclosure of information varies by sector in Ontario. For example, these provisions are set out in the [Health Care Consent Act \(1996\)](#) and [Personal Health Information Protection Act \(2004\)](#) for health care matters and in the [Child, Youth and Family Services Act \(2017\)](#) for child welfare matters. Service providers should consult the policies and practice standards of their organizations, professional colleges, and other relevant regulatory bodies.

In health care, a person is capable of consenting if they are able to *understand* the information relevant to making a decision and *appreciate* the consequences of a decision. A person is presumed to have capacity unless there are reasonable grounds to infer incapacity. Capacity is not static and is contextual. Basis for incapacity includes a person's developmental level, cognitive or affective impairment, and influence of drugs or alcohol. When capacity concerns arise, a substitute decision-maker should be involved. Substitute decision-makers must act in the best interests of the child. When the substitute decision-maker does not provide, refuses to provide, or is unavailable or unable to provide consent to necessary treatment on the child's behalf, a referral to child welfare services may be required.

To be valid, consent must be voluntary and not coerced or unduly influenced. Consent may be express or implied. Express consent is permission for something that is given specifically, either verbally or in writing. Implied consent is a tacit understanding of permission inferred from actions and/or conduct on the part of the individual. Capacity to consent also applies to the protection of personal health information. In Ontario, the Personal Health Information Protection Act (2004) governs the manner in which personal health information may be collected, used, and disclosed within the health sector. It regulates health information custodians, as well as individuals and organizations that receive personal health information from custodians. In accordance with the Health Care Consent Act (1996), if a person has the capacity to consent to health care, they also have the exclusive right to disclose their personal health information, and that right supersedes a parent's rights whether by common law or by family court order. Children should be advised of their [Rights in a Health Care Setting](#) related to consent, capacity, and confidentiality.

Informed consent practices and procedures:

- Apply a child-centred, trauma-informed, rights-based approach to consent and capacity.
- Introduce yourself by name, role, and organization. Explain the nature and purpose of the program, service, or treatment being proposed. Provide balanced information on the risks and benefits of consenting or declining, and offer alternative choices if indicated.
- Explain the type and purpose of personal information being collected, how the information will be used, who could have access to the information, and under what circumstances.
- Advise that the helping process may involve discussing topics that are upsetting and painful to recall.
- Ensure information is provided at an appropriate developmental level of comprehension. Offer use of a professional interpreter or presence of a support person if needed.
- Assess whether they understand the information and appreciate the consequences of their decision to proceed or not proceed. Provide an opportunity to ask questions and discuss concerns.
- Take care not to coerce, pressure, or rush decisions. Decisions should be made freely.
- Obtain consent verbally and/or in writing. The expiration date of consent should be indicated. Standard consent forms should be used, signed, and dated. If verbal consent was given, document in the file that verbal consent was provided, under what circumstances, and who was present.
- Respect the right to refuse care and to withhold, place limitations on, or withdraw consent without care being impacted. Withdrawal of consent is generally not retroactive.
- Unless it is an emergency situation, do not proceed if there are capacity concerns. Consult the substitute decision-maker. Proceeding without consent is a professional and ethical violation, unless permitted or required by law.

Privacy and Confidentiality

Providing CST services generally involves discussing topics of a highly sensitive nature. Victims and survivors and their families have a right to privacy and confidentiality. Children should not be asked personal questions in the absence of privacy, unless they request to have a support person present. Personal information should only be collected and shared with others on a need-to-know basis and with consent. Service providers should be aware of the limitations to confidentiality that are required or permitted by law in Ontario, including child protection and suicide concerns. Refer to section 2.5.1 of the protocol for more on duty to report.

Limitations to confidentiality in Ontario:

- Reasonable grounds to suspect child is in need of protection
- Imminent risk of serious bodily harm to self or other (suicide or homicide)
- Harm, or risk of harm, to elderly person living in long-term care or retirement home
- Sexual abuse by regulated health professional
- Impaired driving ability
- Certain communicable diseases
- Gunshot wounds
- Disclosure ordered by court of law for legal proceedings
- Contact with substitute decision-maker when client is incapacitated
- Client requests or consents to disclosure of information

Engaging in explicit discussions with children and their families about confidentiality limits at the outset and throughout the relationship will enable them to make informed decisions about the information they choose to disclose or withhold. Clients should be advised that it is standard practice to share pertinent information in the context of multidisciplinary teams and circles of care, rather than assuming they understand implied consent. No one else within an organization should access records, unless it is required to perform their job function. Making available or releasing personal information to third parties external to the organization and circle of care requires express consent of the client or substitute decision-maker, in the absence of legal exceptions. In keeping with a trauma-informed approach, information-sharing agreements among partner agencies can limit the need for victims and survivors to retell their stories, thus reducing the potential for re-traumatization and breaches of trust.

Providing a range of communication methods, including phone, email, and text messaging, can improve ease and frequency of communication between service providers and service users. Each approach comes with potential risks and benefits. Organizational policies and consent forms should reflect the inherent risks to confidentiality associated with choosing to communicate on digital platforms with unsecured devices. This includes the possibility of traffickers accessing the devices and related risks to safety.

Documentation

Documentation is a key component of competent professional practice. Record-keeping serves several purposes, including case tracking and planning, safety and risk management, optimization and continuity of care, and professional accountability. Documentation format, level of detail, and reporting timelines should meet the requirements of ministries, organizations, and professions. Standards for the collection, usage, modification, storage, disposal, and disclosure of information in electronic and paper records are established by organizations and regulatory bodies. There should be a transparent discussion with children and their families regarding the purpose of documentation, as well as who may access their records and under what circumstances. Conversation depth will depend on developmental level and context.

Documentation may have legal ramifications in the event of mandatory reporting and criminal or family court subpoenas. Personal information may or may not be able to be redacted for legal proceedings. Disclosing sensitive information can be re-traumatizing for victims and survivors of CST. Service providers should use their professional judgment and clinical discretion when determining the relevance and extent of details recorded. The client's right to privacy and protection of personal information should be balanced with potential legal implications.

Typical cross-disciplinary record contents:

- Client demographics and emergency contact information
- In-person, virtual, phone, and text encounters with child, family, and other significant persons
- Communications with other providers
- Discussions of limits to confidentiality
- Release of information and treatment consent forms
- Safety and risk assessments and plans
- Investigation plans and reports
- Assessment and intervention notes and reports
- Medical reports, diagnoses, and medication lists



- Interview recordings and photographic evidence
- Reports to child welfare and police services
- Referrals to internal and external support services

Documentation and record release practices and procedures:

- Use a trauma-informed, rights-based approach to documentation and release of records.
- Ensure documentation is timely, legible, accurate, and complete. Language should be accessible and respectful.
- Records should contain the client’s name and identification data and be dated and signed by the provider (and supervisor when indicated). Exceptions include barrier-free services that do not require identification.
- Only information relevant to the service provided should be documented. Good professional judgment and discretion should be used when recording sensitive information.
- Use standardized documentation templates to promote consistency and reduce bias.
- Explain the purpose of record-keeping and reason for note-taking during meetings. Asking for permission to take notes in their presence conveys respect and restores a sense of control.
- Make reasonable efforts to honour privacy and confidentiality of personal trauma narratives.
- Review how personal records will be protected and limits to confidentiality. Records should only be released on a need-to-know basis and with express consent, unless court-ordered.
- Personal information should not be shared with persons whose identity has not been verified. Sensitive information should not be provided over the phone or by email.
- Clients are entitled to request access to their own records. Refrain from providing hard copies directly to the child, unless needed for a specified purpose. This may pose safety risks should traffickers obtain access to the records.
- Clients are entitled to request conditions on documentation and corrections to their personal records. Respond to requests in a timely manner.
- Careful consideration should be given to managing guardian requests to access their child’s records.
- Comply with legal, professional, and organizational standards for the collection, usage, modification, storage, disposal, and disclosure of personal information.
- Provide staff training on documentation and release of information policies and strategies for maximizing privacy and confidentiality. Implement quality assurance monitoring.



2.3. IDENTIFYING CHILDREN AT RISK

2.3.1. Indicators of Risk

Community capacity to prevent and intervene in CST is highly dependent on its ability to identify victims and potential victims through official channels. Children who have experienced, or are at risk of, sex trafficking frequently interact with health care, child welfare, law enforcement, schools, and other social service systems. Service providers often fail to detect red flags due to personal biases, discomfort, or gaps in awareness, knowledge, and skill.

Spontaneous, voluntary, and purposeful disclosures by children are atypical due to feelings of shame and stigma, fear of negative consequences, prior unsupportive experiences with systems, and lack of awareness of their exploitation or self-identification as a victim (Greenbaum, 2018). Responsibility lies with providers to accurately detect CST, often in the absence of verbal disclosure. There are physical, behavioural, psychological, and contextual indicators commonly associated with CST, many of which can be subtle or nonspecific (Fedina et al., 2019; Greenbaum et al., 2018a). Service providers should be prepared to recognize potential warning signs.



Red flags:

- Accompanied by unrelated adult
- Accompanied by aggressive or controlling companion
- Companion speaks on child's behalf
- Companion unwilling to leave child alone with provider
- Companion loitering outside, frequently calling or texting
- Presents with peers also requesting service
- Reluctant to provide information or overly protective of privacy
- Disoriented or unaware of time and place
- Unable to provide coherent history
- Signs of physical abuse (e.g., unexplained bruises, scars)
- Signs of neglect (e.g., malnourished, dental decay)
- Physically exhausted or sleep-deprived
- Under the influence of drugs or alcohol
- Flat affect or withdrawn
- Submissive, fearful, or hypervigilant
- Irritable, combative, or uncooperative
- Change in mood, behaviour, or appearance
- Signs of self-harm (e.g., cutting)
- Branding tattoos (e.g., symbols, names)
- Gang paraphernalia
- Uses language associated with sex trade (e.g., "the game," "the life")
- Significantly older "boyfriend"
- Multiple (>5) sex partners
- Sexualized behaviour
- Frequent requests for sexually transmitted infection or pregnancy tests
- Recurring sexually transmitted infections
- Previous pregnancies
- Disconnected from family and friends
- Change in peer group
- Change in social media content (e.g., new profiles, sexualized posts)
- Unexplained absences from home
- Missing for long periods of time
- Loss of interest in prosocial activities
- Works long hours
- No form of identification, fake identification, or lack of control over identification
- Unstable living arrangements
- Frequents hotels or motels
- Money or possessions inconsistent with age, income, or circumstance
- More than one cell phone
- Picked up by different cars
- Poor school attendance or not enrolled in school
- Child welfare or youth justice system involvement
- Multiple placements in care
- Fearful or distrustful of authorities
- History of coerced criminal offences
- Aggressive or violent behaviour

Awareness and detection of red flags can help to accurately identify victims and intervene early. It is important to note that this list of indicators is not a diagnostic tool. Not all children present in the same way. They may exhibit all, some, or none of these signs. The absence of indicators does not negate

the possibility of CST, and the presence of indicators does not confirm CST. Many of these indicators overlap with indicators of other forms of adversity, such as intimate partner violence, mental illness, and substance use. Overgeneralizing and stereotyping cause harm and should be avoided. The clustering of cues should prompt service providers to assess the situation further in a thoughtful way.

2.3.2. Screening and Assessing for Risk

All children are at risk of sex trafficking by virtue of age and related power imbalances. Degree of risk varies depending on unique life circumstances, personal vulnerabilities, intersecting identities, and structural inequalities. Refer to section 1.3.5 of the protocol for a review of individual, interpersonal, and environmental risk factors. Routinely screening and assessing for risk in health and social service settings can be an effective way to identify children who are being, or are at moderate or high risk of being, sex trafficked. Accurate identification of risk allows for earlier intervention and prevention. Failure to detect risk increases the likelihood that children will remain in unsafe situations, be subjected to further harm, and be denied necessary protection and support.

Risk screening and risk assessment are distinct activities. Screening involves a systematic process of brief inquiry. It can be applied universally to an entire population of service users or targeted to a subset of the population who meet predetermined criteria such as certain risk conditions. The goal of screening is to detect risk of CST and signal further assessment. The goal is not to elicit a disclosure of CST. Screening results are not diagnostic. A negative screen does not rule out the possibility of CST, and a positive screen does not confirm the presence of CST. A positive screen is a preliminary step that should prompt service providers to inquire further. Assessment involves more in-depth information gathering to gain a fuller understanding of the child's experiences, risk factors, and needs to direct safety and service planning.

Evaluating risk requires good professional judgment and integration of information from a variety of sources. This may include conversations with the child, observations of the child, administration of standardized measures, review of client records, and information from collateral sources, such as caregivers, teachers, and other providers familiar with the child. A trauma-informed approach to screening and assessment of risk is essential. Priority should be placed on fostering trust and minimizing distress. Screening and assessment should be done with the child alone for privacy and safety reasons. Before asking about sensitive topics, it is important to explain the purpose of the questions and how the information may be used. As discussed in section 2.2.4 of the protocol, limits to confidentiality should be reviewed and consent should be obtained before proceeding. This will empower children and families to share only what they feel safe and comfortable sharing. They should be cautioned that questions will be personal and potentially distressing, and support for trauma responses should be available if needed.

Screening and assessment questions should be carefully worded. It is important for language to be sensitive and accessible. Terminology should be modified according to developmental stage, literacy level, clinical presentation, and situation of the individual. Asking directly about "trafficking" or "exploitation" will generally be unhelpful, since most children will not understand or personally identify with these labels. Instead, questions should tap into risk indicators.

Several tools have been developed to screen for risk and assess level of risk for human trafficking in various settings, including health care and child welfare (Bespalova et al., 2016; Chang et al., 2015; Greenbaum et al., 2018a; Hainaut et al., 2022; Valadez et al., 2022). Systematic screening using

validated [Trafficking Screening Tools](#) increases the likelihood of accurately identifying risk and linking to necessary resources. It promotes consistency in practices among providers and across settings, and it can minimize the impact of biases that result in differential treatment based on presentation. Asking questions in a routine and nonjudgmental manner normalizes the experience, reduces shame, and encourages open and honest discussion about difficult experiences.

The reliability and validity of risk screening and assessment tools vary. Organizations should consider adopting measures that have been robustly evaluated and clinically validated with their specific population. Only qualified service providers with training in CST and trauma-informed care should be responsible for risk screening and assessment and the interpretation of outcomes. It is essential that service providers ask questions only when it is safe to do so, be prepared with an appropriate response plan, and have resources available should CST be identified.

Examples of sexual exploitation and trafficking risk screening and assessment tools:

- [Short Screen for Child Sex Trafficking \(SSCST\)](#)
- [Commercial Sexual Exploitation - Identification Tool \(CSE-IT\)](#)
- [Sexually Exploited Youth \(SEY\) Risk Assessment Tool](#)

The Short Screen for Child Sex Trafficking (SSCST) is a data-driven, brief screening tool designed to identify risk of CST among children in health care settings (Greenbaum et al., 2018a). The tool has been validated with 11- to 17-year-olds receiving care in emergency departments, teen clinics, and child advocacy centres (Greenbaum et al., 2018b; Kaltiso et al., 2018). The SSCST consists of six yes/no questions. The screen is considered positive if two or more items are endorsed.

- *Is there a previous history of drug and/or alcohol use?*
- *Has the youth ever run away from home?*
- *Has the youth ever been involved with law enforcement?*
- *Has the youth ever been knocked unconscious?*
- *Has the youth ever had a sexually transmitted infection?*
- *Does the youth have a history of sexual activity with more than five partners?*

A positive screen should prompt further assessment. Examples of secondary questions following a positive screen include the following (Kaltiso et al., 2018):

- *Has a boyfriend, a girlfriend, or anyone else ever asked you, or forced you, to do something sexual with another person (including oral sex, vaginal sex, or anal sex with someone else)? Do you feel comfortable telling me about it?*
- *Has anyone ever asked or forced you to do some sexual act in public, like dance at a bar or a strip club? Do you feel comfortable telling me about it?*
- *Sometimes kids are in a position where they really need money, drugs, food, or a place to stay. Have you ever traded sex for money, drugs, a place to stay, a cell phone, or something else? Do you feel comfortable telling me about it?*
- *Has anyone ever asked you to pose in a sexy way for a photo or a video? Do you feel comfortable telling me about it?*



The WestCoast Children's Clinic Commercial Sexual Exploitation - Identification Tool (CSE-IT) is a clinically validated information integration tool designed to identify children who have been, or are being, commercially sexually exploited (Basson, 2017). It can be used in a variety of settings with children aged 10 years and older. The CSE-IT is organized into eight key indicators, each consisting of subitems to help rate key indicators. The final CSE-IT score indicates the level of concern at the time of screening: no concern, possible concern, or clear concern. This can assist in determining next steps.

- *Housing and Caregiving: Youth experiences housing or caregiving instability for any reason.*
- *Prior Abuse and Trauma: Youth has experienced trauma (abuse or neglect, not including exploitation).*
- *Physical Health and Appearance: Youth experiences notable changes in health and appearance.*
- *Environment and Exposure: Youth's environment or activities places them at risk.*
- *Relationships and Belongings: Youth's relationships and personal belongings are not consistent with their age or circumstances, suggesting possible recruitment.*
- *Signs of Current Trauma: Youth exhibits signs that may result from exposure to any current trauma.*
- *Coercion: Youth is being controlled or coerced by another person.*
- *Exploitation: Youth exchanges sex for money or material goods, including food or shelter.*

Child welfare agencies in Toronto currently systematically screen for CST at the intake level (when a child protection report is made) using the following five questions:

- *Has the young person been missing for periods of time from school or home?*
- *Does the young person have an increase in any unexplained: money, electronics, clothing, or belongings?*
- *Are you aware of them making any concerning social media posts?*
- *Have there been any changes to their pattern of substance use?*
- *Have there been any marked changes in physical appearance, behaviour, or peer groups?*

A positive screen at the intake level prompts a referral to the Children at Risk of Exploitation Unit, where more in-depth assessment of risk is conducted using the Sexually Exploited Youth (SEY) Risk Assessment Tool. The SEY tool was designed to assess level of commercial sexual exploitation risk and has been validated with child welfare-involved children aged 11 to 17 years (Panlilio et al., 2019, 2022). The tool consists of 39 items under eight sections. It is intended to be completed based on information provided by people closest to the child. Scores are calculated across each section to determine level of risk: very low (little/no risk), low (at-risk), medium (transitioning-in), or high (entrenched).

- *Section 1: Abuse (e.g., Is there a history of sexual abuse?)*
- *Section 2: Absconding (e.g., Has the child ever run away from home/placement?)*
- *Section 3: Addiction (e.g., How often is the child using drugs/alcohol?)*
- *Section 4: Behaviours and Appearance (e.g., How often is the child attending school?)*
- *Section 5: Cognitive Ability and Mental Health (e.g., Does the child have a diagnosed or suspected disability?)*
- *Section 6: Relationships (e.g., Is the child being isolated or bullied?)*
- *Section 7: Exploitation (e.g., Has the child been acquiring unexplained items or cash?)*
- *Section 8: Self-Worth/Belonging (e.g., Does the child have low self-esteem or a lack of self-worth?)*

Refer to section 3.2.10 of the protocol for additional human trafficking screening and assessment tools.



Effectiveness of CST risk screening and assessment is contingent on the tool's sensitivity and specificity, the provider's competency, and the child's trust in the provider and openness to share. Psychometric limitations, including false negatives, should be cautiously considered. Sole reliance on screening tools to identify CST is discouraged. They are not intended to be a substitute for a more comprehensive clinical evaluation or forensic interview. It is important to leave space for victims and survivors to tell their stories in their own words and at their own pace.

2.3.3. Responding to Disclosures

For service providers who are not functioning in a forensic capacity, eliciting a disclosure of sex trafficking from the child should not be the goal. To prevent unnecessary re-traumatization, priority should be placed on assessing and addressing safety and physical and mental health needs. If a child spontaneously discloses exploitation or trafficking, regardless of your professional role, it is important to be mindful of how you respond, both verbally and nonverbally. This will greatly influence whether the child feels safe talking about their experience again and seeks help.



Do's:

- Offer a safe and private space to talk.
- Listen without interrupting. Go at the child's pace.
- Use the child's language.
- Affirm the disclosure and thank the child for telling you.
- Respond in a calm and supportive manner. Keep a relaxed body posture.
- Focus on the child's physical and psychological safety and well-being.
- Reassure the child they are not to blame and are not in trouble.
- Be transparent about mandatory reporting obligations.
- Document the disclosure verbatim and report to proper authorities if indicated.
- Explain to the child what will happen next. Offer continued support.



Don'ts:

- Appear alarmed or panicked.
- Make assumptions.
- Convey judgment or blame.
- Ask questions that imply disbelief or fault (e.g., "Are you sure?" "Why didn't you tell someone before?" "Why did you stay with him?").
- Make false reassurances or promises (e.g., "I'll keep you safe!" "This will stay between us.").
- Interrogate the child or ask for unnecessary details.
- Ask repeated or leading questions that may compromise pending legal proceedings.

2.4. ASSESSMENT AND INTERVENTION

2.4.1. Assessing Needs and Strengths

The needs of children who have been sex trafficked in the past, who are currently being trafficked, or who are at high risk of being trafficked in the future are generally similar, with some unique considerations depending on clinical profiles and life circumstances. Needs are usually complex and require multilevel assessment



and intervention. Service providers should be aware of commonly presenting safety, health, and material needs to guide assessment of children in the context of their environments. Gaining understanding of needs and strengths should occur through a process of appreciative inquiry and caring conversations.

A comprehensive individualized assessment of biopsychosocial factors, needs, and strengths will inform goal setting and service planning. A trauma-informed approach to assessment is child-centred and collaborative and requires a foundation of trust. While there are common elements to all assessments, the focus, format, and extent will depend on the provider's role and scope (e.g., health assessment by a nurse practitioner vs. safety assessment by a child protection worker). Assessments should incorporate information from the child directly, as well as perspectives of collateral sources when available. It is important to explain the type and purpose of questions being asked and to acknowledge that some questions may be distressing to answer. Only information necessary to deliver the specific service being sought should be gathered. Asking for non-essential sensitive details can intrude on the child's right to privacy and increase risk of re-traumatization.

Consideration should be given to the child's immediate, short-term, and long-term needs following commercial sexual exploitation (O'Brien et al., 2019), as well as the family's current and ongoing needs. Assessment should begin with attention to basic material needs and acute medical and mental health needs and then expand from there. The needs of children without naturally-occurring support systems are generally higher. The assessment process should be continuous, as needs tend to be uncovered gradually and fluctuate over time.

Immediate and short-term needs:

- Physical and psychological safety
- Emergency shelter
- Transportation
- Instrumental supplies (e.g., food, clothing, hygiene products, cell phone)
- Acute medical care (e.g., physical injuries, sexual assault care, safe detoxification)
- Acute mental health care (e.g., crisis intervention, suicide risk screening, trauma symptom screening, healthy coping)
- Emergent dental care
- Financial assistance
- Legal support
- Case management

Medium- and long-term needs:

- Physical and psychological safety
- Stable income
- Food security
- Transitional and permanent housing
- Primary health care
- Preventive and restorative dental care
- Ongoing substance use treatment (e.g., residential program)
- Ongoing mental health care (e.g., trauma therapy)
- Family reunification and counselling
- Legal support
- Immigration and refugee services
- Reintegration to school
- Psychoeducational assessment and support
- Job skills training and employment
- Life skills mentorship
- Cultural and community connections
- Faith- and culture-based care
- Case management

Given the disproportionately high rates of neurodevelopmental disabilities, with co-occurring mental health disorders, in children exposed to sex trafficking (Franchino-Olsen et al., 2020; Reid, 2018), comprehensive psychological assessments, including psychoeducational and psychodiagnostic assessments, may be needed. Equitable and timely access to assessments can open the door to more responsive service plans for children with disabilities.

There is a tendency for assessments to be overly focused on deficiencies and pathologies. It is important to get to know clients apart from their problems. Efforts should be made to identify child and family strengths, competencies, and resources, in keeping with the protocol's strengths-based framework presented in section 2.1.4. Children exposed to abuse and trauma sometimes struggle to identify and name their own strengths. Mutual exploration and affirmation of strengths by the service provider can help. These protective factors can then be built upon and mobilized to support the intervention plan.

Strengths:

- Formal support system (e.g., therapist)
- Informal support system (e.g., family)
- Material resources (e.g., income, housing)
- Education and employment
- Personal qualities (e.g., self-esteem, ambition, hope, adaptability, resourcefulness)
- Willingness and ability to seek help
- Healthy coping and survival skills
- Connection to culture and community
- Intersecting cultural identities
- Sources of meaning-making and purpose (e.g., religion, spirituality)
- Life skills and talents
- Hobbies and interests
- Self-expression and creativity

Questions and prompts to elicit strengths:

- *Tell me how you managed to get through this experience.*
- *What are you good at? What are most proud of?*
- *What do you enjoy doing? Tell me about your hobbies and interests.*
- *When are you happiest? What brings you joy? Tell me what makes a day good for you.*
- *Tell me about the most supportive person in your life.*
- *When do you feel most safe? With whom do you feel most safe?*
- *What are your goals, dreams, and hopes for the future?*
- *What gives your life a sense of meaning?*
- *What do you value? What qualities do you most admire in other people?*
- *How would your friends describe you? What are their favourite things about you?*

One example of an assessment tool designed specifically to assess the needs and strengths of young people who have experienced commercial sexual exploitation is the [Child and Adolescent Needs and Strengths - Commercial Sexual Exploitation \(CANS-CSE\)](#). This is a clinically validated instrument that covers a broad range of domains in which support may be required (Basson et al., 2012). Refer to section 2.8.3 of the protocol for guidance on conducting trauma-focused screening, assessment, and treatment.



2.4.2. Multisystem Service Plans

The recovery and rehabilitation process for children exposed to sex trafficking can be complex and extensive, often requiring coordinated access to a full spectrum of services and supports across multiple systems and sectors. Multidisciplinary intervention plans are informed by the assessment of needs, strengths, and stage of change. They should be trauma-informed, strengths-based, developmentally-appropriate, culturally-sensitive, and formulated in collaboration with the child (and their family if involved in a supportive capacity). Carefully tailored service plans should be centred around the child's definition of physical and psychological safety and individualized according to their current state of safety and stability, personal needs, and self-identified goals. Plans require flexibility to adapt to changing circumstances. For guidance on developing comprehensive, coordinated, trauma-informed case plans for multiple system-involved youth, see [A Trauma-Informed Guide for Working With Youth Involved in Multiple Systems](#).

Goal Setting and Attainment Scaling

Multidisciplinary intervention plans should be structured around specific goals that are realistically achievable and relevant to the child (e.g., increase safety online, return to school, form healthy relationships, improve communication with parents, develop coping skills, reduce risks to sexual health). The process for identifying goals should enable self-determination. Victims and survivors of high-control relationships may experience difficulty identifying their own goals. Service providers should collaboratively explore with the client where they currently are and where they would like to be in the future, and then help to frame this in terms of tangible short-term and long-term goals that are meaningful to them. If clients become overwhelmed, the number of goals should be limited. Prioritizing even a single goal is a good start. Goal navigation and attainment should be presented in a phased manner to feel more manageable. It is important to distinguish between goals and outcomes. Outcomes will help to delineate goal attainment.



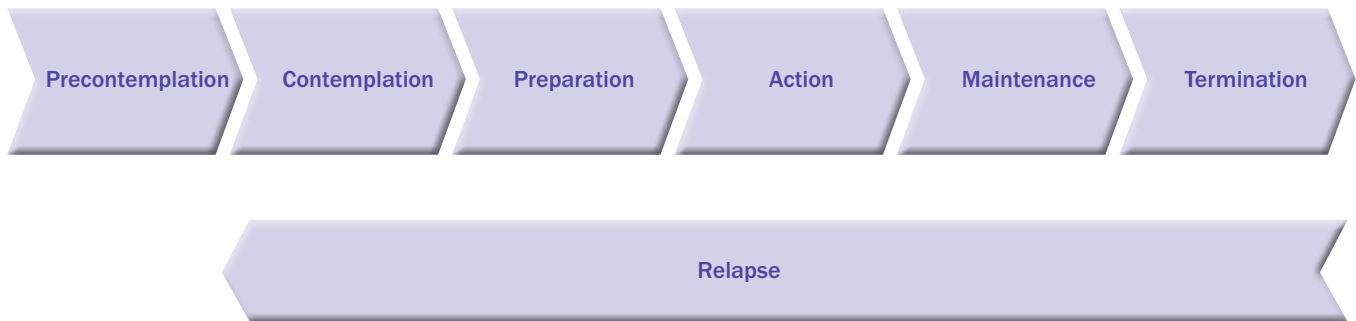
Questions to guide goal attainment:

- *How will you know when the goal is achieved?*
- *What will achieving the goal look like or feel like for you?*
- *What needs to happen for you to get there step-by-step?*
- *What might get in the way of achieving the goal?*
- *What services and resources need to be mobilized to help you get there?*

Goal attainment scaling involves working with the client to determine the range of possible outcomes, from least favourable to most favourable. This process helps to develop reasonable expectations, foster capacity to recognize incremental progress, and identify and manage challenges encountered along the way. Setting a timeline for goal attainment, with interim progress check-ins, promotes accountability. The timeline should be realistic. Obstacles to goal attainment and likelihood of regression should be anticipated and normalized. This will help to counter feelings of failure, shame, and self-doubt in the event of regression. Building confidence, instilling hope, and providing reassurance can be powerful motivators. Goals can change as life circumstances evolve, children mature, coping skills develop, and crises happen. Goals will need to be reassessed periodically. Service plans should be flexible and modified to reflect new or adjusted goals.

2.4.3. Stages of Change and Motivational Interviewing

Assessments and intervention plans should consider the child's capacity and readiness for change. Change processes can be complex and take time. Life circumstances and ways of thinking, behaving, and relating can become entrenched patterns. The stages of change model (Prochaska et al., 1992) offers a useful framework for working with children at various points in their sex trafficking experience, as they move toward safety and stability. It is grounded in the notion that change is a process, not a single event. The stages of change, adapted to CST, include precontemplation, contemplation, preparation, action, maintenance, termination, and relapse (Girls Educational and Mentoring Services, 2008). Stages of change are not linear. They tend to occur with forward and backward movement, sometimes with periods of crisis and stagnation experienced throughout.



Timelines for healing and growing are personal. Helping approaches should be tailored to the stage of change the person is at in the moment and move at their pace. There are multiple individual and environmental barriers to progressing through the stages, as reviewed in section 1.3.4 of the protocol. For those entrenched in CST, it is not uncommon to exit and return several times before reaching a place of stability. Relapse is a part of the change process. It is not an indication of failed efforts on the part of the child, family, or provider. Recognizing conditions of change that fall within and outside of personal control helps to ensure realistic expectations, overcome obstacles, reduce shame, and restore hope. Financial support, trauma-informed care, and guidance from lived experience experts have been found to be crucial for exiting successfully and preventing relapse (Howarth, 2023).



Stages of Change Application to Child Sex Trafficking

Stage	Presentation	Approach
<p>Precontemplation</p> <p>Person does not acknowledge the problem and has no intention to make changes in the near future</p>	<ul style="list-style-type: none"> • Unaware of, or in denial about, CST • Feels it is their choice • Presents as defensive • Defends and protects trafficker • May be trauma-bonded • Not ready or willing to talk about it • Places responsibility and control outside of self • Wants no or minimal intervention 	<ul style="list-style-type: none"> • Focus on engagement and developing rapport • Validate experiences, feelings, and lack of readiness • Gently raise awareness of risk • Encourage re-evaluation and self-exploration, not action • Begin to explore benefits of change • Create safety plan • Use motivational interviewing • Teach harm-reduction strategies
<p>Contemplation</p> <p>Person acknowledges the problem and is considering change but has not taken steps toward change</p>	<ul style="list-style-type: none"> • Begins to recognize CST and need for change • Often triggered by external events • Presents as ambivalent • Fearful of consequences of leaving • Somewhat open to reflecting and weighing options 	<ul style="list-style-type: none"> • Continue building trust • Be patient, listen, and validate ability to make changes • Instill hope • Normalize ambivalence • Explore pros and cons of change • Identify and mitigate barriers to change • Identify and mobilize sources of support • Set small, realistic goals
<p>Preparation</p> <p>Person acknowledges the problem, intends to make changes, and begins taking small steps toward change</p>	<ul style="list-style-type: none"> • Acknowledges CST as a problem and intends to make changes • Tests the waters of change and takes small steps (e.g., begins to distance self from trafficker) • Some ambivalence still exists • Open to receiving help • Attends appointments, sometimes inconsistently • Plans for self-sufficiency (e.g., looks into finishing school, applies for housing) 	<ul style="list-style-type: none"> • Provide encouragement • Build self-esteem and internal motivation • Identify concrete goals collaboratively • Reinforce small gains • Validate fears and ambivalence • Revisit safety plan • Address ongoing barriers to change • Strengthen support system • Assist with accessing income and housing alternatives • Introduce new experiences • Affirm and develop skills for independence • Provide case management

<p>Action</p> <p>Person is committed to making changes and takes action</p>	<ul style="list-style-type: none"> • Doing the change (e.g., leaves trafficker, moves away) • Attends appointments more consistently and engages more meaningfully • Reconnects with people from life before CST • Becomes more self-sufficient (e.g., returns to school, gets a job) 	<ul style="list-style-type: none"> • Praise efforts and progress • Set realistic expectations • Re-evaluate safety plan • Action-oriented intervention • Provide emotional support • Process feelings of loss • Develop coping strategies and promote self-care • Strengthen self-efficacy • Normalize fluctuation • Restructure environment and support system • Reiterate benefits of change • Provide case management
<p>Maintenance</p> <p>Person has made changes and changes have been sustained over time</p>	<ul style="list-style-type: none"> • New behaviours and thoughts are maintained (e.g., lack of contact with trafficker persists) • Low likelihood of returning to CST • Lives in stable environment • Develops new skills • Forms new relationships • Builds support network • Begins to process trauma • Successfully responds to triggers and resists relapse 	<ul style="list-style-type: none"> • Provide ongoing encouragement • Consolidate gains • Recognize and build on strengths and successes • Reinforce emotional regulation and coping skills • Develop relapse prevention strategies • Build life skills • Maintain support system • Engage trauma work • Plan for follow-up support
<p>Termination</p> <p>Change is permanent</p>	<ul style="list-style-type: none"> • Reaches long-term safety and stability • Confident no or very low likelihood of returning to CST 	<ul style="list-style-type: none"> • Occasional check-ins • No or minimal ongoing support required
<p>Relapse</p> <p>Changes are no longer sustained and problem returns</p>	<ul style="list-style-type: none"> • Returns to old life (e.g., reconnects with trafficker, runs away, leaves school) • May engage in recruitment and exploitation of others 	<ul style="list-style-type: none"> • Reaffirm support and instill hope • Normalize relapse • Acknowledge and address feelings of shame and failure • Reassess motivation and barriers to exiting • Evaluate triggers and strengthen coping skills • Reinforce harm-reduction strategies • Use trauma-informed responses to victim-offender intersectionality • Revisit approaches used in previous stages

Successfully exiting from CST is often marked by a trigger event. It is important to recognize and capitalize on potential turning points in the change process.



Potential turning points:

- Surviving an especially violent or scary event
- Medical or mental health crisis
- Drug overdose
- Criminal charges or convictions
- Time in custody
- Embracing religion or spirituality
- Reconnecting with family or culture
- Pregnancy or parenthood
- Younger sibling or child at risk of harm
- Missing or murdered friend
- Returning to school or finding a job
- Forming healthy relationships
- Living in safe and secure home
- Positive experience with provider or program

Forced change is rarely sustainable. It has the potential to place children in more danger. It can harm the relationship with the provider and runs the risk of pushing clients away. Rather than focusing on the rescue, service providers should meet clients where they are currently at, and help them get to where they want to be, by adjusting service plans to correspond to their stage of change. The goal should be to keep children as physically and psychologically safe as possible at every stage and develop a relationship they know they can return to without judgment when ready.

Strategies for working with clients who decline services or engage inconsistently:

- Use a trauma-informed, rights-based, strengths-based, relationship-focused approach.
- Assess readiness for change and tailor the helping approach to the stage of change.
- Meet where they are at and move at their pace.
- Respect self-determination and autonomy. Refrain from forcing, pressuring, or coercing change.
- Avoid labelling as noncompliant, uncooperative, or resistant. Do not shame or blame.
- Prioritize engagement. Demonstrate positive regard, show compassion, and foster trust.
- Gently raise awareness of risks and use harm-reduction strategies.
- Provide validation, reassurance, and hope. Acknowledge ambivalence as a step in the change process.
- Normalize relapse to reduce sense of shame and failure.
- Express concern for their safety and well-being without judging their actions and choices.
- Encourage them to return when ready. Let them know support will be available.
- Intervene without consent only when legally mandated due to imminent threat to safety.
- Apply motivational interviewing strategies to build motivation and commitment to change.

Enhancing Motivation and Commitment to Change

Motivational interviewing can assist victims and survivors of CST, and those at risk, to move through the stages of change and enhance internal motivation and commitment to changing current behaviour (Gerassi & Esbensen, 2021; Knott et al., 2021). It can be applied to increase motivation to reduce CST risk factors, exit CST situations, utilize safer substance use and sex practices, engage in treatment, promote treatment adherence, and prevent relapse.

Motivational interviewing is an evidence-supported, client-centred technique used to foster behavioural change by working through ambivalence and reinforcing change talk (Cushing et al., 2014; Miller & Rollnick, 2013). Motivational interviewing is a dynamic, flexible, nonjudgmental, and collaborative approach. It seeks



to increase insight and resolve ambivalence in two phases corresponding to the stages of change: building motivation to change and strengthening commitment to change. There are four processes of motivational interviewing: engaging (building the relational foundation), focusing (finding a clear direction and goal), evoking (drawing out motivation and ambivalence), and planning (bridging to change).

Elements of motivational interviewing = CAPE:

- **C**ompassion
- **A**cceptance
- **P**artnership
- **E**vocation

Principles of motivational interviewing = DARES:

- **D**evelop discrepancy
- **A**void argumentation
- **R**oll with resistance
- **E**xpress empathy
- **S**upport self-efficacy

Motivation enhancing statements = OARS:

- **O**pen-ended questions
- **A**ffirmations
- **R**eflections
- **S**ummary statements

Recognizing and reinforcing positive change talk = DARN CAT:

- **D**esire to change
- **A**bility to change
- **R**eason to change
- **N**eed to change
- **C**ommitment to change
- **A**ction to change
- **T**aking steps to change

Change rulers are a practical scaling tool that supports the use of motivational interviewing by cultivating change talk and exploring motivation and commitment to change. Change rulers can be used to measure one’s readiness for change, perceived importance of change, and confidence to change.

Change Ruler

*How **ready** are you to make this change?
 How **important** is this change for you right now?
 How **confident** are you about making this change?*

0	1	2	3	4	5	6	7	8	9	10
Not at all			Somewhat or Unsure					Very		



2.5. CHILD WELFARE AND CRIMINAL JUSTICE RESPONSES

2.5.1. Protection Purview and Mandatory Reporting

This community response protocol advocates for child welfare and criminal justice system responses to CST that are rights-based, anti-oppressive, and trauma-informed. Sex trafficking is a form of child maltreatment and criminal offence; it therefore requires engagement with child protection and law enforcement services. Service providers working with CST victims and survivors should be familiar with the role of child welfare and criminal justice systems, mandatory reporting requirements, and standard investigation and prosecution processes. Most child-serving organizations have child abuse and neglect reporting policies and procedures in place. Internal guidelines should also explicitly address CST.

The majority of children who experience sex trafficking never come to the attention of child welfare or criminal justice systems. Those who do are identified in a variety of ways. Some children and families reach out for help themselves. Most are discovered involuntarily. They may be inadvertently located through interactions with police officers or child protection workers for unrelated reasons, or they may be reported by service providers, such as teachers or health care workers, who detect concern based on statements, behaviours, or other risk indicators.

Duty to Report

Every person in Canada, including those working in a professional capacity with children, has a legal duty to report suspected child maltreatment to child welfare services. In the province of Ontario, the Child, Youth and Family Services Act (CYFSA, 2017) governs child welfare matters. The paramount purpose of the Act is to promote the best interests, protection, and well-being of children. [Children's Aid Societies and Indigenous Child and Family Well-Being Agencies](#) are mandated under the CYFSA to deliver child welfare services. They are responsible for investigating reports of child abuse and neglect, intervening to protect children when necessary, supporting families, providing care and supervision to children in their care, and placing children for adoption.

In 2018, the CYFSA raised the age of protection from under 16 years to under 18 years. Duty to report suspected child abuse and neglect to a child welfare agency applies to children who are, or appear to be, under 16 years. For children aged 16 and 17 years, a report may be made, and the full range of child welfare services can be provided. Protocol partners must comply with mandatory reporting obligations.

Child sexual exploitation and sex trafficking are reportable child protection concerns in Ontario. In 2021, the CYFSA was amended to strengthen Ontario's child protection response to CST. The CYFSA sets out the protection and intervention orders available for children who have been, or are at risk of being, sexually exploited as a result of being subjected to sex trafficking. This includes the power to remove 16- and 17-year-olds from CST situations and move them to a safe place for up to 12 hours without their consent. This time is intended to be used to engage the child in safety planning and support. Refer to section 1.4.2 of the protocol for relevant sections of the legislation.

Children affected by sex trafficking often have past or present involvement with the child welfare system for reasons unrelated to the CST situation, such as abuse or neglect by a parent/caregiver, parent/caregiver capacity concerns, or parent/caregiver-child conflict. Grounds for protection in CST are generally not tied to the parent/caregiver. CST is considered a child protection concern irrespective of parent/caregiver

involvement or response. When CST concerns arise, the family should be engaged, as they may play a vital role in protection. If a parent/caregiver is involved in the CST, or if their capacity to protect their child from harm or risk of harm is compromised, there may be additional protection concerns that need to be addressed. When those subjected to CST become parents, potential safety risks to the baby are another important consideration.

Mandatory reporting of human trafficking comes with both benefits and risks (English, 2017). It is critical to be mindful of how implicit biases and stereotypes around race and poverty influence child protection reporting judgments. While there has been movement toward anti-oppressive child welfare practice in Ontario (Yee et al., 2015), child welfare systems have caused, and continue to cause, considerable harm to many Black and Indigenous children and families. In keeping with the protocol's rights-based approach, service providers should be transparent with service users about limits to confidentiality and duty to report at the outset. For some, reporting to child welfare services will be viewed as an opportunity for support. For others, it will be unwelcome and upsetting, particularly if there was prior adversarial involvement. This may negatively impact the relationship with the provider responsible for reporting. Involving the child and family as much as possible in the reporting process may help to alleviate their distress and restore some power. Offering to support them through the investigation and advocate on their behalf can help to repair the alliance.

When to report child protection concerns:

- A person *must* report when there are *reasonable grounds* to suspect a child under 16 years has been, or is at risk of being, sexually exploited as a result of being subjected to sex trafficking. Those between 16 and 17 years *may* be reported. Reasonable grounds refer to information that an average person, using normal and honest judgment, would need to decide to report. Certainty is not required.
- The child protection concern and information upon which it is based must be reported promptly and without delay.
- Even if a person knows a report has been made about a child under 16 years, further reports must be made when there are additional or ongoing reasonable grounds to suspect the child is, or may be, in need of protection.
- Concerns must be reported directly. A person must not rely on anyone else to report on their behalf.
- Reports are not considered a breach of confidentiality or privacy violation when made in good faith to protect the safety and well-being of the child and there are reasonable grounds for the suspicion.

How to report child protection concerns:

- Determine the child's full name, date of birth, primary residence, religion, and Indigenous status.
- Contact the appropriate Children's Aid Society or Indigenous Child and Family Well-Being Agency, according to jurisdiction, religion, and Indigenous status.
- Objectively report the child protection concern and information upon which it is based. Relay the strengths and needs of the child and family.

Child welfare agencies for Toronto Region:

- [Native Child and Family Services of Toronto](#)
- [Children's Aid Society of Toronto](#)
- [Catholic Children's Aid Society of Toronto](#)
- [Jewish Family and Child Service of Greater Toronto](#)



What to expect after child protection concerns are reported:

- [Ontario Child Protection Standards \(2016\)](#) and [Ontario Child Welfare Eligibility Spectrum \(2021\)](#) are applied to determine eligibility for child welfare services, degree of severity, and response time.
- If the concern meets threshold, an investigation is conducted. A joint investigation with police is protocol when there is an allegation of a criminal offence.
- If the child is deemed in need of protection, the least disruptive course of action is taken to protect the child from harm or risk of harm.
- The court system may be engaged for supervision or care applications/orders if there are ongoing threats to the child's safety or need for mandated family support.
- If a child or family feels they have been treated unfairly, complaints can be filed directly to the child welfare agency, [Child and Family Services Review Board](#), or [Ombudsman Ontario](#).

Systematic screening for CST at the intake level is recommended regardless of the reason for the child protection referral. As noted in section 2.3.2 of the protocol, child welfare agencies in Toronto routinely screen for CST at intake. Children who screen positive at intake, as well as those whose CST is suspected or identified over the course of the protection investigation or ongoing service, are referred to the Children at Risk of Exploitation Unit for specialized intervention.

CARE Approach

The Children at Risk of Exploitation (CARE) Unit follows a non-traditional approach where child protection workers and police officers work together to identify, engage, and support children who are being, or are at risk of being, sexually exploited or trafficked and their families. Their role encompasses prevention, intervention, and holding offenders accountable. Using an intensive engagement and stages of change framework, the CARE team works with high-risk children and families in a supportive capacity focusing on risk assessment, psychoeducation, safety planning, and connection to community resources.

Referrals to the CARE Unit may come from a range of sources, including child welfare agencies, police divisions, missing persons reports, and families directly. The CARE Unit provides support to all child welfare agencies in Toronto Region. They can support children province-wide and interprovincially if living in Toronto. Their work is supported by an anti-Black racism lead. CARE officers are not involved in laying criminal charges, but they do provide intelligence to the Human Trafficking Enforcement Team that can lead to criminal charges.

Police Involvement

Law enforcement is part of the broader criminal justice system. The primary role of police is to protect victims of crime and hold offenders accountable. Children who experience sex trafficking have a right to have the crimes committed against them investigated and prosecuted fairly. Reporting an offence to police is not mandatory. Consent is required for service providers to proceed with a police report on a victim's behalf, unless the child or someone else is in imminent danger. Police involvement should be discussed as an option, not an obligation. Potential benefits and harms should be carefully weighed. Reporting to police does not always lead to safety, protection, and justice. In some circumstances, it places victims at increased risk of harm by traffickers. The decision to involve police may be swayed by valid feelings of mistrust and fear of police, especially for racialized individuals. Systemic racism and unfair treatment in policing call for continued efforts to repair damage and build trust within racialized communities.



“Another problem when it comes to police, and again, so much has changed since I was younger, but there’s also an added layer of racism a lot of times, and racial bias and things like that.”
(Survivor)

A police report can be made at any time following a CST-related offence. There is no statute of limitations in Canada. A positive experience with police can be life-changing.

Potential benefits of involving police:

- Opportunity for physical protection
- Statement could result in criminal charges and prosecution
- Protection of other victims
- Sense of justice for self and others
- Gateway to connecting with support services

“The officers I met were really nice and supportive. They were there along the whole way. I didn’t even realize what grooming and trafficking was. Then I started the process on my own.” (Survivor)

“Pretty much every police officer did jack shit to help me except one. Most officers after finding me would bring me to a police station or even just drop me at a Tim Hortons. This one officer actually brought me to a place that provided support to people being trafficked. I didn’t even know I was being trafficked. There I got connected with a worker. I told her I was independent, I didn’t need help. She never let me know that she knew I was lying. She slowly explained to me how trafficking happens to people. As she started talking about the grooming process, I started realizing that fit with my experience. I’m still very grateful to the officer who connected me with her.” (Survivor)

Those considering police involvement need time to weigh their options and should not be rushed into a decision. They should be reassured that the focus of the investigation is intended to be on their experience as a victim of crime as opposed to a participant in criminal activity, that protective measures will be available if there are safety concerns, and that their immigration status will not be affected. If victims opt not to proceed with a police report or cooperate with an investigation, the decision should be respected and not compromise the impartiality of providers or availability of support.

“No one made me make a statement until I was okay to make a statement. They actually cared, not just about arresting people. They care about your well-being as well.” (Survivor)

For those who decide to report to police and provide a statement, service providers can play an important role in bridging the gap by explaining investigation procedures, facilitating introductions, and accompanying to interviews. Establishing collaborative relationships with specialized anti-human trafficking child welfare, law enforcement, and prosecution teams can help to enable a coordinated, trauma-informed approach to protection and justice.



Resources for those contemplating police involvement:

- [A Guide for Human Trafficking Survivors](#)
- [Your Choice: A Guide for Sexual Assault Survivors](#)
- [You Choose What to Do Next: A Guide for Navigating the Criminal Legal System, as a Sexual Assault Survivor](#)
- [Victim Services Toronto](#)

If victims feel they have been treated unfairly by police, a complaint can be filed with the [Office of the Independent Police Review Director](#).

2.5.2. Investigation and Interviewing

CST is grounds for child welfare and criminal justice system intervention. The investigation is an avenue to keeping children safe and holding offenders accountable. It should be conducted in a manner that is rights-based, developmentally-sensitive, trauma-informed, and forensically-sound. A forensically-sound approach requires caution in the collection, preservation, and analysis of oral, physical, and digital evidence using standardized forensic procedures. This maintains the integrity and reliability of evidence presented in legal proceedings and upholds victims' rights to protection and justice.

[Royal Canadian Mounted Police \(RCMP\)](#) investigates human trafficking offences under the Immigration and Refugee Protection Act (2001). [Ontario Provincial Police \(OPP\)](#) investigates Criminal Code of Canada (1985) offences related to child sexual exploitation and trafficking. OPP's jurisdiction is generally parts of Ontario that are not policed by municipal or First Nations police services. OPP leads a Joint Forces Human Trafficking Investigative Unit that investigates multijurisdictional human trafficking in partnership with 21 municipal and First Nations police services. This unit is called the Intelligence-Led Joint Forces Strategy (IJFS) and is charged with investigating CST that has a multijurisdictional dimension and is committed by criminal organizations (generally three or more people working together for a criminal enterprise, such as a street gang or organized crime group).

In Toronto, criminal investigations involving CST-related offences are conducted by [Toronto Police Service, Human Trafficking Enforcement Team](#). Consistent policing standards for investigations are set out in the Community Safety and Policing Act (2019) regulatory framework. In most circumstances, there is a joint or parallel investigation between law enforcement and child welfare services to assess the safety of the child's environment.

The criminal investigation involves gathering evidence to support whether a crime has been committed or not. This may include statements from the victim, accused, and third-party witnesses, as well as other corroborating evidence, such as electronic devices, financial records, photographs of injuries, and biological specimens. Collecting corroborative evidence is vital in CST cases. Investigations and charges should not hinge on a victim's statement alone given the many obstacles to disclosure. While providing a statement helps police to investigate a crime, it is optional. Victims do not have to participate in an investigative interview or answer questions. The decision to not speak to police should be respected. Victims may change their minds at a later time and will be more inclined to come forward if earlier experiences with police and other first responders were positive. The child's safety should be the paramount concern, with or without an interview and disclosure.



Forensic Interviews

Forensic interviews are a key component of child protection and criminal investigations. They are evidence in protection proceedings and prosecution of offences. The objective of the interview is to obtain complete and accurate information directly from the child about their suspected experience of, or witness to, a CST-related event in a way that is developmentally-sensitive and minimizes trauma. Talking about exploitative or violent experiences can be emotionally distressing. Victims may not be forthcoming with information when questioned. They may be reluctant to disclose, respond evasively, maintain false denials, provide inconsistent or incomplete accounts, or recant prior statements for a number of overlapping reasons (Azzopardi et al., 2019; Lavoie et al., 2019; Nogalska et al., 2021). Investigators should temper their expectations with this understanding. It is important to refrain from labelling non-disclosing victims as uncooperative, dishonest, or complicit.

Reasons for non-disclosure in forensic settings:

- Does not view self as a victim
- Does not wish to be identified or want help
- Emotional attachment and loyalty to trafficker
- Financial dependence on trafficker
- Fear of violent reprisals against self or others
- Conditioned or coached to withhold truth
- Lack of rapport, trust, or comfort with interviewer
- Distrust or animosity toward authorities or adults
- Prior negative experiences with child welfare or criminal justice systems
- Concern about legal repercussions (e.g., immigration status, child custody loss)
- Fear of incrimination
- Fear of not being believed
- Prior disclosure met with disbelief or unsupportive response
- Feelings of complicity, guilt, shame, self-blame, and embarrassment
- Societal stigma and fear of judgment and blame
- Cultural barriers to speaking up
- Sense of hopelessness or apathy
- Trauma response (e.g., dysregulation, dissociation, impaired memory)
- Fear of substance use withdrawal
- Impairment due to disability or substance use
- Language barriers and other communication limitations
- Lack of family support
- Fear of being returned to abusive environment
- Concern about being placed in care
- Limited options due to lack of income, education, employment, and housing
- Fear of re-victimization by justice system if matter goes to court

“Police were involved in my experience. I would tell them I was independent and didn’t need help. I believed my trafficker was helping me and that I needed to lie and protect him because the police would get the wrong idea.” (Survivor)

The forensic interview is an opportunity to create a safe space that reduces reluctance and facilitates comfort to talk about difficult experiences. Forensic interviewing is a specialized skill. Investigators tasked with conducting forensic interviews with children who may have been exposed to sex trafficking should have training in research-based forensic interviewing protocols, child development and trauma, and unique dynamics of CST, including the impact of coercive control and trauma bonds on disclosure. It is also important for investigators to understand [How Trauma Impacts Four Different Types of Memory](#) to inform expectations. In addition to training, opportunities for ongoing peer review and personalized feedback help to ensure adherence to best practices for forensically-defensible interviews.



There are well-established, empirically-supported child forensic interviewing protocols intended to promote the highest level of interview proficiency. A flexible, phased approach is recommended to maximize the conditions under which children are most likely to describe their experiences completely and accurately: introductory component, information-gathering component, and closure component (APSAC Taskforce, 2023). Little is currently known about the efficacy of existing protocols with children interviewed for suspicions of sex trafficking. While the general principles and phases set out in forensic interviewing protocols apply, tailoring specific techniques and questions to a CST population will provide optimal opportunity to recount experiences.

Building rapport over time, minimizing the authority role, and being authentic and nonjudgmental have been identified as important strategies in commercial sexual exploitation investigations with children (Ahern et al., 2017). The use of maximization techniques (e.g., negative incentive tactics using intimidation) and open-ended recall questions (e.g., invitations) has been associated with increased reluctance among sexual exploitation victims in police interviews, while the use of closed-ended recognition questions (e.g., yes/no, multiple-choice) has been associated with decreased reluctance (Lindholm et al., 2019; Nogalska et al., 2021). Questions eliciting feeling states do not appear to be helpful in investigative interviews with sexual exploitation victims (Edinburgh et al., 2015).

CST typically involves multiple incidents, multiple people, and multiple locations over extended periods of time. Isolating events to make a case for chargeable offences can be challenging. More than one forensic interview may be required to develop rapport and allow sufficient time to provide complete accounts of events. Caution should be taken to avoid re-traumatizing children with repeated interviews when they are not ready or able to safely tell their stories. It is crucial to not lose sight of the fact that this is a victim interview, not a suspect interrogation.

Forensic interviewing protocols:

- [Forensic Interviewing of Children: APSAC Practice Guidelines](#)
- [National Institute of Child Health and Human Development \(NICHD\) Protocol](#)
- [Ten-Step Investigative Interview Protocol](#)

Forensic interviewing principles and practices:

- Ensure interviewers have specialized knowledge and skills for conducting child forensic interviews using research-informed protocols. Provide opportunities for ongoing training, peer review, and personalized feedback on interview quality.
- Apply trauma-informed, rights-based principles throughout the interview.
- Learn as much as possible about the child before the interview, including allegation details, developmental level, language ability, mental health, family status, and cultural background.
- Conduct the interview as close to the alleged event as possible to maximize memory retrieval. Timing should also consider the child's mental state, level of alertness, and sense of safety.
- Interview in a welcoming, youth-friendly setting. Interview rooms should be quiet and free of distractions. Use a neutral location rather than a police station when possible.
- Create a relaxed and supportive environment. Be friendly, respectful, authentic, and nonjudgmental. Listen actively.
- Use a recognized, phased interview approach, allowing for flexibility to adapt to the unique needs and preferences of the child.



- Explain the interview purpose in a developmentally-sensitive way. Advise of any observers present. Obtain consent to proceed. Give permission to not answer questions and end the interview at any time.
- Respect cultural diversity and be culturally-informed. Interviews should be linguistically- and culturally-appropriate. Use the child's primary language when possible. Qualified independent interpreters should be used if needed.
- Ensure interviewers and interview rooms are equipped to accommodate persons with disabilities.
- Balance power as much as possible. Offer choices to restore a sense of control (e.g., where and when to meet, where to sit in the interview room).
- Accommodate preferred gender of the interviewer when possible to increase feelings of safety and comfort.
- Interviews should be audio/video-recorded with the child's knowledge and consent. Recording will minimize the number of times they have to retell their story. Be transparent about who will have access to the recording, including defence counsel and accused in the event of court proceedings.
- Interview the child alone. Consider exceptions for the presence of a support person or animal if needed.
- Take time to develop rapport and trust. Rapport-building techniques include demonstrating genuine interest and care, asking what would make them feel more comfortable during the interview, minimizing authority status, engaging in conversation on neutral topics, using non-contingent supportive comments and behaviours, and moving at their pace.
- Provide clear instructions and establish expectations for the interview. This promotes mutual understanding and empowerment.
- Provide reassurance that they are not in trouble with the law and their immigration status will not be affected (if applicable).
- Use simple, non-technical language. Question structure, terminology, and concepts should be tailored to the child's developmental level. Inquire about development and disabilities in advance, and assess language use and understanding throughout the interview.
- Phrase questions and prompts in a way that maximizes reliable responses. Exhaust open-ended invitations to elicit free narrative. Use cautiously-worded focused questions to elicit specific details when needed. Use option-posing questions (e.g., yes/no, multiple-choice) only when necessary to reduce reluctance and clarify information, followed by open-ended prompts anchored in the child's own words. Refrain from using leading and suggestive questions.
- Tailor questions to tap into common CST dynamics. Choose language carefully. Avoid words with which they may not identify, such as "victim," "trafficked," "exploited," and "forced."
- Be familiar with sex trade culture and language. This will increase understanding, reduce confusion, and minimize the need for clarifying questions. If unfamiliar terms are used by the child, ask for clarification.
- Allow time and space for them to tell their stories using their own words. Do not rush responses to questions. Be patient and allow for silence.
- Be prepared to recognize and respond to verbal and nonverbal trauma reactions during the interview. Offer breaks as needed. Stop the interview if there are signs of distress.
- Be realistic about how much information can be obtained in a single interview. Be sensitive about asking too much too soon. Follow the child's cues to guide interview length. Offer more than one interview if needed.
- Refrain from pressuring them to talk before it is safe. Gently explore barriers to disclosure.
- End the interview with an invitation to share something else or ask any questions they may have. Explain next steps and attend to their emotional state as the interview closes. Connect with support if needed.

Sexual exploitation-specific interview questions and prompts (Edinburgh et al., 2015):

- *Tell me what happened that very first day.*
- *Tell me about the first time that happened.*
- *How long have you been away from home?*
- *How were you found?*
- *How did it start? How did this stop?*
- *What was he like when you first met him?*
- *What does he know about you? What do you know about him?*
- *Did anyone take pictures of you?*
- *Has anyone ever offered or wanted to post an ad for you?*
- *Tell me when you realized it was something different than what you thought.*
- *Was there anything that happened to you that was physically violent?*
- *Where were you when this happened?*
- *What was the scariest thing that happened to you while you were gone?*
- *Did he ever want you to do something with his friends?*
- *What do you want to do from here?*

Youth-friendly interview spaces with recording equipment in Toronto Region:



Boost Child and Youth Advocacy Centre Interview Room



The Hospital for Sick Children, Lotus Health Interview Room

Corroborating Evidence

Rigorous police investigations involve collecting a breadth of evidence to corroborate the occurrence of a crime beyond the victim's statement. In CST investigations, this may include witness accounts, phone records, text and email exchanges, social media posts, photographs and video-recordings, purchasing receipts, business records, documentation of injuries, and collection of DNA evidence.

If there is a report of a recent sexual assault or any unwanted sexual contact, victims should be offered a sexual assault evidence kit (SAEK). SAEKs are completed by specially-trained forensic nurse examiners in a health care setting, usually within 72 hours of the assault or up to 12 days, depending on the type of contact. The purpose of a SAEK is to document, collect, and preserve forensic evidence of a sex crime. This is a voluntary medical procedure with legal ramifications. Consent from the victim is required to

complete a SAEK and release forensic evidence to the police. Refer to section 2.7.4 of the protocol for physical examination and forensic evidence collection processes in health care settings.

Criminal Charges

Criminal charges are laid at the discretion of the police, often in consultation with Crown prosecutors, when there is a belief on reasonable grounds that a crime has been committed. Given the high standard of proof required for cases to proceed to trial and conviction, charges may not be pursued due to low likelihood of conviction. The strict evidentiary standard should be explained to victims, and the rationale for the decision to not lay charges should be framed as not necessarily an indication that they were not believed. When charges are laid, investigating officers should maintain contact with victims throughout the criminal court process and ensure necessary supports are in place.

Victim-Offender Intersection

If, over the course of the investigation, victim involvement in criminal activity while being trafficked is uncovered, it should be understood in the context of their exploitation and trauma. Illicit behaviour, such as participating in drug offences or recruiting others into sex trafficking, can occur under duress or manipulation. As reviewed in section 1.3.4 of the protocol, victim engagement in recruitment is recognized as a stage of CST, form of coercive control by traffickers, and trauma survival strategy. There is potential for criminal charges and prosecution. This protocol advocates for a rehabilitative rather than retributive justice response to child victim-offender intersectionality. This requires proactive identification of victim-offenders, a trauma-informed lens, and alternative responses that take into account the impact of victimization and coercion. See [Responding to Sex Trafficking Victim-Offender Intersectionality: A Guide for Criminal Justice Stakeholders](#).

Media Releases

When a suspected trafficker is arrested and charged, a media release may be issued by the police. The decision to publicly notify media outlets factors in the potential impact of the release on the integrity of the investigation and the safety of the victim and general public. Media releases for CST-related crimes typically identify the accused by name and photo and state the nature and number of charges. In the case of young offenders, identifying information is withheld due to age protections under the [Youth Criminal Justice Act \(2022\)](#), unless there are special circumstances. Media releases will sometimes include warnings and appeals to other possible victims to come forward. The personal details of victims are not released to the media. Victims should be informed of media releases in advance.

Missing Persons Reports

Consistent runaway behaviour is predictive of CST victimization (O'Brien et al., 2017). It is not uncommon for children at risk of, or subjected to, sex trafficking to leave or go missing from their family homes, foster homes, or congregate care settings. This presents serious risks to safety and well-being. It is important for law enforcement and child welfare services to develop and implement plans to expeditiously locate children who go missing. Efforts should be made to determine the factors contributing to the child's absence, the child's experience while away, and support services that may be required upon return. The Children at Risk of Exploitation Unit, Toronto Police Service, Children's Aid Societies, and Indigenous Child and Family Well-Being Agencies have internal policies and procedures to issue and manage missing persons reports.

2.5.3. Criminal Court Processes

Specialty courts are an integral judicial system response to CST (Godoy et al., 2022). Moving through the criminal justice system can be a distressing and re-traumatizing experience for victims of sex crimes. It can also be an empowering one. Victims present at different stages of exploitation and recovery as they go through the court process. Some will have successfully exited their trafficking situation, while others will remain entrenched. Children and their families require victim-centred, trauma-informed support and information about the criminal court process before, during, and after hearings and trials. To be equipped to provide this support directly or connect victims with appropriate community resources, service providers should be familiar with the legal system and courtroom procedures, as well as victims' rights and needs.

Victim Rights

Consistent with the rights-based framework proposed in section 2.1.1 of the protocol, the rights and dignity of children who have experienced sex trafficking should be a primary consideration at every stage of the criminal justice process. The Canadian Victims Bill of Rights (2015) and Ontario Victims Bill of Rights (1995) are sets of principles that guide how victims of crime should be treated in their interactions with the legal system. Every victim of crime deserves to be treated with courtesy, compassion, and respect for their personal dignity and has a right to information, participation, protection, and restitution. Victims are entitled to privacy safeguards, including publication bans, and independent legal counsel when necessary. Victims can file a complaint with the [Office of the Federal Ombudsperson for Victims of Crime](#) when they feel their rights as victims have not been honoured.

Victim Support

A criminal matter can take months or years to progress through the justice system. This can be an arduous experience for victims who are considered witnesses to the case and may be called to testify in court. The requirements of the legal system do not always align with the needs of victims related to safety, validation, dignity, and power. It is important to ensure victims and their families are offered support throughout the process.

[Victim/Witness Assistance Program \(V/WAP\)](#) is a voluntary, court-based program that provides information and support to victims and witnesses of crime to help them better understand and participate in the criminal court process. This is a free service offered by Ontario Ministry of the Attorney General in all of Ontario's 54 court districts. In Toronto and elsewhere in the province, there are V/WAP workers who specialize in supporting human trafficking victims. V/WAP services begin when criminal charges are laid by the police and continue until the court case is over. This may include the following support:

- Provide victims with information about criminal court processes and their case, rights, and role in court.
- Help victims understand what to expect at each court date and prepare them for their appearance in court.
- Provide victims with key court updates and copies of court orders.
- Coordinate with Crown prosecutors to provide victims' input, concerns, and needs as they relate to the court case.
- Connect victims with police to discuss safety concerns and any other information they may wish to provide about the crime.
- Offer emotional support throughout the court process.
- Refer victims to community agencies, including Indigenous and other culturally-specific agencies, for additional services and supports that may be needed.

- Arrange for language interpreters and help to ensure accommodations for any disabilities are met throughout involvement with the program and while at court.
- Help victims with funding applications, victim impact statements, and statements on restitution.

[Boost Child Victim Witness Support Program \(CVWSP\)](#) provides support to children required to testify in a criminal court proceeding. Boost anti-human trafficking advocates provide support to children and their families from the beginning of the police investigation to the conclusion of the criminal justice process. This includes, but is not limited to, individual court preparation sessions geared to the child's developmental needs, accompaniment to Crown meetings, attending court as a designated support person, advocating for testimonial aids, providing affidavits and testimony in relation to testimonial aids and use of accredited facility dogs, assisting with victim impact statements, and connecting to mental health supports if ready to engage after trial.

Strategies for supporting victims through the court process:

- Ensure rights-based, developmentally-sensitive, trauma-informed support and information are provided before, during, and after court hearings and trials.
- Advise victims of their rights under the Canadian and Ontario Victims Bills of Rights and advocate for those rights to be upheld.
- Involve V/WAP or Boost CVWSP as early as possible to provide general information, practical assistance, and emotional support through the court process.
- Facilitate a meeting between the victim and Crown prosecutor from the Human Trafficking Prosecution Team early in the process, if the victim is in agreement. This is important for building trust and confidence.
- Educate investigators, lawyers, and judges about CST and the need to resist stereotypes of what an “ideal victim” looks and acts like in court.
- Educate victims about criminal court processes, courtroom procedures, and roles in court in plain terms. Explain the types of questions to expect when testifying in court. Roleplay cross-examination. Tour the courthouse in advance of trial. This can be aided with interactive online resources.
- Provide opportunities to ask questions. Discuss worries and trauma reactions. Help to develop healthy coping and self-care strategies. Connect with additional mental health support if needed.
- Advocate for testimonial aids to alleviate anxiety and mitigate trauma.
- Arrange for language interpreters and ensure accommodations for disabilities are provided if needed.
- Anticipate potential threats to safety inside and outside of the courthouse, review safety concerns with police, and work collaboratively on a safety plan. Provide court transportation, escorts, and lodgings if needed.
- Facilitate access to the [Vulnerable Victims and Family Fund](#) for financial and court-based supports to enable fuller participation in the court process.
- Facilitate access to free legal support, including assistance with restraining orders if needed.
- Provide opportunities to debrief after testifying in court. Explain the principles and deciding factors for judgments and sentencing. Validate the full range of emotional responses.
- Assist with [Victim Impact Statements and Statements on Restitution](#).
- Discuss options for notifications on changes to offender status, including parole decisions and incarceration release dates. Suggest registration with [Victim Notification Services](#).

- Continue support after child welfare and criminal justice processes end. Build a strong social support network to facilitate ongoing rehabilitation and reintegration.

Court preparation resources:

- [A Guide for Human Trafficking Survivors](#)
- [Your Choice: A Guide for Sexual Assault Survivors](#)
- [You Choose What to Do Next: A Guide for Navigating the Criminal Legal System, as a Sexual Assault Survivor](#)
- [My Court Case: An Interactive Workbook for Children and Youth Going to Court](#)
- [Courtprep.ca: A Site for Youth Preparing for Court](#)
- [Ontario Court of Justice](#)

Restraining Orders

A human trafficking restraining order is a court order signed by a judge appointed to the Ontario Court of Justice when there are reasonable grounds to believe that a person is being, or is at risk of being, trafficked and needs protection. In Ontario, under the Prevention of and Remedies for Human Trafficking Act (2017), victims of human trafficking, those at risk of being trafficked, and parents/guardians of children under 18 years of age who have been, or are at risk of being, trafficked can apply for restraining orders against current, past, or potential traffickers. Victims and parents/guardians of victims can also authorize someone to make the application on their behalf. Witnesses are not required.

A criminal court case is not required to proceed with a human trafficking restraining order. Restraining orders can limit what traffickers can do, who they can contact, and where they can go. This may include conditions such as prohibiting direct and indirect contact with the victim and returning personal belongings to the victim. Traffickers must follow the conditions set out in the order; otherwise, they may be charged and prosecuted for breaching the order. This applies only after the person has been served with the order and while they are in Ontario. Restraining orders can be in place for up to three years or longer and renewed if required. They are enforced by the police but do not guarantee safety.

[Free Legal Support Program for Victims of Human Trafficking](#) is a trauma-informed, victim-centred program with its own dedicated full-time counsel who provides free legal support for victims of human trafficking and those at risk, their families, and the people who support them. Specialized lawyers are available to provide confidential legal advice, help completing restraining order applications, and representation at application hearings in any Ontario Court of Justice. This service can be accessed through the [Canadian Human Trafficking Hotline](#) and is provided at no cost to the applicant by Ontario Ministry of the Attorney General. Referrals are not required.

Court Process and Crown Role

As reviewed in sections 2.5.1 and 2.5.2 of the protocol, the criminal justice process in Toronto typically begins with the police report and interview by the Human Trafficking Enforcement Team. They gather information about the alleged crime, decide whether there is sufficient evidence to lay criminal charges or pursue alternative measures, and forward the report to the Human Trafficking Prosecution Team (HTPT). Crowns can be consulted prior to the laying of charges to determine the likelihood of prosecution. In



Ontario, the Crown's charge screening standard is whether there is a reasonable prospect of conviction and whether the prosecution is in the public interest. When criminal charges are laid, the matter proceeds through the criminal court system. Human trafficking and other CST-related offences are tried in [Ontario Court of Justice](#) or [Superior Court of Justice](#) for the most serious charges under the Criminal Code. For indictable offences, the accused can choose whether they have their trial heard by judge alone or by judge and jury. Most are heard by judge alone.

The prosecution of crimes involves the state and the accused. Crown prosecutors act on behalf of the state as agents of the Attorney General (not lawyers for the complainant). They have a quasi-Minister of Justice role. The role of Crowns is to fairly present evidence in criminal court to prove offences beyond a reasonable doubt. HTPT Crowns are dedicated to vigorously prosecuting human trafficking cases, holding offenders accountable, and supporting victims from beginning to end of the court process. They are uniquely positioned to educate the court about human trafficking dynamics. HTPT implemented an Enhanced Prosecution Model, with a focus on challenging bail, building the strongest case possible, and forfeiting assets.

Before trial, there is an interim release/show cause (bail) hearing before a judge or justice of the peace to determine if the accused is to be released on bail or held in custody. HTPT Crowns actively seek denial of bail. This helps to ensure the victim's safety and likelihood of testifying in court. If the accused is released pending trial, there will be bail conditions placed upon them, such as no contact orders, by which they must abide. If the accused violates the bail conditions, they can be arrested and prosecuted. Threatening or intimidating the victim into not testifying is considered a violation of release and obstruction of justice.

Prior to trial, there may be a preliminary inquiry to determine whether there is sufficient evidence to proceed to trial. The victim is required to attend the preliminary hearing and trial. Crown counsel is obligated to disclose all potentially relevant evidence to defence counsel in advance of trial. Victims should be made aware of this requirement given the potential implications for their safety and risk of re-traumatization. In certain limited circumstances, the Criminal Code provides victims with the right to be represented by counsel to make submissions on their behalf about the release of private records in which the complainant has a reasonable expectation of privacy, and whether evidence can be led at trial about the complainant's previous sexual history. In Ontario, Ministry of the Attorney General pays for the victim's lawyer in these circumstances.

Victims may be subject to legal proceedings concurrently as a witness and accused or co-accused. A trauma-informed approach to CST victim-offender intersectionality and rehabilitative alternatives to retributive justice responses should be considered.

Standard of Proof

Human trafficking and other CST-related offences, like all criminal offences, carry a high standard of proof. The accused is presumed innocent until proven guilty in a court of law. Crown counsel has the burden to prove the accused committed the offence. The evidence must establish each element of the offence charged in order for the accused to be found guilty. To obtain a conviction, the judge or jury must be convinced of guilt beyond a reasonable doubt. The strict evidentiary standard should be explained to victims so as not to invalidate their experience if there is insufficient evidence to proceed to trial or get a conviction. Low conviction rates have resulted in loss of faith in the system and calls for reform.



Plea Agreements

The accused must enter a plea of guilty or not guilty for each criminal charge. Plea bargaining can occur at any time leading up to or during the trial, wherein the Crown and defence counsel agree for the accused to plead guilty to the offence. This usually comes in exchange for a reduced charge or sentence. Crown counsel must confer with victims before proceeding with a plea. The reasons for the plea should be carefully explained. Victims should be reassured that a plea deal is not always an indication that the offence is being taken less seriously. The judge makes the final decision to accept or reject a plea. If a guilty plea is accepted, victims do not have to testify at trial, unless there is a disputed fact the Crown wishes to prove for sentencing purposes at a Gardiner hearing. If a guilty plea occurs, the victim can deliver a victim impact statement to the court if they choose to do so.

Testifying in Court

Victims may be asked to testify in court as a witness for the Crown in the preliminary hearing and/or trial. Examination-in-chief by Crown counsel is followed by cross-examination by defence counsel, which may be followed by additional clarifying questions from the Crown. The opportunity to share their truth and hold traffickers responsible for the harms they caused can be empowering for victims. However, lack of confidence in the justice system and lasting effects of coercive control by traffickers, including fear of violent retaliation, prevent many victims from feeling that testifying in court is safe and worthwhile. For those who do testify, retelling their story and being subjected to cross-examination can be an intimidating and traumatizing experience. Victims should be well-prepared for the emotional turmoil of testifying in court. As reviewed earlier in section 2.5.3 of the protocol, dedicated human trafficking court support workers are available through V/WAP and Boost CVWSP.

Trauma can affect one's ability to recall events coherently, consistently, and completely. It is important for the judiciary to be educated on the impact of trauma on testimony. The use of expert witnesses to provide information, based on their specialized knowledge, pertaining to CST, child development, and neurobiological impact of traumatic stress can help the court to understand memory and behaviour, which can restore the credibility of victims.

Testimonial Aids

The Criminal Code contains provisions for testimonial aids for victims and witnesses under the age of 18 years. Testimonial aids include testifying outside of the courtroom via closed-circuit television (CCTV) or inside the courtroom behind a screen, having a support person or animal present while testifying, testifying from another jurisdiction, and using a statement recorded prior to trial to avoid having to repeat testimony (though still subject to cross-examination by defence counsel). These measures can help to reduce fear and anxiety associated with testifying in the presence of traffickers and their associates in the courtroom. Cultural supports in the courtroom are also available for Indigenous survivors.

Publication Bans

A common fear of victims and witnesses about testifying in court is that they will be publicly named and the details of their testimony will be reported to the media. [Publication Bans](#) can be imposed to protect their privacy and safety. The judge can order that any information that could identify a victim or witness, such as the person's name, not be published or broadcast in any way. The Crown, or a victim or witness under the age of 18 years, can apply for a publication ban. Upon application by the Crown, or a victim or witness under the age of 18 years in a human trafficking trial, the judge must make the order.



Verdict and Sentencing

At the conclusion of trial, the judge or jury make a determination of guilt. When the verdict is not guilty, the accused is acquitted of the charge and free to go (with the exception of those found not guilty on account of mental disorder). When the accused is found guilty or pleads guilty, there is a sentencing hearing. In arriving at a sentence, the court considers aggravating and mitigating factors related to the offender and the offence, as well as victim impact statements.

The Criminal Code sets out sentencing provisions. The purpose of sentencing is to protect society and to contribute to respect for the law and the maintenance of a just, peaceful, and safe society by imposing just sanctions. Sentences and penalties may include incarceration followed by probation or parole; intermittent, conditional, or suspended sentences with probation; and other accompanying measures, such as no contact orders, DNA orders, firearms prohibition and forfeiture orders, monetary fines, restitution, and community service. The verdict and sentence can be appealed to a higher court by the accused or Crown on certain grounds. Victims should be informed of the option to register with [Victim Notification Services](#) for updates on parole hearings and decisions, scheduled and actual releases from provincial jails and federal prisons, and other important changes in offender status.

Verdict and sentencing decisions can evoke mixed emotions in victims. It is important to acknowledge, normalize, and validate all feelings, including confusing and conflicting ones. Victims have notions of justice that may or may not align with those of the justice system. What holds meaning for most trauma survivors' sense of justice is acknowledgment of their experience and prevention of future harm (Herman, 2023).

Victim Impact Statements

If the accused is found guilty or pleads guilty, victims have the right to submit a [Victim Impact Statement](#) to the court describing how the crime personally impacted them physically, emotionally, and financially. Filing a victim impact statement is optional. V/WAP and other support workers can help victims write their impact statements. Victims have the option of reading their statement at the sentencing hearing with testimonial aids in place, having the Crown read it in court on their behalf, or filing it as an exhibit at the sentencing hearing. The statement is considered by the judge when imposing a sentence. It can also be considered by parole boards.

Victim Compensation

Financial compensation can help victims of crime to rebuild their lives. Victims of crime have a right to fair restitution. [Restitution Orders](#) require offenders to pay victims for financial losses and damages suffered as a result of their crime. Victims can file a [Statement on Restitution](#), which documents their losses and damages due to the crime, including damaged or lost property and bodily injury or psychological harm (and related expenses, such as loss of income and treatment costs). Restitution orders can be part of a plea deal, issued by a judge during sentencing, or part of a probation order.

Financial support in the aftermath of a crime is available from various organizations in Toronto, including [Victim Services Toronto](#). Initiatives such as [Project Recover](#) provide survivors of human trafficking with financial advocacy and guidance in dealing with negative impacts on their credit profile resulting from fraud and coercive debt schemes committed by traffickers. Advocates act as intermediaries between survivors and creditors, eliminating the need for them to communicate directly and the possibility for

re-traumatization. Restoring positive credit file information removes some of the barriers to accessing housing, employment, and education loans/grants. These services are provided at no cost to survivors.

2.6. RESIDENTIAL SERVICES

All children are entitled to a safe and secure place to live. Those who are at risk of, entrenched in, or exiting from sex trafficking may not have a supportive family home to remain in or return to. Many lack the developmental readiness and financial means for independent living. Housing insecurity co-occurs with CST at a high rate, both as a risk factor for, and outcome of, victimization, especially among racialized and 2SLGBTQI+ young people (Chisolm-Straker et al., 2017; Greeson et al., 2019). Lack of specialized housing programs is a structural barrier to escaping trafficking (Noble et al., 2020). Low-barrier access to safe and stable housing is imperative for preventing CST, as well as exiting successfully. It is a basic necessity without which more advanced health and wellness goals cannot be achieved. An effective community response to CST must include a range of developmentally-appropriate, trauma-informed residential options, from emergency shelter to permanent housing, corresponding to different stages of exploitation and rehabilitation.

Spectrum of housing options:

- Therapeutic foster care
- Group homes
- Residential treatment facilities
- Emergency shelters
- Intermediate housing
- Transitional housing
- Permanent housing

Traffickers' accessibility to children increases in the context of family separation and limited adult supervision. Children in the care of the child welfare system are particularly vulnerable to sex trafficking when placed in traditional group home settings. Family-based homes are preferred, though not always possible. Placement decisions should be carefully considered in collaboration with clients. They should be responsive to physical and psychological needs and potential risks to safety and well-being. In emergency situations, however, time and resources may not allow for a comprehensive assessment of needs and risks. Placing children in ill-equipped and misattuned settings may lead to placement breakdown and running away. Moving around to multiple foster and group homes causes repeated attachment disruptions and life instability with detrimental impacts on health and safety. The greater the number of placements, the higher the risk of trafficking (Latzman et al., 2019).

“Group homes are the worst place to be recruited from. You can’t put young people in group homes, it doesn’t work. It’s probably more detrimental for them than anything. If CAS is going to apprehend a young girl who’s being trafficked, they need to go into a loving home, so foster care. Foster parents that are extensively trained on how to be there and love, like show unconditional love to somebody who’s experienced trafficking. The reason you go to your trafficker and keep returning is because he’s meeting a need and usually that need is unconditional love and support.”
(Survivor)

Residential staff and guardians must be prepared to recognize and respond to safety threats for system-involved children and provide trauma-informed care, attention, and affection. Congregate care settings, such



as youth shelters and group homes, are magnets for traffickers preying on vulnerable young people who are not getting their material and emotional needs met. There is also potential for peer recruitment on the inside when those entrenched in trafficking are integrated with those at risk. This underscores the need for service providers to be diligent in identifying these dynamics and implementing appropriate safety measures.

“It seemed like some shelters set us up to fall into the hands of traffickers. There are people there recruiting from the shelter. A lot of shelters kick you out during the day, even in the winter. Traffickers know this and use that to lure you in. They offer you a warm place to stay when you have nowhere else.” (Survivor)

“Some safety measures go way too far. As if somehow we are at fault, we are dangerous.” (Survivor)

[Building Trauma-Informed Practices for Anti-Trafficking Housing Programs](#) offers guidance on creating person-centred, trauma-informed, voluntary housing for victims and survivors of human trafficking. The Housing First approach advocates for immediate access to housing as a precondition for recovery. This entails moving away from traditional eligibility criteria (such as sobriety and treatment compliance), honouring the right to self-determination, building relationships that support recovery, integrating accessible support services beyond housing, and applying a harm-reduction and safety planning approach. Enforcing strict compliance requirements and eviction as a consequence to rule-breaking runs the risk of returning residents to the harms of trafficking. Safety and risk management policies and procedures must balance the goal of protection with respect for autonomy.

Specialized emergency and transitional housing programs that are trauma-informed and responsive to both physical and psychological needs are recommended for children subjected to, and exiting from, sex trafficking. Creating a gradual transition from crisis beds to more structured programming will help young people to adapt to changing environments (Covenant House Toronto, 2017). Toronto and Greater Toronto Area have residential options targeted for victims and survivors at various ages and stages of human trafficking. [Covenant House Toronto \(CHT\)](#) is currently the only residence in Toronto designated specifically for youth survivors of sex trafficking and exploitation, though others are in development by protocol partners. CHT has two assigned crisis shelter beds and two specialized housing programs that provide intermediate and transitional homes. These homes offer 24/7 care and a range of services, including medical and mental health care, education and employment assistance, and legal and court supports.

Since most children in need of residential care have past or present involvement with the child welfare system, developing coordinated policies and service pathways between child welfare and residential services will help to ensure necessary communication and joint safety planning. This includes transitional supports for young people leaving care. Special consideration should be given to those with precarious immigration status whose access to housing subsidies and priority housing may be limited.

Core components of specialized housing programs:

- Survivor- and trauma-informed
- Low barrier access to around-the-clock care
- CST training for staff
- Multidisciplinary team approach



- Array of intensive onsite services
- Collaboration with community resources
- Secure facilities with safety and risk management protocols

Residential service principles and practices:

- Ensure compliance with provincial residential licensing policies, regulations, and legislation.
- Policies, practices, and spaces should be victim- and survivor-centred, rights-based, trauma-informed, developmentally-sensitive, and culturally-safe.
- Code of conduct protocols should not reinforce power and control over residents. Foster mutual trust, respect, collaboration, and partnership from the start.
- Engage survivors in policy and program development in meaningful ways. Create opportunities for resident and staff feedback.
- Provide adequate training to guardians and staff. Basic curriculum should include CST dynamics, traumatic stress responses, trauma-informed care, mandatory reporting, crisis intervention, conflict resolution, safety planning, and self-care.
- Determine the most suitable residential option based on developmental stage, cultural identity, and service needs.
- Eligibility criteria for admission should not be overly restrictive. Lengths of stay should be flexible and needs-based.
- Move away from compliance-oriented conditions for service. Access should not be contingent on abstaining from substance use, participating in treatment, attending school, or reporting to police.
- Ensure residents have a clear understanding of expectations and schedules. Avoid unilateral establishment of rules. Be sensitive to how trauma can impact adherence.
- Refrain from restricting external communication and confiscating communication devices. Access to support systems and emergency contacts may be a lifeline for some.
- Presenting under the influence of substances should not be grounds for eviction. Use a stages of change approach and harm-reduction strategies grounded in acceptance to minimize risk and maximize safety.
- Environment should look and feel like a welcoming home, not an institution. Premises should be kept clean and free of hazards.
- Ensure physical space and food options are culturally-appropriate. Sites and services should be accessible to people with different languages, customs, and abilities.
- To promote healthy boundaries, provide residents with private rooms when possible. Separate living spaces based on age and CST stage if known (e.g., at risk vs. entrenched). Consider preferences based on gender and unique needs of transgender and gender-diverse individuals.
- Formulate service plans collaboratively. Provide choice as much as possible. Honour self-determination and agency while promoting safety.
- Offer wraparound programming onsite, including access to school, primary health care, trauma therapy, substance use treatment, life skills training, recreational activities, and case management.
- Establish coordinated service pathways with community partners, including child welfare, to ensure the full range of needs are met.
- Encourage respectful and caring relationships between residents and staff and among residents. Model effective communication and conflict resolution skills.
- Offer consistent workers to allow for trusting relationships to develop over time.

- Foster a sense of belonging. Encourage outside connections with supportive family and community.
- Respect privacy and confidentiality. Refrain from requiring residents to share personal stories of trauma. Information about residents should not be shared with other residents without consent.
- Develop individualized safety plans that are victim- and survivor-driven. Review plans periodically and modify as needed.
- Remain vigilant to potential traffickers and recruiters onsite and nearby. Visitors should not be permitted unannounced or unchecked as a safety precaution.
- Refrain from publicly advertising residence location to increase protection from traffickers.
- Safety and risk management protocols should be reviewed and updated on a regular basis.
- Staff-to-resident ratio should reasonably reflect safety, supervision, and care needs.
- Ensure appropriate mechanisms for oversight and accountability. Provide confidential processes for residents and staff to report safety concerns or policy violations.
- Advocate for structural and systemic change, including more equitable and affordable access to safe and stable housing options.

Young people leaving child welfare care and residential programs require ongoing support and services. The ultimate goal is to prepare children for eventual independent living in permanent housing, with adequate community supports in place. Waiting lists for subsidized housing in Toronto are currently years-long. Under Toronto Community Housing's [Special Priority Program](#), victims of abuse and trafficking over 16 years of age are eligible for priority ranking for social housing. The wait with priority status can still be lengthy. Current market rates for rent in Toronto are unaffordable for many. This is further complicated by young people's lack of stable employment and rental history, poor credit ratings due to coerced debt, and discrimination by property owners and managers. Service providers can help to navigate the housing market, assist with complicated application processes, provide financial literacy and life skills coaching, and play an important advocacy role in securing safe and stable housing.

2.7. PEDIATRIC MEDICAL CARE

2.7.1. Medical Presentations and Provider Roles

Children exposed to sex trafficking are at risk of experiencing overlapping and compounding medical sequelae, as outlined in section 1.3.7 of the protocol. For some of those entrenched in CST, contact with the outside world is restricted. Traffickers may limit interactions to essential medical services. The majority of young victims encounter a health care provider during their exploitation (Goldberg et al., 2016). Health care providers are therefore well-positioned to assume an important role in CST identification, assessment, intervention, and prevention (Chaffee & English, 2015; Chisolm-Straker et al., 2016). Good medical care provides individuals with the opportunity to regain a sense of dignity and control over their bodies. A developmentally-sensitive, trauma-informed approach to holistic pediatric health care is a vital component of a CST community response protocol.

Children with a history of commercial sexual exploitation report worse overall health in physical, behavioural, and social domains, compared to those without (Barnert et al., 2022). Among the most prevalent physical effects secondary to CST are sexually transmitted infections, adverse reproductive health issues, traumatic

injuries, and complications related to substance use (Greenbaum, 2014, 2018). Physical symptoms may cause negative psychological responses, which in turn contribute to additional and more serious physical effects. Health consequences can become more severe as degree and duration of CST increase, underscoring the need for an early and effective pediatric health care response.

Children who have not yet been identified as being sex trafficked or connected with CST services are most likely to seek medical care at emergency departments and primary care clinics. Trafficking is rarely the chief complaint when victims and survivors present for service. Some may be more trusting of physicians and nurses than child welfare and law enforcement authorities, and thus more inclined to share their CST experiences in health settings. Most children, however, do not spontaneously disclose. This highlights the importance of health care providers being able to accurately recognize the indicators of CST risk, ask the right questions, and connect to the appropriate services. Refer to sections 2.3.1 and 2.3.2 of the protocol for a review of warning signs and screening approaches.

Given the extensive health impacts of sex trafficking, children known or suspected to have experienced past or present CST should be referred for a medical evaluation with consent. The medical assessment should be comprehensive and include assessment for acute and chronic medical and mental health needs, dental needs, and overall nutritional status, as well as testing for sexually transmitted infections, pregnancy, and alcohol and drugs as indicated (Greenbaum et al., 2015; Kellogg et al., 2023). There should be attention to the health effects of prolonged physical and psychological stress related to CST, coinciding with inequitable distribution of social determinants of health (Raphael et al., 2020).

A positive health care experience has the potential to improve health and safety and increase the likelihood of return for ongoing care. There are, however, numerous personal and systemic barriers to access and utilization of health care services for trafficked young people (Albright et al., 2020; Garg et al., 2020; Ijadi-Maghsoodi et al., 2018; Panda et al., 2021). Non-stigmatizing, flexible, and adaptable health care services are required to facilitate engagement and trust.



Consistent with recommended health care approaches for human trafficking survivors (Hemmings et al., 2016), this community response protocol promotes a model of pediatric health care that is trauma-informed, rights-based, culturally-safe, relationship-focused, and well-coordinated with allied disciplines and systems. Health professionals providing care to children exposed to sex trafficking, and those at risk, should have adequate training in medical evaluation of CST, sexual assault, and childhood trauma. Research-based guidelines for health care responses to human trafficking should inform practice.

Resources to guide health care responses:

- [Improving Physical and Mental Health Care for Those at Risk of, and Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#)
- [Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings](#)
- [Human Trafficking Response Program: Shared Learnings Manual](#)
- [The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment, and Treatment: APSAC Practice Guidelines](#)
- [Addressing Human Trafficking Through Health Systems: A Scoping Review](#)

Pediatric health care principles and practices:

- Use a rights-based, trauma-informed approach to holistic pediatric health care.
- Provide health care services that are developmentally-appropriate. The environment, procedures, equipment, and supplies should be youth-friendly.
- Approaches to medical evaluation should follow evidence-based standards of care for pediatrics. Ensure training incorporates practice guidelines for CST identification, assessment, intervention, and prevention.
- Offer a comprehensive continuum of health care across primary, secondary, and tertiary levels. Link with allied health professionals and community partners.
- Use a social determinants of health approach. Examine and address upstream drivers of health through a public health lens.
- Consider implementing CST screening protocols for victim identification in health settings. Ensure positive screens are followed by further assessment and appropriate intervention.
- Refrain from pathologizing patients and focusing on problems, deficits, and diagnoses. Use a strengths-based approach to identify attributes that promote health and healing.
- Foster the patient-provider relationship. Take care to not erode trust. Practice from a place of compassion and empathy. Demonstrate a respectful and nonjudgmental attitude.
- Normalize asking health questions that may be personal or embarrassing and request permission to proceed (e.g., *“At this point, I usually ask patients questions about their sex life. I understand it may be uncomfortable to talk about. It is important to overall health. Will that be okay with you?”*).
- Ensure consent to medical procedures is fully informed and non-coercive. Use plain language and provide ample opportunity for questions and discussion.
- Respect privacy and confidentiality. Offer private waiting areas. Review limits to confidentiality at every visit.
- Partner with patients in their health care. Offer choices. Engage in shared decision-making. Encourage self-determination and autonomy.
- Focus on self-identified health priorities and goals. These may change and require flexible care plans. Meet patients where they are at. Apply a stages of change and harm-reduction approach.
- If the medical evaluation uses a multidisciplinary team approach, limit the number of times patients have to provide a clinical history to different providers to avoid re-traumatization.
- Reduce logistical and financial barriers to accessing health care (e.g., central location, transportation to clinic, flexible appointment times, no waitlists, streamlined referrals, assistance with obtaining a health card). Provide support in navigating health systems and processes.
- Ensure care plans are coordinated, with well-defined referral and service pathways. Use patient navigators or case managers to assist with medically complex cases requiring multisystem involvement.
- Provide culturally-sensitive, anti-oppressive health care. Recognize the value of Indigenous healing practices and use them in the treatment of Indigenous patients, in collaboration with Indigenous healers and Elders where requested, as per the [Truth and Reconciliation Commission of Canada: Calls to Action](#).
- Adhere to Personal Health Information Protection Act (2004) and Health Care Consent Act (1996) regulations.

Most basic and emergency health care services are provided at no cost to individuals living in Ontario under the [Ontario Health Insurance Plan \(OHIP and OHIP+\)](#). This includes most prescription medication for those under 24 years of age not covered by a private plan. For those without OHIP or other health insurance, there should be flexibility to provide medical services without coverage. Assistance may be

required to access flexible payment plans or free health care services at clinics that accept non-insured individuals. This protocol advocates for equitable access to universal health care regardless of identity or circumstance.

Primary Health Care

Primary health care is a whole-of-society approach to health that aims to maximize health and well-being by providing integrative health services with an emphasis on primary care and public health; addressing social determinants of health through multisectoral policy and action; and empowering individuals, families, and communities to take charge of their own health (World Health Organization & United Nations Children's Fund, 2020). The role of first-contact primary care providers (e.g., community pediatricians, family physicians, nurse practitioners, public health nurses) is to promote the health and wellness of their patients over the life course. Primary care needs in childhood and adolescence are uniquely related to identity formation, sexual development, experimentation and risk-taking, and increasing autonomy.

Primary care providers play a key role in CST prevention and recognition (VanGraafeiland et al., 2022). All children at risk of sex trafficking can benefit from a consistent and trusting relationship with a primary care provider. As children transition to adolescence and adulthood, it is important for them to feel confident in their ability to access primary care services in the form of general advice, prevention, and treatment and learn to advocate for themselves, independent from their parents/caregivers.

Routine primary health care roles:

- Disease prevention and management
- Diagnosis and treatment of illness
- Developmental surveillance and screening
- Height, weight, and blood pressure checks
- Vaccinations and bloodwork
- Nutrition counselling
- Mental health and substance use screening and management
- Sexual and reproductive health care
- Link to specialty health care

Primary health care services in Toronto Region:

- [Community Health Centres](#)
- [Youth Wellness Hubs Ontario](#)
- [Family Health Teams](#)

Specialty Health Care

The unique and comprehensive health care needs of children presenting with histories of sex trafficking tend to be best met by multidisciplinary pediatric health care teams specializing in CST, sexual and physical assault, and complex trauma. The Hospital for Sick Children's [Lotus Health](#) is a specialty program that provides acute and non-acute multidisciplinary health care, including sexual assault care and some primary care services, to children exposed to sex trafficking and those at risk. The benefits of specialty programs situated in tertiary-level pediatric health sciences centres include access to pediatric care providers with highly specialized clinical knowledge and skill sets; provision of evidence-guided, trauma-focused, multidisciplinary treatments and resources; and availability of subspecialties (e.g., gynecology, psychiatry, substance use), labs, and equipment onsite. This facilitates a more coordinated and integrated approach to holistic pediatric health care.



2.7.2. General Health Assessment and Physical Examination

When a child presents for health care, a medical and psychosocial history should be collected directly from the child and relevant collateral sources if indicated. The clinical interview is a key component to better understanding the child's overall health status and adverse experiences to which they have been exposed. The range and complexity of physical and mental health issues faced by those subjected to CST can sometimes feel overwhelming. Health needs and goals should be prioritized in collaboration with the patient. The health care provider should start the clinic visit by empowering the patient to identify their own needs and strengths and fostering their sense of safety, trust, and control.

Opening questions to guide health care:

- *What is most important to you today? What part of your health care do you want to focus on today?*
- *What would be helpful to make you feel comfortable and safer during this visit?*
- *What has your past experience with health care been like?*

Most pediatric care providers apply the HEEADSSS approach with adolescents (Cohen et al., 1991). Using a semi-structured, in-depth clinical interview format, the goal of the HEEADSSS assessment is to facilitate communication and identify psychosocial risks through history gathering. For children who have experienced, or are at risk of, sex trafficking, the HEEADSSS framework can be helpful with identifying risks at the initial clinic visit that can then inform further assessment and treatment planning.

HEEADSSS review of systems:

- **H**ome
- **E**ducation and employment
- **E**ating
- **A**ctivities
- **D**rugs and alcohol
- **S**exuality
- **S**uicide and depression
- **S**afety from injury and violence

The 5-Ps framework can help to guide sexual health assessments. This is a useful approach to obtaining comprehensive sexual and reproductive health information to guide care pathways. See [A Guide to Taking a Sexual History](#) and [Comprehensive Sexual Health Assessments for Adolescents](#).

5-Ps approach to sexual health history:

- **P**artners
- **P**ractices
- **P**rotection from STIs
- **P**ast history of STIs
- **P**regnancy intention/prevention

Private discussions about sexual orientation, sexual abuse and exploitation, sexual consent, and healthy sexuality and relationships should be routinely incorporated into sexual health assessments. Standardized CST screening questions (e.g., [SSCST](#)) can be seamlessly integrated into the HEADSSS and 5-Ps assessment frameworks to determine level of sex trafficking risk.

There are several additional clinically validated screening tools for mental health and trauma symptoms (e.g., [UCLA PTSD-RI](#)), suicidality (e.g., [C-SSRS](#)), and substance use (e.g., [CRAFT](#)) that can supplement the clinical interview component of the medical evaluation. As discussed in section 2.3.2 of the protocol, screening tools are an efficient and effective approach to identification that can direct the multidisciplinary plan of care. Caution should be taken to not overwhelm patients with extensive and invasive questioning in a single visit before rapport has been established. Further assessment and intervention in problem areas, including referrals to mental health clinicians and other allied health professionals, should be initiated as required. Refer to section 2.8 of the protocol for mental health, suicide, and substance use considerations.

Health care providers should expect patient narratives to be somewhat scattered and inconsistent at times. This is not uncommon with trafficked children due to the impacts of trauma, fear, shame, substance use, and sleep deprivation. Questions may have to be repeated or rephrased to elicit a coherent response in a way that does not confuse or frustrate the patient.

A head-to-toe physical examination should be offered if physical symptoms or concerns are reported. With consent, anogenital examinations may be performed with the aid of a colposcope or other magnifying instrument to improve visualization (in certain cases). The examination process inherently places patients in a vulnerable position and carries the risk of re-traumatization. For some victims and survivors of CST, anogenital examinations can bring up memories of past experiences of sexual violence, causing distress and discomfort. Health care providers should follow clinical practice guidelines for trauma-informed physical examinations using language and techniques that convey respect and foster a sense of safety, trust, and autonomy. Refer to section 2.1.2 of the protocol for a review of general trauma-informed care principles and practices.

Clinical practice guidelines for trauma-informed physical examinations:

- [Trauma-Informed Physical Examinations and STBBI Testing: A Guide for Service Providers](#)
- [Recommendations for Trauma- and Violence-Informed Physical Examinations for Patients](#)

Strategies for trauma-informed physical examinations:

- Accommodate patient requests for providers of a specific gender when possible.
- Have a third-party present in the examination room to chaperone when requested and available. Limit the number of trainee observers. Ask for permission to have trainees present and respect the decision.
- Before proceeding, clearly and calmly explain the purpose and process of the physical examination. Make it standard and set an agenda (e.g., *“I recommend a genital exam. This is something we do with all patients who are experiencing symptoms of an infection. The goal is to see if you have an infection and keep you healthy. It should only take five minutes to complete and will involve...”*).
- Identify and explain the purpose of any equipment being used (e.g., colposcope). If photos are taken for clinical documentation, ensure policies for consent, storage, transfer, and retention are established and explained.



- Provide opportunities for patients to ask questions or express concerns before and after proceeding. Normalize and validate anxiety. Ask if there is anything that can be done to help make them feel more comfortable during the examination. Offer the presence of a support person.
- Always state what is being done before doing it and ask permission to proceed (e.g., “You are going to feel my hand on the outside of your vaginal area. You may feel a bit of pressure and pulling. Is it okay to proceed?”).
- Be mindful of personal space. Touch only when needed. Stay within eyesight and remain at eye level.
- Restore a sense of bodily control and respect privacy. Always knock on the clinic room door before entering and wait to be invited in. Only expose body parts that are being examined at the time. Enable patients to move the gown or drape as needed.
- Empower patients to take control over the process (e.g., “Please tell me if you want to stop at any time.”).
- Regularly check in to ensure patients feels comfortable. Be patient and take breaks as needed. Complete the examination as efficiently as possible.
- Choose language carefully. Avoid words with sexual connotations that may serve as trauma reminders (e.g., use “exam table” instead of “bed,” say “Please lift up your shirt so I can examine your abdomen” instead of “Undress for me.”).
- Be open to using new or different methods for medical procedures that reduce the risk of re-traumatization and restore control (e.g., self-insertion of swabs, foregoing stirrups). Using a speculum is not recommended.
- Warn of the possibility for trauma triggers during the examination. Be attuned to nonverbal cues and trauma reactions (e.g., tensing muscles, rapid breathing) and be prepared to respond sensitively.
- Explain the results of the examination and next steps, leave time for questions, and express thanks.

“For me what was positive was the nurses that I met with or the social worker that I met with had some knowledge of what human trafficking was, so it wasn’t like people were asking me a million questions about my experience... They weren’t judgmental, but most importantly, they were patient. They explained every single thing to me that they were going to do and they asked permission to do it to me. They took that extra time to do that. She asked me if I was comfortable with it. She took the time to understand that this is something that’s going to be really difficult for me and go at my pace and allow me to almost be in the driver’s seat. It was very thought out, step by step. It was very accommodating. And I think that’s what’s helpful. But the biggest thing that was helpful is this nurse actually had knowledge on human trafficking. If someone doesn’t have knowledge on human trafficking, sex work, or exploitation, it’s not going to be helpful because they’re going to ask questions that are irrelevant or that are going to be offensive.” (Survivor)

2.7.3. Sexual and Reproductive Health

Young people who experience commercial sexual exploitation are at high risk for pregnancy and sexually transmitted infections (STIs), and they generally view their sexual and reproductive health as critical (Barnert et al., 2019a, 2019b; Godoy et al., 2020; Kelly et al., 2019). Sexual and reproductive health care needs, particularly contraception and STI care, are a primary motivator for seeking medical services. Despite their sexual history, CST victims and survivors may present with significant gaps in knowledge about their own bodies and sexual and reproductive health, including the physical and emotional risks associated with unprotected sex. This presents a valuable opportunity for health care providers to offer sexual health education and harm-reduction strategies, which can organically create a pathway toward

meaningful conversations about sexual exploitation, healthy relationships, and consent. Sexual and reproductive health care should be trauma-informed, non-stigmatizing, culturally-sensitive, confidential, and delivered in a way that promotes fully informed, voluntary, and coercion-free decision-making. A sex-positive, reproductive justice approach is recommended.

Sexually Transmitted Infections

More than half of young people subjected to sex trafficking contract STIs (Lederer & Wetzel, 2014; Varma et al., 2015). For some, recurrent infections are common due to the number of partners, type of sexual contact, lack of choice over condom use, and hygiene practices. STIs can be asymptomatic or have noticeable symptoms. In addition to STI prevention education, STI testing and treatment should be routinely offered to patients who request it or report clinical symptoms, a history of unprotected sex, sex with multiple partners, or otherwise high-risk behaviours and circumstances. Evidence-based clinical practice guidelines for STI prevention, testing, and treatment should be followed.

Standard practice is to use nucleic acid amplification test (NAAT) swabs for gonorrhea and chlamydia at any site of contact (vaginal, rectal, pharyngeal) and for trichomoniasis vaginally. Rectal swabs for chlamydia should be considered even when anal-penile contact was not reported. Swabs can be collected by the provider or patients may self-swab. If patients are uncomfortable with swabbing, it can be substituted with less invasive urine NAATs. Urine NAATs are used for urethral infections (in those with a penis). Vaginal culture and sensitivity (C&S) tests are used for yeast and bacterial infections. Polymerase chain reaction (PCR) or viral cultures can be collected for herpes simplex virus (HSV-1 and HSV-2) in patients with genital lesions. Testing for human papillomavirus (HPV) is not routinely warranted; diagnosis can be based on clinical presentation. Serology tests are used for HIV, hepatitis B and C, and syphilis if clinically indicated.

Patient preference to be notified of STI test results by phone or in-person should be determined in advance. If STI tests are positive, patients should be notified of the diagnosis and treatment as soon as possible. It is preferable to provide medication to treat STIs at the clinic on the same day, rather than sending them off with a prescription. Situations wherein returning to clinic is highly unlikely, treating STIs prophylactically with antibiotics should be considered. Frequent use of the same antibiotic regimen can lead to antibiotic resistance. This points to the importance of obtaining a thorough clinical history of prior treatments and considering emerging antibiotic resistance when determining treatment, as well as strategies for prevention. Test of cure should be completed at least four weeks following STI treatments.

Under the [Health Protection and Promotion Act \(1990\)](#), health professionals in Ontario have a duty to report communicable diseases of public health significance, including certain STIs, to their local medical officer of health in a timely manner. Those practicing in Toronto report to [Toronto Public Health](#). Public health units are required to ensure sexual partners are notified of potential STI exposure to allow them to seek care, prevent transmission, and reduce the incidence of serious complications. Confidentiality is maintained during contact tracing. Some patients decline or are unable to safely provide information about partners, making contact tracing and treatment of partners difficult. This may contribute to further spread. Working collaboratively with public health units can promote safe notification plans, including strategies for treating partners without disclosure of personal health information.

Encouraging vaccinations can reduce the risk of some viral STIs, including HPV and hepatitis B, and their associated diseases. Given frequent school absenteeism among children at highest risk of CST, many miss vaccinations through school-based public health programs. They may require serology testing to

determine immunity and access to vaccinations elsewhere. See [Canadian Immunization Guide](#). While prevalence of HIV in Canadian children exposed to CST is low, HIV post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) should be considered on a case-by-case basis. Decision-making factors include degree of HIV exposure risk (e.g., high-risk sexual behaviours, diagnoses of other infections, intravenous drug use), medication side effects and toxicity risks, and barriers to drug regimen adherence. Strict adherence and follow-up care are required to maximize efficacy. This can be challenging for the CST population due to lifestyle and safety concerns, thus requiring strategies for mitigating barriers.

Clinical practice guidelines for STI prevention, testing, and treatment:

- [Sexually Transmitted and Blood-Borne Infections: Guide for Health Professionals](#)
- [Diagnosis and Management of Sexually Transmitted Infections in Adolescents](#)
- [Sexually Transmitted Infections Treatment Guidelines, 2021](#)
- [Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach](#)
- [Canadian Guideline on HIV Pre-Exposure Prophylaxis and Nonoccupational Postexposure Prophylaxis](#)
- [HIV Pre-Exposure Prophylaxis: It is Time to Consider Harm Reduction Care for Adolescents in Canada](#)
- Medical Guidelines for HIV Post-Exposure Prophylaxis for Sexual Assault Victims/Survivors (available internally to SA/DVTC staff)
- [Guide to Taking HIV PEP](#)
- [Trauma- and Violence-Informed Care Toolkit for Reducing Stigma Related to Sexually Transmitted and Blood-Borne Infections](#)

Contraceptive and Pregnancy Care

Sexually active young people require fertility education, balanced information about contraception, and access to a range of methods for pregnancy and STI prevention. Health care providers should engage patients in a collaborative decision-making process to select a method of contraception that is safe, effective, and practical for them. Options include first-tier long-acting reversible contraceptives (subdermal implant, intrauterine device), second-tier hormonal contraceptives (pill, patch, ring, injection), and third-tier in-the-moment methods (condom, diaphragm, cervical cap, spermicide, sponge) or near-the-moment methods (emergency contraception). Long-acting reversible contraceptives to prevent pregnancy, combined with condom use to prevent STIs, are recommended as the first-line option for Canadian youth due to their low failure rate and not being user-reliant (Di Meglio et al., 2018). See [Contraceptive Care for Canadian Youth](#).

For the CST population, long-acting reversible contraceptives come with the benefits of being discreet and reliable, eliminating the need to take/hide daily pills, fostering autonomy and control, stopping menstruation, and requiring minimal follow-up care. While highly effective, an intrauterine device (IUD) can feel invasive and distressing, particularly for those who have experienced sexual violence. The pelvic examination and device insertion can activate a trauma response, emphasizing the importance of a trauma-informed approach. Injectable contraceptives (e.g., Depo-Provera) and subdermal implants (e.g., Nexplanon) are alternative methods. Options covered by OHIP+ and same-day administration (when patients are present in clinic) are recommended.

Through a reproductive justice lens, common barriers to contraceptive use among commercially sexually exploited young people should be addressed by providing safer sex education, dispelling myths, discussing

side effects, and emphasizing autonomy, especially with regard to condom use (Kelly et al., 2019). Providing clear and concrete technical guidance on condom use is important to prevent leaks, slips, and breaks. Adherence should be strongly encouraged for those wishing to avoid pregnancy and STIs. Health care providers should be aware of reproductive coercion dynamics in CST. Reproductive coercion can be used by traffickers to control a victim's reproductive autonomy for the purpose of preventing or promoting pregnancy to maintain their control (Reid, 2016; Tarzia & Hegarty, 2021).

Approximately one-third of girls impacted by commercial sexual exploitation become pregnant (Barnert et al., 2019a). Pregnancy testing should be provided when requested by the patient or when the clinical history dictates (e.g., late menstrual period). Urine beta-human chorionic gonadotropin (b-hCG) should be offered immediately in clinic, and if there is a positive result, serology b-hCG should be used to confirm the result. In the event of unintended pregnancy, options counselling should be provided. All options (parenting, adoption, abortion) should be presented in an objective, nonjudgmental, culturally-sensitive manner. Given the high prevalence of maternal and infant complications in trafficked young people (Le et al., 2018), timely referrals should be provided to hospital- or community-based clinics for trauma-informed approaches to pregnancy termination or obstetrics and parenting support for those who choose to parent.

Sexual and reproductive health and maternal and infant health services in Toronto Region:

- [The Hospital for Sick Children, Young Families Program](#)
- [The Hospital for Sick Children, Lotus Health](#)
- [Toronto Morgentaler Clinic](#)
- [Women's College Hospital, The Bay Centre](#)
- [Jessie's: The June Callwood Centre for Young Women](#)
- [Planned Parenthood Toronto](#)

Sexual health resources:

- [SickKids, About Kids Health, Sexual Health Learning Hub](#)
- [Action Canada for Sexual Health and Rights, Sexual Health Information Hub](#)
- [The Society of Obstetricians and Gynaecologists of Canada, Sex & U](#)
- [Planned Parenthood Toronto, Factsheets](#)
- [Not Just the Tip: Toolkit for Sexual Health Educators](#)
- [Amaze](#)

Refer to section 3.2.5 of the protocol for additional medical and sexual health resources.

2.7.4. Acute Sexual and Physical Assault Care

Children who experience sex trafficking report high rates of co-occurring physical and sexual violence (Ottisova et al., 2016; Varma et al., 2015). All victims of acute assault are entitled to trauma-informed medical evaluation and collection of forensic evidence for potential use in criminal justice proceedings, with or without current police involvement. Consent must be obtained before proceeding with a physical examination and forensic evidence collection. When patients are unable to provide consent due to loss of consciousness or impairment, medical evaluation should be deferred until capacity to consent is regained.

If capacity to consent is not expected within 72 hours of the assault, substitute decision-makers should be consulted. Health professionals should follow institutional decision-making guidelines for working with persons who are unable to provide consent to health care.

Hospital-based [Sexual Assault/Domestic Violence Treatment Centres \(SA/DVTCs\)](#) across Ontario provide 24/7 specialized medical evaluation and crisis counselling in the aftermath of sexual or physical assault. Anti-human trafficking organizations should develop a close working relationship with their local SA/DVTC.

Sexual Assault/Domestic Violence Treatment Centres in Toronto Region:

- [The Hospital for Sick Children, Suspected Child Abuse and Neglect Program](#) (<18 years)
- [Women's College Hospital, Sexual Assault/Domestic Violence Care Centre](#) (>16 years)
- [Scarborough Health Network, Sexual Assault/Domestic Violence Care Centre](#) (>12 years)

Sexual Assault Care

The purpose of sexual assault medical evaluation is to address health care needs, promote healing, and offer forensic evidence collection. Timing of care is determined case-by-case. Acute sexual assault care is typically provided within 72 hours or up to 12 days following the assault at hospital-based SA/DVTCs by a sexual assault nurse examiner (SANE) or physician with special training in medical, psychological, and forensic aspects of sexual assault examinations. After this timeframe, assaults are considered non-acute and can be managed in a clinic setting on a non-urgent basis. Evidence-based clinical practice guidelines for sexual assault care and interpretation of medical findings should be followed. Mechanisms for peer review of findings are encouraged.

Clinical practice guidelines for medical evaluation of sexual assault:

- [Hospital Guidelines for the Treatment of Persons Who Have Been Sexually Assaulted \(3rd Ed.\)](#)
- [Ontario Network of Sexual Assault/Domestic Violence Treatment Centres Standards of Care \(2nd Ed.\)](#)
- [Clinical Practice Guideline: Management of Acute Child and Adolescent Sexual Abuse and Assault](#)
- [Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2023](#)
- [National Protocol for Sexual Abuse Medical Forensic Examinations](#)
- [National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach](#)

Components of acute sexual assault care:

- Clinical history and physical examination
- STI testing and treatment
- Post-exposure prophylaxis
- Emergency contraception
- Toxicology screening
- Forensic care
- Risk assessment and safety planning
- Crisis counselling and support

When a recent sexual assault is disclosed or suspected, the option and process of collecting forensic evidence using a sexual assault evidence kit (SAEK) should be discussed with patients. Designed by Ontario's [Centre of Forensic Sciences \(CFS\)](#), the purpose of the SAEK is to document, collect, and preserve forensic evidence of a crime using standardized procedures. This involves detailed forensic documentation, physical examination, and removal of DNA evidence from the body, clothing, and belongings. Based on

CFS recommendations, forensic evidence can be collected within 72 hours or up to 12 days post-assault, depending on the type of contact. Timeframes for evidence collection are supported by the current state of DNA technology. Biological evidence can be lost through mechanisms such as degradation and washing. Prompt collection of forensic samples is essential, as likelihood of obtaining viable specimens decreases over time.

Forensic evidence may be used in the criminal investigation and prosecution of sex crimes, thus it is imperative to preserve the integrity of samples, maintain the continuity of evidence, and document the chain of custody. Specimens should be properly bagged, sealed, and stored until police handover occurs, otherwise it may be deemed invalid. Consent is required to release the SAEK to police for evidentiary purposes. If police are not currently involved, but may become involved in the future, the option to collect and store specimens at the hospital should be offered. Evidence can be stored at SA/DVTCs for up to six to 12 months pending the decision to report to police. This allows time for victims to carefully contemplate police involvement and not feel pressured into making rushed decisions during a time of crisis. Refer to sections 2.5.1 and 3.2.3 of the protocol for police report considerations and resources.

While there is considerable variability in child sexual assault examination findings, the majority of anogenital examinations demonstrate normal or nonspecific findings (Kellogg et al., 2023; Smith et al., 2018). There may be no resulting anogenital injuries, and when there are injuries, they tend to heal quickly. It is important for investigators to understand that the absence of physical trauma on exam does not exclude the possibility of sexual assault.

Physical injuries resulting from sexual assault should be carefully documented using body-map diagrams, and photo-documentation should be completed when possible. Forensic practice standards for [Photograph Evidence](#) should be followed, including use of appropriate equipment, proper photography elements, considerations for patient comfort and privacy, and policies for consent, storage, transfer, and retention. Care should be taken to minimize trauma during this process, particularly for those whose victimization involved photographing or video-recording, as it may trigger a trauma reaction. Consultation with a child maltreatment pediatrician may be necessary to provide a forensic medical opinion and assist in the assessment of other injuries. If the sexual assault involved non-fatal strangulation, a full strangulation assessment should be conducted (see below).

If needed, [Emergency Contraception](#) can be provided up to five days post-assault. Effectiveness decreases as time passes. [HIV Post-Exposure Prophylaxis](#) should be provided within 72 hours post-assault to ensure full effectiveness. When [Drug-Facilitated Sexual Assault](#) is suspected due to loss of consciousness or inability to recall details, toxicology screening should be a consideration.

Physical Assault Care

Physical assault care for children who have experienced violence in the context of CST should include a thorough review of any acute and previous injuries by a pediatrician with specialization in child maltreatment. Musculoskeletal injuries require assessment and consideration for x-rays to examine for possible fractures. Skin injuries, such as lacerations and burns, may require treatment and involvement of plastic surgery specialists. For extensive bruising, bloodwork, including creatinine kinase and kidney function, should be completed to assess for the risk of developing rhabdomyolysis from tissue injury. For patients with abdominal bruising, a computed tomography (CT) scan of the abdomen should be performed to assess for intra-abdominal injury given the high level of force required to bruise the abdomen. Evidence-based clinical practice guidelines for medical assessment and management of injuries should be followed.



Clinical practice guidelines for medical evaluation of physical injuries:

- [Medical Assessment of Bruising in Suspected Child Maltreatment](#)
- [Medical Assessment of Fractures in Suspected Child Maltreatment](#)

Due to the high prevalence of traumatic head injuries associated with CST, screening for head injuries should be standard practice. Loss of consciousness, headaches, memory loss, and difficulty concentrating are typical symptoms of head injury. Patients may require head imaging to rule out intracranial findings. Concussion counselling and management strategies can provide symptom relief. [Guidelines for Pediatric Concussion Care](#) should be followed to ensure best practices in recognition, assessment, and management.

Strangulation can lead to a range of serious injuries, including hypoxic-ischaemic brain injury and injuries to the vasculature of the neck. A comprehensive evaluation should be completed for patients who report or show signs of strangulation. This includes forensic documentation and a low threshold for imaging with CT angiogram of the head and neck. [Strangulation Aftercare Instructions](#) should be provided to patients for monitoring and management of symptoms following discharge from hospital.

Characteristics of inflicted trauma generally include injuries occurring in protected parts of the body, injuries with a patterned appearance, and explanations that are inconsistent with the mechanism of injuries (Greenbaum et al., 2015). Objectivity, accuracy, clarity, and completeness are essential in medical documentation of acute and healed injuries. Written notes and body-maps should be supplemented with forensic photography consisting of various orientations and a scaling device. This is important given the potential medicolegal implications of health records in future criminal court proceedings.

2.8. MENTAL HEALTH AND SOCIAL SUPPORT

2.8.1. Mental Health Presentations and Provider Roles

CST pervades body and mind. It can rupture a child's sense of self, safety, and security at a critical period of development. The mental health effects of coercion, exploitation, isolation, and violence can be severe and enduring, as outlined in section 1.3.7 of the protocol. Children with a history of sex trafficking experience high rates of post-traumatic stress disorder, affective disorders, and adjustment disorders, among other conditions (Oram et al., 2015; Ottisova et al., 2016). For those with past or present exposure to multiple other types of toxic stress and trauma, effects are interactive and cumulative. Individual responses are influenced by personal and environmental vulnerabilities and resources. An important component of a community response protocol is a continuum of trauma-informed mental health care for children and their families that recognizes the wide-ranging impacts of CST, alongside other adverse experiences, and promotes safety, healing, and healthy development.

Mental health care providers work in a variety of settings, including primary care clinics, hospital-based inpatient and outpatient programs, community-based organizations, and private practices. Mental health services are provided primarily by clinical psychologists, psychiatrists, social workers, and psychotherapists in generalist or specialist roles. Clinicians working with children affected by sex trafficking should be registered with a regulated professional body, have clinical supervision available, and be familiar with sentinel CST literature and recommended mental health practices (Basson et al.,

2018; Ijadi-Maghsoodi et al., 2016; Robitz et al., 2022; Salami et al., 2018; Scott et al., 2019). It is important for those providing therapy to be highly knowledgeable and skilled in developmental trauma, biopsychosocial aspects of CST, and evidence-guided, trauma-focused assessment and treatment approaches. If hybrid models of in-person and virtual services are provided, guidelines for trauma-informed telemental health care should be consulted (Azzopardi et al., 2021; Briere et al., 2020).

Children can benefit from integrated, multimodal psychotherapeutic approaches that attend to the unique dynamics of commercial sexual exploitation, complex trauma, and co-occurring mental health and addiction issues, such as anxiety, depression, and substance use disorder. This is typically provided in conjunction with multiagency supports addressing overlapping issues related to child protection, criminal justice, and housing insecurity, among others. Promising interventions have been proposed to foster healing for sexually exploited children, including intensive case management, psychoeducational groups, and residential programs (Moynihan et al., 2018). Evidence-based assessment and treatment approaches designed for comparable social problems may also apply to this population (O'Brien et al., 2022). Therapeutic interventions for CST and converging problems are most commonly offered on an individual basis. Family and group modalities and peer support may also be beneficial, depending on circumstances and needs through the recovery process. Duration of work can range from a single session to years-long treatment.

Direct and indirect mental health care provider roles:

- Clinical consultation and case conferencing
- Suicide risk screening, assessment, and management
- Crisis intervention and safety planning
- Anticipatory guidance and psychoeducation
- Trauma-focused assessment and treatment
- Substance use screening, assessment, and treatment
- Intensive residential treatment
- Pharmacotherapy
- Parent/caregiver and family support
- Case management
- Outreach and resource links
- Prevention and advocacy
- Research and education

Specialized CST mental health and trauma services in Toronto Region:

- [The Hospital for Sick Children, Lotus Health](#)
- [Boost Child and Youth Advocacy Centre](#)
- [Native Child and Family Services of Toronto](#)
- [Strides Toronto](#)
- [Covenant House Toronto](#)
- [Victim Services Toronto](#)
- [Native Women's Resource Centre of Toronto](#)

Refer to section 3.1 of the protocol for a directory of additional mental health and trauma services in Toronto and Greater Toronto Area.

Therapeutic Engagement and Goals

The mutual trust and support of a mental health clinician or team can have a profound impact on children's healing process and post-traumatic growth. Trauma-focused mental health care in CST aims to help keep children safe and healthy by building resilience in the face of trauma and adversity. This begins with honouring where the client currently is and where they want to be. The specific types of services, supports, and strategies required to help clients rebuild their lives will vary based on individual needs, strengths, and goals across different stages of exploitation and recovery. Goals should be personalized, and goal setting should be a collaborative process between the client and clinician. Assessment of symptom complexity and life circumstances should inform carefully tailored intervention plans. Before commencing, it is important to determine if mental health supports were previously provided, or are currently being provided elsewhere, to avoid duplication and enable integration.



Guiding mental health care principles:

- Trauma-informed
- Relationally-focused
- Child-centred
- Holistic and flexible
- Collaborative
- Harm-reduction
- Strengths-based
- Developmentally-sensitive
- Empowerment-driven
- Anti-oppressive and anti-racist
- Culturally-attuned
- Social justice-aware
- Critically-reflective
- Evidence-guided

Meaningful mental health care goals:

- Build engagement and trust.
- Reduce risks and enhance safety and stability.
- Understand relational trauma and exploitation.
- Retrain the brain to enhance resilience.
- Develop distress tolerance, emotional regulation, and coping skills.
- Increase sense of identity and belonging.
- Improve self-concept and self-efficacy.
- Regain sense of agency and control.
- Foster healthy attachment relationships.
- Strengthen support system.

Relationship-based models of mental health care are especially crucial with this population of children who have experienced abuses of power by adults. Attention to power dynamics and how the relational effects of CST, particularly shame and distrust, impact the therapeutic relationship is important. Using the trauma-informed care and relationship-focused strategies proposed in sections 2.1.2 and 2.1.4 of the protocol, developing a therapeutic alliance grounded in mutual respect, authenticity, empathy, and trust should be a priority at the outset and throughout the helping relationship. An extended period of relationship building prior to commencing treatment is recommended (Hopper, 2017). As stability and continuity are key to engagement, maintaining a consistent therapeutic presence is vital. In the context of disrupted and exploitative caregiving and intimate relationships, developing secure attachment within the treatment

relationship is a primary intervention (Basson et al., 2018). Patterns of engagement and disengagement and relational ruptures and repairs should be expected and processed as a therapeutic tool.

It is necessary to assess and address relational barriers to engagement in therapy. Many children seeking mental health care for CST and related challenges present with extensive histories of negative interactions with providers and unsuccessful attempts at treatment, which reinforce distrust, shame, and hopelessness. This can contribute to reluctance to commit to accessing support and difficulties with engaging and connecting. Mental health clinicians should explore clients' prior experiences with providers and treatments and validate feelings of distrust, skepticism, and ambivalence. Communicating how this intervention will be different from the others will help to instill hope, offer reassurance, and encourage follow through. Offering flexible services that adapt to physical absences, emotional distancing, and patterns of testing and rejecting demonstrates understanding and acceptance. Clients should be collaboratively involved in setting the agenda, boundaries, and pace of the work. This shows that their voice matters and strengthens the alliance.

"I had a therapist when I was growing up that knew a bit of what was going on, but she also knew that she couldn't fix everything for me. So her approach was more about survival than it was about recovery. I was not in a headspace to be in recovery because I was still experiencing trauma. Instead, she helped me survive everything, and even though she didn't really give me "treatment," she helped to keep me alive, which allowed me to actually receive treatment for recovery from those traumatic events when I was ready and older. Even though she didn't get to "fix" or "treat" my issues, she played the most important role in my life by helping me survive it all." (Survivor)

2.8.2. Crisis Intervention and Short-Term Support

Regardless of stage, the nature of CST and associated trauma is often characterized by recurring periods of instability and crisis. Physiological and emotional dysregulation resulting from CST and other trauma exposures contributes to disruptions in mood and behaviour. This is exacerbated by chaotic life circumstances, dysfunctional family systems, untreated physical and mental health conditions, and problematic substance use, resulting in unpredictability and turbulence.

Models of trauma-informed mental health care should be structured to accommodate fluctuating needs, episodes of crisis, and inconsistent engagement patterns. Mental health clinicians should be prepared to respond to psychiatric and situational emergencies and urgent needs as they arise. At times of crisis, trauma-informed interventions should focus on meeting basic needs and addressing acute medical and mental health concerns. Ensuring safety, building rapport, demonstrating calm and care, offering validation, containing and de-escalating, modelling grounding strategies, and reinforcing help-seeking are foundational elements of crisis response. This may warrant temporary diversion away from service plans and adjustment of immediate goals. It can be helpful to make connections between crisis situations and longer-term treatment goals to restore hope for the future. Since returning for follow-up care is never guaranteed, it is important to capitalize on every clinical encounter as though it may be the last. Clients should feel as safe and grounded as possible before leaving the room each time.

Short-term support from mental health care providers may entail providing outreach services, consulting with other professionals, participating in multiagency case conferences, offering brief bridging to longer-



term services, and facilitating warm handovers to other providers. These interventions should focus on fostering engagement, contextualizing needs and strengths, and advocating for individualized, comprehensive, coordinated trauma-informed care plans.

Suicide Risk Screening and Assessment

Approximately one-third of treatment-seeking children who have experienced trafficking present with a history of deliberate self-harm and suicide attempts (Ottisova et al., 2018). Self-harm and suicidal thoughts and behaviours are reactions to trauma and consequences of dysregulation. Self-harm (e.g., cutting) may be used to relieve emotional distress or overcome a sense of numbness. Not all clients who self-harm are suicidal. However, self-harm and suicidal ideation can co-occur, and self-harm is a risk factor for future suicide attempts. Differentiating between non-suicidal self-harm and suicidal behaviours requires assessment of intentions.

When victims of CST are focused on day-to-day survival, they may not present with self-harm in explicit forms or clear suicidal ideation with a plan to die. There may be passive indicators, such as high-risk sex practices or severe substance use, which are not consciously perceived as having self-harming or suicidal intent. There may be active denial or minimization of risk. Apathetic or disconnected presentations are common. This should be understood in the context of life circumstances that do not allow time or space to fully recognize the impact of trauma and unsafe behaviours due to preoccupation with meeting basic survival needs.

Anti-human trafficking organizations should provide suicide prevention training and have protocols in place for the identification and management of suicidal ideation and behaviour. Trauma-informed screening for risk of suicide should be a consideration at every visit. [Suicide Risk Assessment Tools](#) can help to identify the presence of suicidal desire, intent, capability, risk factors, and protective factors. Use of a brief, validated suicide risk screening tool, such as the [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#), can be systematically and feasibly implemented in most health and social service settings (Azzopardi et al., 2020; Posner et al., 2011). The C-SSRS screener version is comprised of six yes/no questions to help identify suicidal thoughts and behaviours within the past month in children over 10 years of age. Results inform the nature of support required. A positive screen necessitates further suicide risk assessment, safety planning, and ongoing management. Depending on severity of risk and intention, immediate transfer to an emergency department or acute care centre may be required.

- *Have you wished you were dead or wished you could go to sleep and not wake up?*
- *Have you actually had any thoughts of killing yourself?*
- *Have you been thinking about how you might kill yourself?*
- *Have you had these thoughts and had some intention of acting on them?*
- *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*
- *Have you ever done anything, started to do anything, or prepared to do anything to end your life? If yes, how long ago did you do any of these?*

Suicide risk screening tools are meant to inform, not replace, clinical judgment. They should be incorporated within more comprehensive clinical assessments. It is important to be aware of the limitations of screening tools related to measurement and cultural relevancy. A negative screen does not eliminate the risk of suicide or need for ongoing assessment and monitoring. More in-depth discussion about mental health, relationships, and hopes for the future will garner additional insights. Culturally-responsive suicide risk assessment with young people of colour considers factors such as stigma, acculturation, racism and

discrimination, health care and community infrastructure, community violence, neighbourhood resources, family history and values, and ethno-racial socialization (Molock et al., 2023).

Safety Planning

Risk of harm to self by self, of self by others, and by self of others is an inherent part of sex trafficking for many children. Danger may present itself in the form of self-injury and suicide, substance use, unsafe sex practices, running away, gang activity, access to weapons, and direct or indirect exposure to psychological, physical, or sexual violence by traffickers and others. Level of risk tends to increase at certain stages, such as when severely entrenched in the life, attempting to exit, involving the police, and testifying in court. Continually assessing and re-establishing safety is a core component of violence- and trauma-informed mental health care.

Safety planning is an ongoing, collaborative process to mitigate risk of acute harm. This begins with the service provider communicating genuine care, concern, support, and hope. Realistic safety plans should be co-created with clients, reflecting their voice and concerns. There can be a therapeutic element to safety planning in that it validates worries and self-worth and puts into practice some of the skills that are targeted in treatment (e.g., self-awareness, verbalizing emotions, coping strategies).

Planning for safety requires exploration of the client's understanding of risk and danger, what alerts them to risk, and what constitutes a safe situation or relationship from their perspective. Both internal and external sources of threat should be identified and addressed. This includes access to lethal means and exposure to potentially harmful people, places, and things (e.g., drugs, weapons, social media). The safety plan should incorporate risk and danger recognition strategies, alternative methods of coping and self-soothing, harm-reduction approaches, problem-solving skills, and systems of support and protection, such as safe people, places, and resources to access for help. This may include trusted family members, friends, crisis helplines, and emergency services. Assessment of parent/caregiver capacity to help keep their child safe may be a necessary component of safety planning.

Personalized safety plans should be carefully documented in the file and regularly revisited and revised to reflect changing states and contexts. Safety planning interventions with clients in unsafe situations can be facilitated by structured toolkits and smartphone applications.

Safety planning resources:

- [Stanley-Brown Safety Planning Intervention](#)
- [Children's Hospital of Eastern Ontario, My Safety Plan](#)
- [Hope by CAMH: Suicide Prevention Mobile App](#)
- [Canadian Human Trafficking Hotline, Safety Planning](#)

Refer to sections 2.1.3 and 3.2.6 of the protocol for additional safety planning considerations and resources.

Psychoeducation

Psychoeducation is a key component of crisis intervention, safety planning, and short-term counselling with children and families impacted by sex trafficking. It is also integrated throughout more intensive trauma



assessment and treatment to build awareness and regulatory capacity. Providing psychoeducation helps clients to better understand and cope with their experiences, conditions, and challenges by arming them with information and empowering them with knowledge and strategies to make decisions in their own best interests. Gradual exposure to information can be an effective way of establishing common language and developing comfort with difficult concepts.

Some trafficked children have never experienced healthy relationships with secure attachments and appropriate boundaries. Early sexual encounters linked with manipulation, coercion, and violence contribute to feelings of confusion, self-doubt, and shame. Cognitive distortions and irrational beliefs resulting from, and contributing to, mental health and trauma effects are commonly reinforced by traffickers as control tactics (e.g., *“He’s the only one that will ever love me,” “This was my choice.”*), influencing feelings and behaviours. CST functions by altering reality, limiting access to information and options, and undermining self-determination and autonomy.

Psychoeducation can be a compelling way of counteracting these dynamics by normalizing and destigmatizing experiences and responses, confronting deeply held misconceptions, creating a greater sense of control, and imparting hope. Increasing awareness about CST victimization and traumatization, and how personal experiences with systemic discrimination and marginalization exacerbate risk and impact, can effectively decrease internalized blame, shame, and stigma. Teaching skills for engaging in healthy relationships, regulating emotions, and coping with stress can enhance safety and well-being. This enables school attendance and academic achievement. Verbal information can be supplemented with multimedia education tools and infographics for added effect.

Psychoeducation can be provided on an individual basis or in group settings with cautions attached. Most groupwork includes a psychoeducational component. Groupwork in CST has the potential to reduce social stigma and isolation and build community, but it can also present risks when children come together at different stages of exploitation and recovery. Engagement in the recruitment of others should be acknowledged as a CST stage and survival strategy for some and addressed at the outset for prevention purposes. General distrust of others can impede group cohesion. Exposure to others with varying levels of trauma can be activating. Individual assessments should be conducted to carefully determine psychoeducation group composition, and group dynamics should be closely monitored.

General psychoeducation topics:

- Impact of toxic stress and trauma on mind and body
- Adaptive nature of traumatic stress responses for survival
- Common feelings of shame and guilt
- Stress reduction, emotional regulation, coping, and self-care strategies
- CST relational dynamics and trauma bonds
- Warning signs of luring and grooming
- Enmeshment and entrapment tactics
- Risks of technology-facilitated exploitation and internet safety strategies
- Elements of healthy (and unhealthy) relationships
- Principles of healthy sexuality and consent
- Motivations for, and harms of, engaging in high-risk behaviours
- Self-protection and harm-reduction strategies
- Social competencies and life skills
- Systemic oppression and social injustices
- Multisystem roles and processes
- Sources of support and treatment options

Examples of physical and cognitive grounding techniques and coping strategies:

- Focus on the here-and-now.
- Notice breathing. Inhale and exhale to a slow count.
- Use progressive muscle relaxation.
- Describe surroundings in detail using all senses.
- Count to 10 slowly. Count backward from 150 in 7s.
- Think of favourites (e.g., colour, food, clothing).
- Carry a grounding object.
- Notice body sensations (e.g., feel weight in chair, wiggle toes).
- Run cool or warm water over hands.
- Hold icepack against face or chew ice cubes.
- Use guided imagery.
- Take care of body and mind (e.g., sleep, exercise, nutrition).
- Sit in nature.
- Use movement (e.g., yoga, walking).
- Set a structured schedule.
- Practice arts (e.g., music, dance, drawing).
- Engage in leisure activities that bring joy.
- Write in a journal.
- Make time for reflection.
- Use positive self-talk. Say kind and encouraging things to self.
- Set healthy boundaries.
- Connect with higher power (e.g., prayer, nature).
- Build social connections.
- Reach out to safe people for support.

“We each have primary workers. Mine has never interrogated me, ever. I’m more open about things now than I was before. We’ve had conversations about it, but she’s never made me talk about it or anything like that. They’re definitely trauma-informed. I have a thing, I dissociate. I guess it was happening a lot and they ended up making a bunch of grounding boxes, and they put them all around the house. It helped a lot, which is really cool. And they also listen. They’re like equal level with you.” (Survivor)

Open and nonjudgmental dialogue about sexual health and consent should be incorporated into psychoeducational components of medical and mental health support, as discussed in section 2.7.2 of the protocol. For guidance on sexual health conversations with young people who have experienced trauma, see [Sexual Health and Trauma](#).

Principles of healthy sexuality:

- Consent (vs. coercion)
- Non-exploitative
- Honesty
- Shared values
- Mutual pleasure
- Protection from risks (STIs, pregnancy)

Elements of sexual consent:

- Fully informed
- Freely given
- Mutual agreement
- Communicated (silence or passivity does not equal consent)
- Fully conscious (not incapacitated)
- Reversible at any time
- Asked for each time
- Enthusiastic

From a legal perspective, consent means voluntary agreement to engage in the sexual activity at the time it takes place. This requires a conscious operating mind capable of granting, revoking, or withholding consent to each and every sexual act. The individual must be capable of understanding the physical act, the sexual nature of the act, the specific identity of the sexual partner, and that they have a choice to refuse to participate in the sexual act. Refer to section 1.4.2 of the protocol for legal age of consent for sexual activity in Canada.

Psychoeducational resources for youth:

- [The Trap: Human Trafficking Digital Education Tool](#) (to be facilitated by an adult)
- [What is Sex Trafficking?](#)
- [Sex Trafficking: What is it?](#)
- Sex Trafficking: Youth Guide (available from CAST or CHT)
- [Speak Out: Stop Sex Trafficking – Addressing, Preventing and Ending the Sexual Exploitation of Indigenous Women and Youth](#)
- [Covenant House Toronto, Traffick Stop: Sex Trafficking 101](#)
- [Stop Sex Trafficking in Ontario](#)
- [Aura Freedom International, Human Trafficking Info Hub](#)
- [I Am Little Red](#)
- [What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them](#)
- [How Trauma Can Affect Your Window of Tolerance](#)
- [Mapping Your Nervous System's Response to Trauma](#)
- [Using Drugs to Deal With Stress and Trauma: A Reality Check for Teens](#)
- [Using Grounding to Detach from Emotional Pain](#)
- [Six Ways to Practice Self-Care](#)
- [Caring for Yourself](#)
- [A Guide for Human Trafficking Survivors](#)
- [Can You See Me?](#)
- [SickKids, About Kids Health, Mental Health Learning Hub](#)
- [SickKids, About Kids Health, Sexual Health Learning Hub](#)
- [The Society of Obstetricians and Gynaecologists of Canada, Sex & U](#)
- [Action Canada for Sexual Health and Rights, Sexual Health Information Hub](#)
- [Planned Parenthood Toronto, Factsheets](#)
- [Amaze](#)
- [Likely Story: The Game](#)
- [A Quick Guide on Sexual Image Based Abuse](#)
- [Tech Safety Canada](#)
- [Get Cyber Safe](#)

Refer to section 3.2.11 of the protocol for additional psychoeducational resources.



2.8.3. Trauma-Focused Therapy

Through trauma-focused therapy, children gain understanding of the causes and effects of trauma in their lives. Trauma-focused therapy with children exposed to sex trafficking centres on addressing trauma resulting from, or increasing risk of, CST that may be at the root of presenting problems and symptoms. Not all CST victims and survivors demonstrate the functional impairments associated with complex trauma. Prevalence of PTSD and C-PTSD in trafficked children has been found to be 13% and 8% respectively (Evans et al., 2022), though possibly underestimated due to research limitations. Trauma-focused assessment and treatment work toward identifying and alleviating symptoms of post-traumatic stress in children who may or may not meet the diagnostic criteria for PTSD or C-PTSD.

Relevant theoretical frameworks for trauma-informed therapy models include psychodynamic theories, attachment theories, cognitive and behavioural theories, social justice theories, and trauma theories, with neuroscience influences. Therapeutic modalities used with most children who have experienced sex trafficking should be grounded in the principles of trauma-focused intervention. Research evaluating the effectiveness of trauma therapy tailored to the distinct needs of the CST population is currently limited, though mental health practice recommendations have begun to emerge (Ijadi-Maghsoodi et al., 2016; Salami et al., 2018). Trauma-focused work ranges from brief intervention to intensive long-term treatment.

Resources to guide therapy practices:

- [Psychotherapy for Commercially Sexually Exploited Children: A Guide for Community-Based Behavioral Health Practitioners and Agencies](#)
- [Trauma-Focused Cognitive Behavioral Therapy for Commercially Sexually Exploited Youth](#)
- [Promising Practices: An Overview of Trauma-Informed Therapeutic Support for Survivors of Human Trafficking](#)
- [Supporting Survivors of Human Trafficking: Counselling Guide](#)

It is beneficial to present the option of trauma therapy as a possibility for change and pathway forward. The informed consent process should include a clear explanation of the purpose, structure, and content of trauma therapy, in addition to limits to confidentiality. If there is a decision to proceed with assessment and treatment, clients should be advised of their collaborative role in determining pacing, taking breaks, and changing topics as needed. This creates opportunities for choice, self-reflection, and limit-setting. It also fosters the therapeutic alliance and self-determination.

Distrust of adults and systems, extreme self-reliance, avoidant relational patterns, discomfort with intimacy, trauma denial or minimization, triggering content, ongoing control by traffickers, vigilance about mandated reporting, and trouble keeping track of appointments are among the many factors that can impede treatment engagement and completion. Trauma-informed care plans, as reviewed in section 2.1.2 of the protocol, will require flexibility and accommodations. Absences should be anticipated, and disruptions should be tolerated to some extent. While important to move at the client's pace, avoidance should be recognized as a core symptom of trauma among children who have experienced commercial sexual exploitation (Cole et al., 2016). Intensive engagement, persistence, encouragement, and boundaries are required to avoid reinforcing maladaptive coping in the form of avoidance that leads to further harm. The motivational interviewing strategies presented in section 2.4.3 of the protocol can help to optimize engagement and movement toward change.

Trauma Assessment

The goal of trauma-focused assessment is to gain understanding of the child in the context of their environments, their traumatic experiences, and their post-traumatic stress reactions. This is the first step to clinical formulation, goal setting, and treatment planning, as well as broader multisystem service coordination. Assessment is an ongoing, dynamic process that is woven together with engagement, psychoeducation, and treatment. Children engage in help-seeking at varying states of physical and psychological safety and readiness for change. Evolving needs and situations require continuous assessment over time. A child-centred, trauma-informed approach to assessment takes care to create a safe environment and not overwhelm clients with too many sensitive questions, intake forms, and screening instruments at the outset. Learning about a person and their experiences takes time, space, trust, and vulnerability.

As discussed in section 2.4.1 of the protocol, assessment structures will vary depending on clinical role, purpose, and modality. While no single standard exists, following general guidelines for the [Assessment of Complex Trauma](#) derived from collective clinical expertise and research is recommended. Some children present with a myriad of diagnoses for medical, mental health, and neurodevelopmental disorders. There may have been little or no prior connection between these diagnoses and traumatic experiences. A trauma assessment allows for the trauma history to ground understanding of the full range of symptoms and treatment needs. Clinicians should differentiate between trauma disorders and psychiatric disorders and between primary and secondary mental health needs. For some children, there may be a primary diagnosis pre-existing or unrelated to trauma that requires prioritizing (e.g., psychotic disorder, substance use disorder). It should not be assumed that everyone who has experienced CST requires trauma treatment applications.



The assessment process can be empowering, as it gives voice to struggles, needs, strengths, and goals. Using the strengths-based approach proposed in section 2.1.4 of the protocol extends assessment from problems to possibilities. Learning about who children were before the exploitation, and who they currently are apart from their symptoms, fosters engagement and offers a more complete profile of assets that can be mobilized in treatment. The process of reframing negative self-concept and problem-saturated narratives begins at assessment. The language of questions and comments should reinforce resiliency instead of pathology (e.g., “*Tell me how you managed to get through this difficult experience*” instead of “*What maladaptive coping strategies do you use?*”).

Assessment of trauma exposures and responses entails developing an in-depth understanding of the child in the context of their developmental milestones and social environments to fully appreciate impact. This includes consideration of other interpersonal traumas, as well as system-induced and identity-based traumas such as racial trauma. Assessment should not focus on the specific details of CST events early on, as recalling traumatic memories and talking about traumatic events prematurely can be emotionally overwhelming and dysregulating. It is important to note again that not all victims and survivors of CST characterize their exploitative experiences as traumas. Integration of psychoeducation strategies can help to gradually expand perspectives. Regulatory capacity should be built throughout the assessment process.

General trauma assessment domains:

- Safety and risk factors (including self-harm and suicide)
- Family relationships and attachment history
- Adverse childhood experiences and toxic stress
- Trauma exposure (relational, identity-based, system-induced, generational, collective)
- Trauma-related symptoms (onset, duration, intensity, frequency, context)
- Trauma reminders and triggers
- Other mental health symptoms and disorders
- Emotional (dys)regulation and coping styles
- Substance use
- Self-concept and cognitive appraisals
- Unmet needs and stressors
- Family functioning and response to trauma
- Social skills and peer relationships (online and offline)
- Culture and community
- System involvement
- Education and employment
- Strengths and protective factors (including social supports)
- Treatment readiness

Post-traumatic stress symptoms:

- Persistent involuntary re-experiencing of the traumatic event (e.g., flashbacks)
- Avoidance, or efforts to avoid, trauma-related reminders, thoughts, or feelings
- Increased trauma-related arousal and reactivity (e.g., hypervigilance)
- Negative thoughts or feelings associated with the traumatic event (e.g., self-blame)

Additional symptoms of complex trauma:

- Affect dysregulation
- Negative self-concept
- Disturbed relationships

Children who have experienced sex trafficking commonly present with fragmented histories due to trauma-related memory impairment and frequent changes in caregivers, communities, residences, and schools. This can result in difficulties providing a coherent developmental history, as well as access to few reliable historians to provide accurate information. Where possible, obtaining data from multiple collateral sources, such as parents and teachers, or existing records from prior assessments can help to identify additional information and perspectives to integrate into the assessment.

Clinical interviews with children and collaterals can be supplemented with a variety of [Complex Trauma Standardized Measures](#) with good psychometric properties. While not diagnostic, validated trauma screening and assessment tools can help to inform the clinical assessment and formulation. Systematic use can help to normalize symptoms, reduce disclosure hesitancy, and facilitate discussion. They should be selected based on goodness-of-fit with the child, family, and service. Cultural applicability should be a consideration, as most are centred on Western concepts and criteria that may not resonate with differing worldviews. Training in administration and interpretation is required.



Examples of trauma exposure and symptom screening tools:

- [UCLA Posttraumatic Stress Disorder - Reaction Index \(UCLA PTSD-RI\)](#)
- [Trauma Symptom Checklist for Children \(TSCC\)](#)
- [Traumatic Events Screening Inventory - Child Report Form \(TESI-CRF\) and Parent Report Revised \(TESI-PRR\)](#)
- [Pediatric Traumatic Stress Screening Tool \(PTSST\)](#)
- [Child PTSD Symptom Scale for DSM-5 \(CPSS-5\)](#)
- [Child and Adolescent Trauma Screen \(CATS\) - Youth Report and Caregiver Report](#)
- [Child Trauma Screen \(CTS\)](#)
- [Childhood Trauma Questionnaire \(CTQ\)](#)

Refer to section 3.2.10 of the protocol for additional trauma screening and assessment tools.

Consolidating the information gained through the trauma assessment process informs collaborative goal setting and individualized trauma-focused treatment planning. If the trauma assessment reveals that the child is not currently experiencing clinically significant post-traumatic stress symptoms requiring trauma-focused treatment, other forms of support may still be indicated. It should be remembered that trauma symptoms can take subtle forms or may emerge at a later time. Using non-technical terms, assessment findings should be communicated to the child (and parent/caregiver with consent, if involved) as partial information reflecting the current point in time. When multiple agencies are involved, results should be shared with consent, if relevant to their role.

Assessment includes consideration of stage of change, readiness for treatment, and willingness to engage. The clinical decision to proceed with trauma-focused treatment before reaching a place of safety and stability should be weighed carefully. Safety and stabilization mean different things to different people. Some children survive in chronically unsafe and unstable environments or unsafe yet stable environments. It may not always be in their best interests to wait until they are safe and stabilized to begin trauma work. While clients may not be ready for safe trauma processing, treatment targeting the goals of enhancing motivation to change and building safety and stability should move forward. For some, pharmacotherapy combined with psychotherapy can help to facilitate stabilization.

Current exploitation and recovery status should be considered when interpreting symptoms and determining corresponding treatment goals. For example, children who have recently exited from trafficking commonly experience disordered sleeping as a result of chronic sleep deprivation, requiring integration of sleep hygiene into treatment; whereas this may not be a realistic goal for those actively being trafficked. There may be incongruence between what the client and clinician identify as salient for the treatment plan, particularly where safety is concerned. Reaching consensus on treatment goals and tasks will strengthen the therapeutic alliance and promote treatment success. For this to happen, clients must feel heard, understood, and validated.

Trauma Treatment

Directed by the trauma assessment and treatment goals, trauma-focused treatment plans will vary depending on individual clinical presentations, cultural backgrounds, external events, and responses to treatment. There are a number of evidence-based and evidence-supported [Trauma Treatments](#) for children, ranging from robustly evaluated to newly emerging. Treatment approaches should be adapted to address the unique interpersonal dynamics (e.g., coercive control, trauma bond) and conditions (e.g., recurring

crises, treatment interruptions) of CST. Though mechanisms of change differ across various modalities, there are common components to most trauma-focused treatments and similar themes that tend to emerge. With the therapeutic relationship as one of the primary drivers of change and healing, treatment phases broadly centre around establishing safety and stability, processing trauma, developing alternatives to unhealthy responses, consolidating progress, and re-engaging in a meaningful life.

Examples of trauma-informed and trauma-focused treatment modalities:

- [Trauma-Focused Cognitive Behavioral Therapy \(TF-CBT\)](#)
- [Integrative Treatment of Complex Trauma for Adolescents \(ITCT-A\)](#)
- [Dialectical Behavioral Therapy \(DBT\)](#)
- [Trauma Affect Regulation: Guide for Education and Therapy for Adolescents \(TARGET-A\)](#)
- [Eye Movement Desensitization and Reprocessing \(EMDR\)](#)
- [Attachment, Regulation and Competency \(ARC\) Framework](#)
- [Seeking Safety: Treatment for PTSD and Substance Abuse](#)

Common components of trauma-focused treatments:

- Ongoing focus on client engagement and therapeutic alliance.
- Enhance safety and reduce risk. Teach safety skills.
- Increase understanding of trauma, sexual exploitation, coercive control, and trauma bonds.
- Address attachment needs arising from relational trauma and foster secure attachments.
- Construct a trauma narrative and engage in trauma memory (or trauma theme) processing when safe to do so (i.e., no active CST).
- Recognize post-traumatic stress reactions, trauma reminders, and survival strategies. Strengthen coping to reduce or eliminate trauma-related symptoms.
- Validate thoughts, feelings, and behaviours. Understand connections between them and undo unhealthy connections. Identify and balance cognitive distortions.
- Address the role of trauma-induced shame and build self-compassion.
- Increase ability to name, express, and regulate emotions. Develop distress tolerance, grounding, and self-soothing skills.
- Support self-determination, self-advocacy, and self-efficacy.
- Develop understanding of healthy sexuality, body ownership, consent, and boundaries.
- Attend to developing identities (e.g., gender, sexual, racial) and social context.
- Promote adaptive routines and prosocial activities as healthy replacement behaviours.
- Build a robust network of non-exploitative relationships and community supports.
- Encourage themes of hope, resilience, and strength. Build on strengths and consolidate skills to apply to everyday life challenges.
- Rebuild and strengthen relationships. Involve family or partners in treatment if safe.
- Attend to power imbalances and impacts of transference and countertransference on the therapeutic relationship.
- Monitor progress and evaluate treatment effectiveness.
- Recognize and mitigate secondary traumatic stress and vicarious trauma in the therapist.



Applying a systems approach using multiple intervention modalities is important with this population (Basson et al., 2012, 2018). Treatment structure should allow for some flexibility in application, including number of sessions, based on individual needs and circumstances. Linear progression through the typical stages of trauma treatment may be unrealistic for some CST clients, particularly those still involved in the life. The therapeutic process may need to be slowed down and adjusted to accommodate engagement difficulties, intermittent crises, and prolonged absences. This underscores the need for ongoing assessment to direct the course of treatment. Given the ebbs and flows of emotional states and external conditions, it is helpful to explore at the beginning of each session what the client is hoping to gain and work from there.

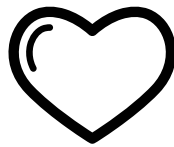
Building safety should always be an integral and ongoing part of treatment. Clients need to feel safe, grounded, and calm in order to process trauma in the body and mind. Extended time focused on engagement, safety, stabilization, and coping is usually required before moving forward with trauma processing. Considering the nature and extent of CST-related trauma, treatment approaches that do not require clients to provide a detailed trauma account may promote tolerability and reduce dropout (Salami et al., 2018). Dialectical behaviour therapy, for example, offers flexibility in this regard (Linehan, 2014). When there are multiple chronic traumas, they tend to be interrelated. Treatment goals should focus on the impact of traumatic experiences most significant to the client, connections between traumas, or unifying themes emerging across various trauma events related to safety, trust, intimacy, power and control, and self-worth.



Safety



Trust



Intimacy



Power and Control



Self-Worth

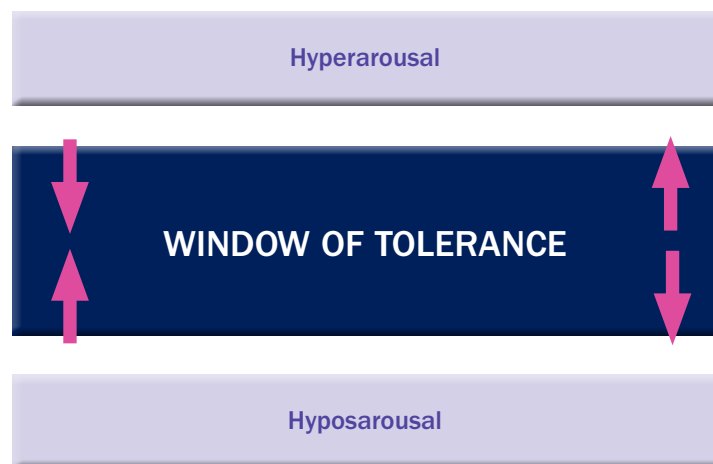
CST is distinct from other forms of childhood abuse and trauma in terms of the relational dynamics and trauma bond with the trafficker. Clinicians must be sensitive to the complexity of this attachment, without dismissing or minimizing the strength of the bond. As clients begin to unpack the coercive and exploitative elements of the relationship with a person they loved and trusted, they need space and support to process new insights and grieve the loss. Mixed emotions should be acknowledged and validated, while attending to safety risks associated with resulting dysregulation. Treatment should include strategies for optimizing safety and coping as they adjust to life away from the high-control relationship and find alternative ways to meet the needs previously fulfilled by the trafficker to prevent a return to the trafficker or another exploitative situation.

Another unique trauma treatment consideration for some CST victims and survivors is the effects of their involvement in recruiting others into trafficking, including feelings of guilt, shame, and identity confusion. This may need to be processed as another trauma, with help to understand their actions in the context of their own victimization, coercive control by traffickers, and trauma survival. Depending on the nature and extent of their offending behaviour and intersection with the criminal justice system, specialized victim-offender treatment may be required.

More than half of young people with substantiated commercial sexual exploitation experience post-traumatic cognitions, which are associated with higher levels of post-traumatic stress symptoms (Perry et al., 2022). The relational dynamics of CST make victims and survivors particularly vulnerable to

developing cognitive distortions about self and others. Trafficker enmeshment and entrapment tactics induce shame, self-blame, unworthiness, and hopelessness, which can create and maintain other trauma-related symptoms. An important component of processing trauma narratives in treatment is identifying maladaptive cognitions and negative appraisals (e.g., “*This was my fault,*” “*I’m damaged goods and no one will ever love me,*” “*I can’t trust anyone.*”) and replacing or balancing them with healthier thoughts. Efforts to change negative thinking patterns can impact the associated feelings and behaviours. New neural pathways can be formed and reinforced over time. This can be done effectively with cognitive behavioural techniques (Cohen et al., 2012, 2017).

Traumatized children need help identifying hyperarousal and hypoarousal states, returning their [Nervous System](#) to a state of calm, and expanding their [Window of Tolerance](#) to better cope with challenges (Siegel, 1999). Physiological and emotional dysregulation is a prominent feature of complex trauma. Victims and survivors of CST often have difficulty identifying, expressing, and modulating feeling states linked to sensorial trauma reminders. Dysregulation, with high levels of impulsivity or avoidance, contributes to high-risk behaviours, such as substance use, self-injury, disordered eating, running away, and unsafe sex, which in turn get reinforced as efforts to cope with dysregulation. These behaviours should be validated as originally serving a survival function in very difficult circumstances, which now may be causing more harm. Identifying internal and external triggers for maladaptive coping and reinforcing healthy replacement behaviours are central treatment aims. Since family conflict commonly activates dysregulation leading to risky behaviours, it is important to involve parents/caregivers in the treatment process when possible.



Alternatives to traditional talk therapies, such as arts-based and land-based therapies, can complement the mental health care plan. Some trauma-informed interventions incorporate somatic approaches, including mindfulness and other sensory-based practices (Polaris & Sanar, 2015). Grounding exercises have the potential to promote self-compassion and help calm the body’s stress response in the moment, particularly when flooded with emotion, thus enabling presence in treatment. These approaches should be used with caution, as they may be activating if engaged prematurely or without appropriate guidance.

Trauma treatment content and process should be monitored along the way. This includes progression toward goals, critical reflection on power dynamics and personal biases impacting the clinician-client relationship, transference and countertransference dynamics, and patterns of rupture and repair. Treatment concludes with a consolidation of new learning and change maintenance. With sensitivity to the attachment relationship that forms, planning for treatment termination should begin well in advance

to mitigate feelings of abandonment and rejection. A holistic approach to treatment entails connecting clients with additional and ongoing services to support self-efficacy, such as life skills training and financial literacy programs, as well as prosocial activities and hobbies to promote sense of self and support coping. Building positive and sustainable connections increases visibility and access to support as they regain a sense of purpose and belonging in the community. Refer to section 2.2.3 of the protocol for termination and transition considerations when moving from child-centred to adult-centred systems of care.

2.8.4. Substance Use and Addictions Services

Early mental health concerns are a potential pathway to later problematic substance use in young people, with rates of concurrence increasing with age (Henderson et al., 2021). Substance use co-occurs with commercial sexual exploitation in the range of 70% to 88%, with strong associations between substance use and mental health disorders (Bath et al., 2020; Cook et al., 2018; Varma et al., 2015). Substance use disorder (SUD) can be both a risk factor for, and consequence of, CST. Some children have pre-existing addictions that contribute to their engagement in sex for money for substances. This is a vulnerability that is targeted by traffickers. Substances may be used as a recruitment, entrapment, or reward strategy by traffickers to manipulate the mood and behaviour of their victims (Koepler et al., 2022). Substance dependence facilitates victim compliance and trafficker control. Substance use often continues as a means of coping with the trauma of exploitation and violence, while entrenched and after exiting, which can in turn exacerbate mental health symptoms. SUD and PTSD commonly co-occur in this population and are both characterized by emotional and behavioural dysregulation (Ijadi-Maghsoodi et al., 2016).

Service providers should gain understanding of the spectrum of substance use, neurobiology of addiction, and functional relationship between traumatic stress and substance use. Given the high rate of substance use in children exposed to sex trafficking, a systematic approach to substance use screening and intervention is recommended. [Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#) is an evidence-based public health model promoting early detection and appropriate management of substance use (Babor et al., 2007; Levy et al., 2016). Routinely administering a well-validated screening instrument can be an efficient and effective way of identifying substance use. For example, the [CRAFFT 2.1](#) is a brief screening tool designed to identify substance use, substance-related riding/driving risk, and SUD in individuals aged 12 to 21 years (Knight et al., 1999). The tool is comprised of a series of yes/no questions that can be administered by trained clinicians or self-administered. Two or more yes answers indicate that there may be a serious problem that requires further assessment.

CRAFFT = Car, Relax, Alone, Forget, Family or Friends, Trouble:

- *During the past 12 months, how many days did you drink alcohol, use marijuana, or use anything else to get high?*
- *Have you ever ridden in a **C**AR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?*
- *Do you ever use alcohol or drugs to **R**ELAX, feel better about yourself, or fit in?*
- *Do you ever use alcohol or drugs while you are by yourself or **A**LONE?*
- *Do you ever **F**ORGET things you did while using alcohol or drugs?*
- *Do your **F**AMILY or **F**RRIENDS ever tell you that you should cut down on your drinking or drug use?*
- *Have you ever gotten into **T**ROUBLE while you were using alcohol or drugs?*

Screening periodically can help to detect changes in substance use. When problematic use is identified, there should be an assessment of motivation to address the substance use. As suggested in section 2.4.3 of the protocol, change rulers can be used to elicit change talk and assess importance of, readiness for, and confidence to change from their perspective. If clients declare motivation to take steps toward reducing or eliminating substance use, brief intervention and a referral to specialized low-barrier substance use services should be offered. Safe detoxification and treatment may be provided on an inpatient or outpatient basis, depending on severity of use and clinical needs. Evidence-based interventions for SUD in youth should be made available (Becker et al., 2008; Steele et al., 2020; Yuma-Guerrero et al., 2012), though specialized programs to address the intersection of SUD and CST are lacking. Integrated approaches that treat both substance use and traumatic stress are recommended to optimize recovery. This may involve combinations of individual therapy, group support, and pharmacological treatment. [Seeking Safety](#) is one example of an evidence-based treatment model for youth with comorbid SUD and PTSD (Najavits, 2002b).

Total abstinence should not be a prerequisite for anti-human trafficking service eligibility, unless stopping drugs and alcohol is the client's goal. Expecting sobriety before safely detoxing and replacing unhealthy coping mechanisms with healthy coping mechanisms can cause further harm. Victims and survivors of CST may be ready to engage some support services, but not yet motivated or able to stop using substances. They may not view their substance use as a problem, or they may feel too overwhelmed with their life circumstances to change the behaviour. Motivation and capacity to change are enmeshed with symptoms of trauma and emotional dysregulation, underscoring the importance of attending to underlying issues.

Clients who continue to use substances should be supported using the stages of change framework, motivational interviewing, and harm-reduction strategies reviewed in sections 2.1.5 and 2.4.3 of the protocol. Strengthening motivation and commitment to behaviour change requires a nonjudgmental, relational, collaborative approach. Psychoeducation and counselling efforts should be directed toward helping clients gain a better understanding of why they are using, how it is affecting their health and well-being, how it is impacting the people who care about them, strategies for safer use, and alternative avenues for coping and self-soothing. It is also important to help family members build skills for talking to their children about substance use, reinforcing harm-reduction measures, managing stress and conflict at home, and supporting the treatment process.

Specialty substance use services in Toronto Region:

- [The Hospital for Sick Children, Substance Abuse Outreach Program](#)
- [Centre for Addiction and Mental Health, Youth Addiction and Concurrent Disorders Service](#)
- [Centre for Addiction and Mental Health, Substance Abuse Program for African Canadian and Caribbean Youth](#)
- [Breakaway Community Services](#)
- [Anishnawbe Health Toronto](#)

Substance use resources:

- [Substance Use and Substance Use Disorder: Overview](#)
- [Substance Use Disorder: How to Help Your Teen at Home](#)
- [How to Talk With Your Teen About Drugs: Communication Tips for Parents](#)



- [Talking With Teens About Alcohol and Other Drugs](#)
- [Using Drugs to Deal With Stress and Trauma: A Reality Check for Teens](#)
- [Helping Your Teen Cope With Traumatic Stress and Substance Abuse](#)
- [Understanding the Links Between Adolescent Trauma and Substance Use: A Toolkit for Providers \(2nd Ed.\)](#)

Refer to section 3.2.6 of the protocol for additional substance use and harm-reduction resources.

2.8.5. Nonoffending Family Support

Parents and other significant caregivers have the potential to be their child's strongest allies and natural sources of support and protection from sex trafficking. Feeling a sense of love, belonging, and safety at home offers the greatest defence against traffickers. Family variables mitigate level of risk, intensity of effects, and success of treatment. Positive familial relationships are a key factor influencing resilience in trafficking survivors (Knight et al., 2021). Family engagement has been shown to have the most significant impact on successfully exiting commercial sexual exploitation in childhood (Corbett, 2018). Reflective of service provider tendency to adultify young victims and survivors of CST, parents/caregivers are frequently excluded from their child's treatment or involved only minimally.

CST can be acutely and chronically stressful for families, underscoring the need for support, education, and guidance to rebuild and strengthen relationships. This community response protocol calls for mental health care to be extended to nonoffending parents/caregivers, including kinship and foster families, in the form of individual, group, or family interventions. Active engagement of parents/caregivers in child-focused treatment, with the child's consent, is recommended for optimal outcomes. Deciding who to include should be done in collaboration with the child by exploring the adults in their life with whom they feel safe and trust. It is important to determine that parents/caregivers were not perpetrators of abuse and have no affiliation with the CST situation before proceeding. There should be ongoing discussions and negotiations with the child to establish what personal information should and can be safely shared with family.

In some cases, parent/caregiver involvement is not in the child's best interests and potentially harmful. Some parents/caregivers do not perceive themselves as part of the problem or solution and are therefore unwilling to engage services. Some may be physically or emotionally unavailable to participate due to their own trauma, mental illness, medical conditions, substance use, incarceration, and abusive or neglectful behaviour. These parents/caregivers should be offered their own service referrals, with the goal of helping them to reach a place where they are willing and able to be involved in caregiving and treatment in a consistent, safe, and meaningful way. When attachment relationships are weak or beyond repair, it is critical to facilitate positive and consistent connections with other trusted adults.

Extensive child welfare system involvement and generational trauma are prevalent in the CST population. There may be unresolved relational and attachment-based traumas in the parent/caregiver-child relationship to process. Many parents/caregivers are coping with their own histories of childhood abuse, sexual assault, intimate partner violence, or other adversities, making it difficult to fully participate in their child's trauma treatment. Therapeutic content may activate their own traumatic memories and become overwhelming. This can impact the caregiving relationship and their capacity for being a source of support and protection. The need for individual parent/caregiver trauma treatment prior to, or in parallel with, child-focused work should not be overlooked.

“Managing my child’s care means subjugating my own self-care... It doesn’t really feel all that good. The implications of that is what I would call like a low-grade depression that makes it sometimes hard for me to sleep, so then I’m tired in the morning and I’m not getting out of bed and I don’t get to appointments.” (Parent of Child Victim)

For parents/caregivers who are open to seeking support for themselves or participating in their child’s treatment, there may be several engagement barriers to overcome. They may have competing household and childcare responsibilities, limited financial resources, distrust of providers, fear of being blamed, or little hope for change. Efforts should be directed toward collaborating with families to promote full engagement by problem solving to reduce barriers through material support, psychoeducation, and encouragement. Many parents/caregivers, especially mothers, have experienced adversarial and punitive relationships with providers and systems (Azzopardi, 2021). It is important to empower and partner with parents/caregivers in their child’s safety and recovery process, without shaming or blaming them for the situation. Focusing on the shared goal of keeping the child safe, validating their experiences and desire to help, and praising their efforts can alleviate self-blame, anxiety, and reluctance to engage.

Using trauma-informed support, anticipatory guidance, and psychoeducation, mental health care for parents/caregivers should focus on helping them cope with their distress, increasing their understanding of CST and trauma, and improving their ability to support, protect, and empower their child. This includes fostering positive relational parenting strategies, recalibrating developmentally-appropriate expectations, opening lines of communication, identifying and responding to trauma symptoms, learning to respond without reinforcing blame, setting healthy boundaries, and co-creating safety plans. For families where there has been a separation, reunification may present additional challenges. Children returning home after trafficking often have difficulty adjusting and reconnecting. There may be boundary-testing, lingering resentment, and rebellion against rules. More intensive family reunification support may be required.

Goals of parent/caregiver support:

- Identify and validate common parent/caregiver reactions, including negative emotions.
- Gain awareness of CST scope, stages, risk factors, and effects.
- Learn about technology, online harms, and cyber safety.
- Build capacity to identify threats, reduce risky behaviours, and provide protection. Reinforce safety plans and harm-reduction strategies.
- Increase knowledge about child development and healthy sexuality.
- Recognize and respond appropriately to child’s post-traumatic stress responses, trauma reminders, and family triggers.
- Understand how personal history of trauma impacts parenting and attachment.
- Promote healthy parent/caregiver-child relationship dynamics, open communication, and conflict management. Enhance empathy, attunement, and responsivity to child’s feelings and behaviours.
- Identify and manage dysregulation in self and child, develop positive coping strategies, and practice self-care. Role model self-regulated emotions and behaviours. Engage co-regulation.
- Establish developmentally-appropriate expectations, routines, and structure.
- Support child’s self-esteem, sense of belonging, emerging identity, and personal autonomy.

- Encourage positive reinforcement of prosocial behaviours.
- Identify and build on family strengths. Enhance safety and support system.

Psychoeducational resources for parents/caregivers:

- [Sex Trafficking Prevention: A Guide for Caregivers](#)
- [Covenant House Toronto, Traffick Stop for Caregivers](#)
- [What is Sex Trafficking?](#)
- [Speak Out: Stop Sex Trafficking – Addressing, Preventing and Ending the Sexual Exploitation of Indigenous Women and Youth](#)
- [Aura Freedom International, Human Trafficking Info Hub](#)
- [What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them](#)
- [Understanding Child Traumatic Stress: A Guide for Parents](#)
- [Complex Trauma: Facts for Caregivers](#)
- [Trauma and Your Family](#)
- [How a Caregiver’s Trauma Can Impact a Child’s Development](#)
- [Substance Use Disorder: How to Help Your Teen at Home](#)
- [How to Talk With Your Teen About Drugs: Communication Tips for Parents](#)
- [Talking With Teens About Alcohol and Other Drugs](#)
- [Staying Safe While Staying Connected: Tips for Caregivers](#)
- [A Guide for Trusted Adults: Practical Tips and Tools for Supporting Girls and Young Women Navigating Life Online](#)
- [Protect Kids Online](#)
- [Amaze for Parents](#)
- [Tech Safety Canada](#)
- [Get Cyber Safe](#)

Refer to section 3.2.11 of the protocol for additional psychoeducational resources.

2.8.6. Cultural Considerations and Traditional Healing Practices

Culture shapes understandings, sources, and expressions of trauma, healing, and wellness. It is important to recognize and appreciate the role and value of culture and tradition in health and healing journeys. Culture can ground one’s sense of identity, purpose, and belonging apart from sex trafficking. Providing culturally-attuned mental health care should be guided by the principles of allyship, respect, collaboration, humility, reflection, self-determination, anti-oppression, anti-racism, and social justice.

For Indigenous and Black communities in Canada, the systems designed to provide care and protection have been responsible for causing harm and eroding trust. As discussed in sections 1.3.3 and 2.1.1 of the protocol, it is critical to understand, acknowledge, and address the role of past and present systems of colonialism and racism in inducing individual, collective, and generational trauma. Personal experiences of sex trafficking cannot be separated from the historical trauma of colonization and racism. The effects of oppression and discrimination should be a key consideration in every component of trauma assessment

and treatment with human trafficking victims and survivors from marginalized groups (Bryant-Davis & Tummala-Narra, 2017).

Acknowledging racial trauma enables opportunities for healing invisible wounds (St. Jean et al., 2020; Williams et al., 2022). Through a radical healing lens, healing requires a restoration of wholeness and self-acceptance of all parts (Ballentine, 1999). A holistic approach to mental health and wellness expands conceptualizations of healing to include the body, mind, soul, and spirit. In many cultures, the healing journey entails working toward balance, harmony, and interconnectedness. This extends beyond individual coping to include family, community, nature, and higher power. Traditional systems of knowledge, customs, and practices that children and families identify as meaningful to them should guide culturally-grounded care plans.



Decolonizing trauma work involves challenging mainstream treatment approaches, advancing the principle of self-determination, addressing the soul wounds of colonization, and using holistic healing strategies embedded in Indigenous worldviews (Linklater, 2014). [First Nations Mental Wellness Continuum Framework](#) recognizes that mental wellness is a balance of the mental, physical, spiritual, and emotional parts of self. Balance and interconnectedness are enriched when individuals have purpose, hope, belonging, and meaning. For Indigenous victims and survivors of sex trafficking, traditional ways of healing and cultural programming options can be comforting, grounding, and a positive road forward (Ontario Native Women's Association, 2019). Indigenous strategies for helping and healing include honouring and integrating teachings based in the Four Directions of the Medicine Wheel and Seven Sacred Teachings: Wisdom, Love, Respect, Bravery, Honesty, Humility, and Truth. [Speak Out: Stop Sex Trafficking – Discussion Guide for Facilitators: Addressing, Preventing and Ending Sex Trafficking](#) provides instruction on the use of healing activities centred on Indigenous ways of knowing and being.

Examples of Indigenous healing practices and teachings:

- Survivor talks
- Arts-based activities
- Land-based learning
- Sharing circles
- Storytelling
- Smudging
- Sacred medicines
- Visioning exercises
- Healing/sweat lodges
- Drumming circles
- Ceremonial gatherings
- Connection with traditional healers and Elders

Culturally-responsive approaches to mental health and wellness care:

- Provide education and training on cultural approaches to mental health and wellness.
- Build relationships with culture-based organizations and traditional healers. Support Indigenous, Africentric, and other cultural approaches to healing. Weave them together with mainstream trauma therapies when appropriate.
- Shift from a focus on diagnosing and treating to a focus on healing. Understand healing as seeking balance across mental, physical, emotional, and spiritual parts of self.
- Demonstrate genuine interest in learning about cultural identities. Apply a cultural humility lens.
- Practice self-reflection. Be mindful of inherent power imbalances within the helping relationship.

- Be attuned to system-induced and identity-based trauma and injustice. Acknowledge collective and generational trauma and integrate this history with individual CST experiences to create a coherent narrative.
- Recognize and validate ways in which colonialism, racism, sexism, ableism, trans/homophobia, classism, and other oppressions cause and exacerbate trauma. Explore how negative stereotypes have been internalized and contribute to feelings of shame and self-blame.
- Consider unique manifestations of stigma and shame related to sex, mental health, and help-seeking in diverse cultures. This may impact ability to engage with therapy and involve family in the process.
- Identify, affirm, and build on cultural strengths and intersecting identities as protective factors and recovery strategies. Help to develop a strong identity and value separate from CST.
- Explore sources of connection, meaning, and purpose.
- Encourage reconnecting and deepening relationships with culture and community after separation and loss to regain a sense of belonging and support.
- Facilitate access to healing spaces that reflect cultural traditions, values, and beliefs.
- Encourage use of cultural, spiritual, and religious coping strategies that hold meaning and support healing. Examples include mindfulness, meditation, prayer, rituals, ceremonies, and connection to land and nature.
- Incorporate expressive arts in trauma narratives and emotion expression and regulation. Examples include creative writing, storytelling, visual arts, music, and movement.
- Encourage themes of individual and collective healing, hope, strength, and transformation.
- Promote empowerment through resistance and activism, such as community organizing, consciousness-raising, and pursuing restorative justice.

Culture-based mental health and wellness services in Toronto Region:

- [Canadian Mental Health Association, Mental Health and Wellness Services for Indigenous Children and Youth](#)
- [Centre for Addiction and Mental Health, Shkaabe Makwa](#)
- [Centre for Addiction and Mental Health, Substance Abuse Program for African Canadian and Caribbean Youth](#)
- [Caribbean African Canadian Social Services](#)
- [Native Child and Family Services of Toronto](#)
- [Native Women's Resource Centre of Toronto](#)
- [Anishnawbe Health Toronto](#)
- [Ontario Native Women's Association](#)
- [FCJ Refugee Centre](#)

Led by the Ontario Native Women's Association and delivered by the Native Women's Resource Centre of Toronto, the [Indigenous Anti-Human Trafficking Liaison \(IAHTL\) Program](#) supports Indigenous communities in providing survivor-focused and localized responses to human trafficking, including culturally-grounded, trauma-informed services and supports. Specialized mental health and addictions liaisons work with communities, organizations, and individuals to identify needs and build capacity to address mental health, addictions, and trafficking. In partnership with IAHTL, [Aakwa'ode'ewin \(Courage for Change\)](#) supports the unique needs of Indigenous women and girls affected by sexual exploitation with an integration of cultural

and mainstream approaches using a trauma-informed, anti-oppressive framework. Refer to sections 3.1 and 3.2.9 of the protocol for additional culture-based and anti-oppressive practice resources.

2.8.7. Peer Support and Mentorship

Peer support is one of the key principles of trauma-informed care (Substance Abuse and Mental Health Services Administration, 2014). Peer support is a unique form of social support wherein a survivor of human trafficking uses the knowledge and insights gained through lived experience to provide emotional and practical help to others enduring a life experience like their own. Peer support is grounded in the belief that those who have survived adversity can offer useful information, encouragement, and mentorship to others. Connecting with another person with similar lived experience can create a vital link for someone struggling with their circumstances and inspire hope in recovery. Peer support workers draw from their experiential knowledge to engage with, listen to, and support peers in meaningful ways. Lived experience enables deeper understanding, authentic connection, and nonjudgmental acceptance. When the identities and backgrounds of workers reflect those of the population served, it can add credibility and confidence in care. The peer relationship helps to counter shame, stigma, and invisibility of experiences and demonstrates what is possible through recovery. Peer support overcomes the challenges related to loss of trust in providers and systems that are common among victims and survivors of CST. Relationship is the foundation of a person-centred approach to peer support (Sunderland et al., 2013).

“Workers with lived experience have passion for the work. They want to help people. The more passion they have for their job, the more compassion. Those little moments helped so much. A little bit of empathy can go a really long way. It just warmed my heart.” (Survivor)



Peer support is based in principles of shared power, hope, recovery, and empowerment. Peer support with the CST population aims to build safety, encourage self-determination, promote personal growth, and foster hope. Mentorship from survivors creates relatability, models a hopeful future, and mitigates power imbalances (Deer & Baumgartner, 2019). Child survivors of sex trafficking who receive survivor-mentor services have been shown to experience improved well-being and less exploitation, drug use, and behavioural problems (Rothman et al., 2020). Peer support in comparable areas of practice has been associated with a range of positive psychosocial, behavioural, and health outcomes, including improved coping, increased control over symptoms, greater confidence, reduced isolation, and better quality of life (Cyr et al., 2016; National Voices & Nesta, 2015). This work has the potential to benefit the peer-supporter and peer-supported, providing both with a sense of pride, purpose, and connection that facilitates healing.

“I had peer support, I am a peer support worker today, and the relationship is much different. You relate more. You can ask questions that maybe you wouldn’t have asked otherwise because you’re like, oh I’m gonna get judged for this. It’s the gateway to other resources.” (Survivor)

Part of a holistic recovery and empowerment approach, peer support is intended to complement other forms of trauma-informed mental health and social support. Ensuring role clarity is important. Most peer support is not psychotherapy. It is generally a non-clinical role that can be standalone care in survivor-led programs or embedded within multidisciplinary teams in a variety of settings, including community mental

health centres and hospitals. Several anti-human trafficking organizations in Toronto have peer support workers, peer navigators, and peer advisors on staff.

Peer support roles:

- Peer-led support and psychoeducation groups
- Mentorship and coaching
- Life skills development (e.g., budgeting, resume building)
- Recreation-based support
- Community referrals and resource links
- Case management and system navigation
- Online discussion forums
- Advisory committee work
- Advocacy and empowerment
- Prevention and education

Developing Peer Support Programs

Peer support program development and implementation should be grounded in established standards of practice and training and core values and ethics, such as those developed by [Peer Support Canada](#) and [Mental Health Commission of Canada](#). It is important for this to be an open and transparent process. Lived experience experts from diverse backgrounds should be engaged as leaders and advisors, rather than passive recipients. Partnering with survivor-led organizations to guide role development, training content, and supervision structure can help to ensure the integrity and quality of peer support services. Organizational awareness of the marginalization and discrimination that often comes with lived experience, and commitment to anti-oppression policies and practices, will help to validate and sustain the peer support role.

Survivor readiness to transition to peer support work, including stage of exploitation and recovery, is a key consideration. Rather than imposing judgment, self-assessment of trauma status and self-defined pathways to healing should be supported. Lived experience alone does not automatically translate to clinical expertise. Building on the knowledge generated through lived experience and personal attributes, peer support training should cover the full range of principles and competencies required for effective and ethical practice with children affected by sex trafficking. Mentorship and supervision should be provided by qualified individuals who are knowledgeable about the peer support model and have expertise in CST and trauma-informed care. Building a community of practice can provide opportunities for personal development, social support, and ongoing connection among peers (Sunderland et al., 2013).

Training, mentorship, and supervision should address the challenges that can emerge from the dynamics underpinning peer support relationships, such as use of self-disclosure, managing trauma responses, and setting therapeutic boundaries. Recovery from trafficking is a lifelong process. Peer support workers are simultaneously engaged in their own healing journey while helping others. While there should be no expectation to share personal stories, intentional sharing of lived experience is the foundation of peer support philosophy. Revisiting traumatic experiences carries the risk of activating trauma reactions in self and others. Rather than sharing individual-level details of traumatic events, talking generally about exploitation dynamics and helpful coping strategies, for example, can reduce the potential for re-traumatization in both peer supporter and peer supported. Use of self-disclosure by peer support workers should be approached thoughtfully, serve a clear purpose, and used only when there is an intended benefit for the client, with the focus remaining on the client.

Maintaining personal and professional boundaries and respecting limits to scope of practice, particularly in crisis situations, are fundamental requirements of the role. Critical self-awareness, ongoing assessment of personal impacts of the work, and commitment to self-care and wellness should be encouraged.



Organizations must ensure sufficient opportunities for periodic training, trauma-informed support, reflection and debriefing, and appropriate supervision for peer support workers. Refer to sections 2.10.2, 3.2.7, and 3.2.10 of the protocol for secondary traumatic stress management strategies, resources, and tools.

“I’ve been on both sides. Living in those homes and working in those homes, you’re still in survival mode. It’s hard. And then being on the other side, I remember what it’s like. You need limits. It’s hard to navigate. I could relate to so many different people, and relate them to other people in my life. It’s hard to come to an understanding. It’s important for workers to get more training on de-escalation of trauma responses.” (Survivor)

Peer support values (Peer Support Canada, 2019a):

- Hope and recovery
- Empathic and equal relationships
- Self-determination
- Dignity, respect, and social inclusion
- Integrity, authenticity, and trust
- Health and wellness
- Lifelong learning and personal growth

Peer support competencies (Peer Support Canada, 2019b):

- Interpersonal relations
- Demeanour
- Communication
- Critical thinking
- Hope
- Self-management and resiliency
- Flexibility and adaptability
- Self-awareness and competence
- Initiative and commitment
- Teamwork
- Continuous learning and development

Training themes to promote peer-to-peer effectiveness (Sunderland et al., 2013):

- Developing effective interpersonal communication skills.
- Building supportive relationships.
- Understanding the process of recovery and change.
- Building resilience through self-care and wellness plans.
- Negotiating limits and boundaries within the peer relationship.
- Recognizing and responding to crisis situations.
- Understanding symptoms and where to seek help.
- Connecting with community resources.

Peer support program development, training, and supervision resources:

- [Peer Support Canada](#)
- [Canadian Mental Health Association, Centre for Excellence in Peer Support](#)
- [Support House, Centre for Innovation in Peer Support](#)
- [Guidelines for the Practice and Training of Peer Support](#)
- [Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Substance Use/Addiction Organizations](#)

Survivor mentorship and leadership resources:

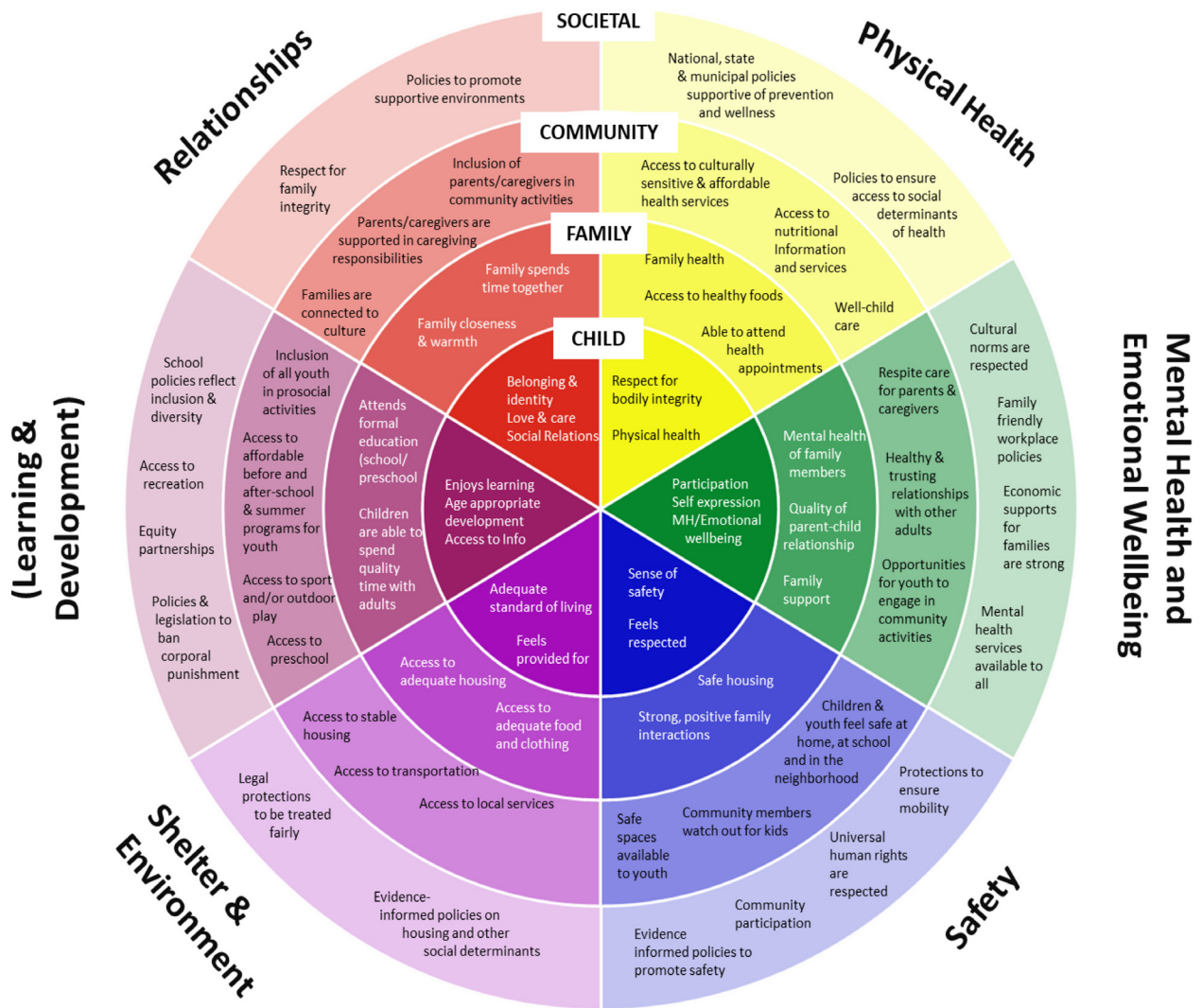
- [Project iRISE](#)
- [Girls Educational and Mentoring Services \(GEMS\)](#)
- [My Life My Choice](#)
- [Elevate Academy](#)
- [Voice Found](#)
- [Survivor Alliance](#)
- [Courage for Freedom](#)

Refer to sections 2.10.1 and 3.2.8 of the protocol for additional survivor-informed practice considerations and resources.



2.9. PREVENTION AND ADVOCACY

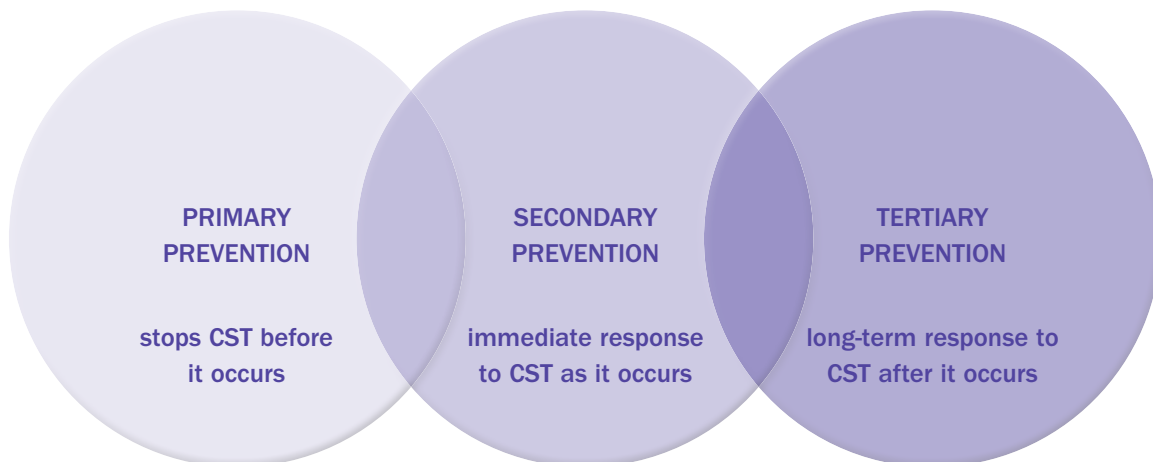
A rights-based, public health approach to CST prioritizes primary prevention, which aims to stop sex trafficking before it occurs. Understanding and addressing the systems of oppression and inequality at the root of trafficking is the greatest protection against it. This demands a shift from reactive responses to proactive responses to combat the problem. Prevention and advocacy efforts should target modifiable risk and protective factors spanning all levels of the ecological system, as reviewed in section 1.3.5 of the protocol. A socioecological model for prevention of child trafficking emphasizes intentional interconnected strategies across individual, relationship, community, and societal domains to promote the safety, health, and well-being of children in their environments (Greenbaum et al., 2018c; Jaffe et al., 2022). This encompasses sociocultural, economic, legislative, and political action to advance social determinants of health, strengthen relationships and communities, enact data-driven prevention and protection policies and practices, ensure equitable access to resources, and eliminate underlying structural and systemic power disparities.



Source: [Primary Prevention Framework for Child Trafficking](#) (Global Alliance for Behavioral Health and Social Justice, 2020)

Promising child trafficking prevention policies and programs centre on: 1) tackling demand by strengthening the legal framework through legislation and law enforcement, and identifying exploiters and facilitators; 2) reducing supply by promoting competence and resilience through education and life skills, ensuring safe migration, and preventing re-victimization and providing rehabilitation and reintegration for victims; and 3) strengthening communities through enhanced child protection systems, economic opportunities, gender equality, interdisciplinary collaboration and partnerships, frontline staff training, and children’s participation (Rafferty, 2013). Government investment in human trafficking prevention has the potential to result in substantial cost savings when the economic and social consequences for individual victims and society are factored in (Barrett, 2013). Raising awareness to prevent human trafficking through marketing campaigns, public education materials, and multisectoral training is a pillar of [Ontario’s Anti-Human Trafficking Strategy \(2020 - 2025\)](#).

This community response protocol advocates for concurrent prevention efforts targeting three levels across the risk continuum: primary prevention, secondary prevention, and tertiary prevention. Preventive measures should target upstream drivers that get to the root of inequalities, in combination with midstream and downstream interventions focused on providing equitable access to care. Multitiered CST prevention strategies should be incorporated by individuals, organizations, and systems within practice, policy, research, and education to increase awareness and decrease risk. This requires collaboration, cooperation, and creativity across disciplines and sectors involved in the anti-human trafficking movement.



Strategies for multilevel prevention and advocacy:

- Organize multiplatform education campaigns to raise awareness and change perceptions about CST among the general public and targeted populations. Have a clear communication strategy and use media effectively. Use Ontario's annual [Human Trafficking Awareness Day](#) on February 22 to educate the public about CST prevalence, warning signs, and help available.
- Address structural and systemic root causes through community organizing, public education, collective action, and equitable access to resources.
- Influence change by resisting gender- and race-based ideologies, attitudes, and behaviours that perpetuate CST. Challenge the stigma that prevents victims from coming forward.
- Educate governments about CST and push for prevention agendas to be prioritized. Advocate for responsive local, provincial, national, and international legislative frameworks. Unite parliamentary efforts across party lines (e.g., [All Party Parliamentary Group to End Modern Slavery and Human Trafficking](#)).
- Mobilize data-driven prevention approaches at the level of the individual, family, community, and society.
- Infuse prevention principles in organizational policies and programs to reinforce commitment. Engage diverse communities and lived experience experts in prevention policy and program development.
- Provide interprofessional education and training to increase knowledge and skills for recognizing and responding to indicators of CST, reducing risk, and supporting prevention efforts. Expand training beyond health and social service settings to industries such as finance and tourism.
- Embed CST content into the core curriculum of undergraduate and graduate programs to better prepare students in helping professions for the field.
- Advocate for social and economic policies and programs that promote community health and wellness, and support equitable distribution of the social determinants of health, including guaranteed basic income, food security, affordable housing, and accessible health care.

- Provide universal school-based prevention education to all students to raise awareness about CST and healthy relationships. Provide targeted education to populations at high risk.
- Empower youth and survivors to lead CST prevention, education, and advocacy work (e.g., [Project iRISE](#), [OneChild Youth Advisory Squad](#)). Engage boys and men in creating solutions.
- Engage the entire family system in prevention. Educate parents/caregivers on early warning signs and how to talk to children about CST, healthy sexuality, and online safety.
- Strengthen family and community connections. Create opportunities for community engagement to foster a sense of social inclusion and belonging.
- Enhance victim identification and early intervention. Routinely monitor for signs of CST and other adverse childhood experiences. Display placards with helpline information. Do community outreach.
- Educate criminal justice stakeholders on CST. Uphold victim rights to justice system responses that hold sellers and purchasers of child sex accountable. Apply a trauma-informed approach to CST victim-offender intersectionality.
- Consider restorative justice approaches to repair harm, support rehabilitation, and reduce recidivism.
- Provide mentorship, psychoeducation, and treatment to those convicted of CST-related offences to prevent re-offending. Provide viable opportunities to escape poverty.
- Monitor use of technology to facilitate recruitment, luring, and grooming. Enhance laws to keep children safe online. Improve regulation of the internet.
- Strengthen child welfare system capacity to better safeguard children by supporting families and keeping families together. Implement safety and risk reduction measures in high-risk settings such as group homes. Enhance support for children leaving care.
- Connect at-risk children to community resources that address risk factors and build resilience. Increase competencies to recognize and resist exploitation through education and life skills development. Reduce the vulnerability of girls through social and economic empowerment.
- Ensure children exiting from sex trafficking have access to reasonable economic alternatives. Provide timely and effective trauma-informed services to reduce risk of adverse effects and re-victimization. Connect with gender- and culturally-affirming programs and prosocial recreation activities.
- Prepare to enact special measures to prevent CST during large-scale emergencies and events, such as natural disasters, infectious disease pandemics, geopolitical conflicts, and sports conventions.
- Seek out diverse funding sources from all levels of government, private sectors, charitable donations, and endowment funds to sustainably support prevention initiatives.
- Form or partner with grassroots anti-human trafficking organizations (e.g., [Aura Freedom International](#)). Volunteer time or donate money to prevention and advocacy efforts.
- Engage local businesses (e.g., hotels) to strengthen their commitment to preventing CST.
- Leverage multisector, multiagency, multidisciplinary collaboration and resource-sharing. Expand anti-human trafficking coalitions nationally and internationally. Join organized networks dedicated to prevention and advocacy (e.g., [HEAL Trafficking](#), [Human Trafficking Health Alliance of Canada](#)).
- Systematically collect data on CST to inform prevention policies and programs. Conduct research to rigorously evaluate the effectiveness of risk reduction models and prevention practices. Mobilize knowledge generated through research to inform prevention directions.

Education Sector

The education sector has a pivotal role in preventing, recognizing, and responding to CST. Given the magnitude of risk among school-aged children, elementary and secondary schools are well-situated to lead universal prevention efforts. A comprehensive school-based prevention framework encompasses creating a safe and supportive school climate, rolling out multimodal education targeting all students to raise awareness of CST, training teachers and other school personnel to recognize and mitigate risk in students, and enacting policies and protocols to support prevention and intervention strategies. Given their almost daily contact with students, educators are well-positioned to teach about prevention, promote healthy relationships, spot warning signs, connect with students as caring adults, and safely engage community services and supports.

In 2021, Ontario Ministry of Education issued [Policy/Program Memorandum 166 - Keeping Students Safe: Policy Framework for School Board Anti-Sex Trafficking Protocols](#) to set the foundation for the public education system's response to sex trafficking. The provincial framework directs the development of school board protocols for preventing, recognizing, and responding to CST, in partnership with communities, families, and students. Core elements of anti-sex trafficking protocols include strategies to raise awareness and prevent sex trafficking, procedures for responding to students at risk or being trafficked, training for school board employees, and accountability and evaluation measures.

Developmentally-appropriate learning related to CST content is incorporated in Ontario's [Elementary Curriculum](#) and [Secondary Curriculum](#) for health and physical education. Funded by Ontario Ministry of Education, White Ribbon Canada's [Digital Learning Resource](#) offers secondary school educators tools, resources, and lesson plans to discuss child sexual exploitation and sex trafficking in their classrooms through preventive, safe, and positive learning experiences. Aligning with the provincial health and physical education curriculum, Covenant House Toronto developed an [Educator Guide on Sex Trafficking Prevention](#) suitable for students in grades 7 to 12.

School disengagement and academic difficulties are common among children at highest risk of sex trafficking. School-based prevention programs and support services may not reach those most in need. School systems must be trauma-informed to feel safe and foster attendance, resiliency, and self-regulated learning in the context of adversity. Education, child welfare, and health sectors should work together to implement coordinated policies and practices that promote school reintegration and academic achievement. This can provide protection against CST and other adversities.

Intervening with Traffickers and Youth at Risk of Trafficking

Effective action to prevent CST must seek to deter traffickers and potential traffickers, the vast majority of whom are young males, from offending and re-offending by tackling root causes. Prevention education with boys and men should start early and address sex trafficking in the context of gender-based violence, gender inequality, gender role socialization, unhealthy masculinity, male entitlement, sexism, and misogyny. Increasing awareness of the harms of exploitation and building empathy for victims can serve as deterrents. Promoting community engagement and connections with positive male role models can help to develop self-concept and identity, create a template for healthy relationships, instill a sense of belonging, and provide a source of inspiration.

Addressing the economic drivers of sex trafficking is a fundamental component of prevention. Diminishing the financial incentive to sexually exploit children for personal profit will help to keep children safe. This demands alternative avenues for generating income and equitable opportunities for financial support, continuing education, job training, and stable employment. There must be viable replacements for negative behaviours, including accessible options for prosocial activities, life skills and resiliency development, and leadership mentoring.

CST prevention efforts also include enhancing the capacity of specialized joint force police investigation, intelligence gathering, and Crown prosecutors to hold offenders accountable through vigorous prosecution and sentencing. Asset forfeiture can be particularly effective. It should be noted that some survivors of human trafficking prefer preventive remedies outside of the criminal justice system over traditional forms of retributive justice such as incarceration (Love et al., 2018). This includes restorative justice approaches to prevent recurrence and foster healing through rehabilitation of offenders and reconciliation with victims and communities.

Between 2010 and 2020, 6% of persons accused in police-reported human trafficking incidents were between the ages of 12 and 17 years (Conroy & Sutton, 2022). Recognizing the unique needs of this young population of offenders, Ontario's [Youth Justice System](#) pursues accountability through proportionate measures and provides developmentally-sensitive responses to reduce re-offending behaviour and improve outcomes. Young people who perpetrate CST often have their own histories of maltreatment, trauma, and poverty. Some engage willingly; for others, it is a coerced behaviour or survival strategy. For the subset of young people who participate in the recruitment or exploitation of others while being victims of trafficking themselves, a trauma-informed, non-retributive approach that focuses on restorative justice and rehabilitation, coupled with alternative sources of income, will likely be most impactful for prevention of recurrence. Evidence-based prevention and intervention programs for CST victim-offenders are currently lacking. Refer to sections 1.3.4, 2.5.2, and 2.8.3 of the protocol for more on victim-offender intersectionality.

[Youth Violence and Human Trafficking Prevention Program](#), funded by Ontario Ministry of Children, Community and Social Services under the [Guns, Gangs, and Violence Reduction Strategy](#), supports targeted culturally-responsive prevention and resilience programs aimed at reducing risk of violence and victimization among youth and young adults.

Youth violence and human trafficking prevention services in Toronto Region:

- [Urban Rez Solutions Social Enterprise](#)
- [Dixon Hall](#)
- [Uzima Women Relief Group International](#)
- [Arab Community Centre of Toronto](#)
- [Victim Services Toronto](#)
- [Aura Freedom International](#)

2.10. PROTOCOL IMPLEMENTATION AND MONITORING

2.10.1. Survivor Inclusion and Survivor-Informed Practice

Survivor voices are fundamental to the success of anti-human trafficking efforts. This community response protocol was developed in cooperation, consultation, and collaboration with lived experience experts and survivors of sex trafficking. Anti-human trafficking organizations should adopt a survivor-informed practice model that is trauma-informed and anti-oppressive. Being survivor-informed means that meaningful input from a diverse community of survivors has been intentionally and systematically sought and integrated to inform policy, program, and project development, implementation, and evaluation so that it accurately reflects the views, needs, and interests of the population served (Office for Victims of Crime).

Survivor-informed practice entails recognizing, honouring, and leveraging the wisdom derived from lived experience. The goal is to engage authentically with survivors, elevate their voices, and follow their lead. Survivor inclusion serves as a reality check and helps to ensure anti-human trafficking efforts are survivor-centred and culturally-appropriate (Lockyer, 2020). Actions to include survivors should not be re-traumatizing, sensationalistic, or tokenistic, as relying on survivors simply as a check-box exercise can perpetuate exploitation (Countryman-Roswurm & Brackin, 2017). Survivor engagement should be trauma-sensitive, empowerment-focused, and ethically-grounded. Their well-being should be at the forefront. This framework moves away from the paternalistic approach that has historically been applied to survivor inclusion in anti-human trafficking movements.

Creating survivor-informed spaces requires sustained support from leadership, investment of human and fiscal resources, and shift in workplace culture. Transforming to empowering beliefs and behaviours helps organizations and allies to share power with survivors (Dang et al., 2020). Survivors are uniquely equipped to co-create policies and programs, inform prevention and research directions, engage with the public in awareness-raising and advocacy, and collaborate with governments and stakeholders to improve legislation and service delivery models. Survivor leadership frameworks can tap into experiential knowledge, skills, and other strengths of people with lived experience in paid staff positions, on advisory boards, and as volunteers (Deer & Baumgartner, 2019). Providing opportunities for trafficked children aging out of child-serving systems to remain involved with programs in an advisory capacity can have a powerful impact on their healing journey.

“It’s so important for service providers to not start their program without people with lived experience. You can have good intentions and do things that are harmful and re-traumatizing. In one program, they took my phone away. I was more isolated in this program than I was when being trafficked. There was no lived experience involved. They followed some guideline created by people with no first-hand experience.” (Survivor)

“It helps if an organization is flexible. Having the option to be part of the team and being really respectful of the person’s role. Don’t force their story out of them. Paying a good wage and actually valuing the work, that will allow them to keep doing the work and enjoy it.” (Survivor)



Questions to guide survivor-informed practice readiness assessment:

- *What value do we place on lived experience?*
- *Are we genuinely interested in the perspectives of survivors?*
- *Are we prepared to include survivors in meaningful and ethical ways?*
- *Are we willing to share power and support equitable participation of survivors?*
- *Are we committed to incorporating survivor input in decision-making?*
- *Is there sustainable funding to fairly compensate survivors for their time and expertise?*
- *How will we work through biases, conflicts, and tensions as they arise?*

Forms of meaningful survivor inclusion:

- Develop and implement peer support models of care.
- Appoint survivors to a range of leadership and frontline positions.
- Ensure survivors are represented on governing boards.
- Include survivors on planning, steering, and advisory committees.
- Retain consultation services from survivors on policy and program development.
- Involve survivors in creating equity, diversity, and inclusion strategies.
- Create volunteer opportunities for survivors.
- Engage, collaborate, and partner with survivor leaders and survivor-led organizations.
- Provide mechanisms for survivor feedback (e.g., surveys, focus groups).
- Involve survivors in education and training curriculum development and delivery.
- Invite survivors to attend and present at conferences and trainings.
- Engage survivors in public-facing prevention campaigns and community organizing.
- Consult and collaborate with survivors on research design, implementation, and dissemination.

Survivor-informed care principles and practices:

- Assess organizational and provider readiness to engage in meaningful and ethical survivor-informed practice.
- Prioritize survivor engagement across all levels of policy, program, and project development, implementation, and evaluation. Refrain from restricting survivor input to retelling personal stories of trauma.
- Incorporate survivor-informed practice in mission statements, guiding principles, policies, procedures, and workplans to reinforce organizational commitment.
- Balance power by recognizing and treating survivors as equals and experts in their lived experience. Attend to oppressive power dynamics and be prepared to manage tensions that may arise.
- Encourage critical self-reflection to identify and work through personal biases.
- Processes for survivor inclusion should be equitable, transparent, authentic, respectful, and trustworthy. Motives and desired outcomes should be clearly stated.
- Be open to transitioning away from traditional approaches for establishing job qualifications, supervision models, and performance measures (e.g., look beyond academic credentials).
- Advocate for sufficient and sustainable funding to support survivor-informed programming.
- Provide fair financial compensation for survivor time and expertise. Unpaid survivor volunteers should be offered a token of appreciation (e.g., gift card honorarium).

- Reduce potential for isolation in the workplace. Foster an inclusive and supportive team culture and positive relationships between peer and non-peer colleagues.
- Ensure a shared understanding of organizational values, roles, and models of care. Facilitate access to adequate training and supervision.
- Provide avenues for career advancement. Invest in survivor leaders by offering professional development opportunities.
- Survivor readiness to engage in anti-human trafficking work should consider where survivors are at in their personal recovery and professional development. This should be self-directed.
- Be mindful of the potential for dual relationships, identity conflicts, and conflicts of interest in survivor roles.
- Do not assume individuals with lived experience self-identify with the term “survivor.” Ask for preferred language and use it.
- Protect survivor privacy and well-being. Do not expect survivors to disclose details of their lived experience. Survivors own their stories. While there are benefits to sharing personal histories, the decision should be their choice and respected.
- Appreciate that survivors are more than their trauma stories. They can offer a diverse range of knowledge and skill sets.
- Recognize that the work involves sharing intimate parts of self. Apply trauma-informed care principles and practices to minimize risk of re-traumatization. Ensure support is provided to protect mental health and wellness. Destigmatize trauma responses and encourage self-care.
- Reduce barriers to survivor engagement. Ask what will facilitate their engagement. Communicate in direct and accessible language. Provide accommodations if needed.
- Recognize differences across lived experiences based on race, gender, 2SLGBTQI+ status, ability, and other intersecting identities. Ensure diverse representation in survivor inclusion by addressing barriers to equitable participation.

Resources for building survivor engagement:

- [Toolkit for Building Survivor-Informed Organizations](#)
- [Practical Guide: Survivor-Informed Services](#)
- [Survivor Alliance, Survivor Engagement Resources](#)
- [Allies Toolkit for Survivor Empowerment \(2nd Ed.\)](#)
- [Survivor-Informed Practice: Self-Guided Assessment Tool](#)

Refer to sections 2.8.7 and 3.2.8 of the protocol for additional survivor inclusion considerations and resources.

2.10.2. Secondary Traumatic Stress

Working with children exposed to sex trafficking can impact service providers in positive and negative ways. It can provide a sense of purpose and meaning, present opportunities for learning and growth, inspire hope, and foster vicarious resilience (Hernandez et al., 2007). It can also contribute to professional burnout, compassion fatigue, vicarious trauma, and secondary traumatic stress (Newell & MacNeil, 2010). Secondary traumatic stress (STS) is a stress response that develops in helping professionals after directly or indirectly learning about another person’s traumatic experience (Sprang et al., 2019). Effects can mirror PTSD reactions, including intrusive, avoidant, and arousal symptoms. STS takes a toll on the health and well-being of providers, functioning of teams, and culture of organizations.



Chronic exposure to the trauma narratives of others, coupled with work-related stressors in the context of unsupportive environments, can diminish personal and professional quality of life and adversely affect mental health and wellness. Empathic strain and emotional depletion from engaging in CST work are deepened by its unique relational dynamics and continual risk of harm to children that can weigh heavily on the hearts and minds of providers. This can be amplified when faced with frustrating service roadblocks and administrative pressures. STS also intersects with personal identities. Extent of the effects of high-intensity work with human trafficking victims and survivors is influenced by multiple factors, including personal trauma history and use of self-care strategies (Corbett-Hone & Johnson, 2022).

This community response protocol urges trauma-informed anti-human trafficking organizations to be vigilant about preventing, monitoring, and mitigating the effects of STS on staff across all parts of the organization. It is vital to create a nonjudgmental workplace culture in which trauma responses are understood and destigmatized. Individual- and organizational-level strategies for buffering the impact of STS and promoting resilience should be systematically integrated. STS prevention, identification, and intervention efforts are an ethical imperative, without which organizations and providers run the risk of compromising program effectiveness and client outcomes.

Signs of secondary traumatic stress:

- Reduced empathy
- Emotional numbing
- Anxiety and depression
- Trouble sleeping
- Difficulty with concentration and memory
- Sense of hopelessness, apathy, and jadedness
- Critical and irritable
- Altered outlook on life or negative worldview
- Decreased sense of safety
- Withdrawal from family and social life
- Isolation from colleagues
- Preoccupation with clients
- Distancing from clients
- Physical, emotional, and spiritual exhaustion
- Somatic symptoms
- Inability to embrace complexity and nuance
- Diminished self-efficacy and confidence
- Reduced clinical competence and service effectiveness
- Loss of faith in systems
- Loss of passion for work
- Not showing up for work
- High staff turnover

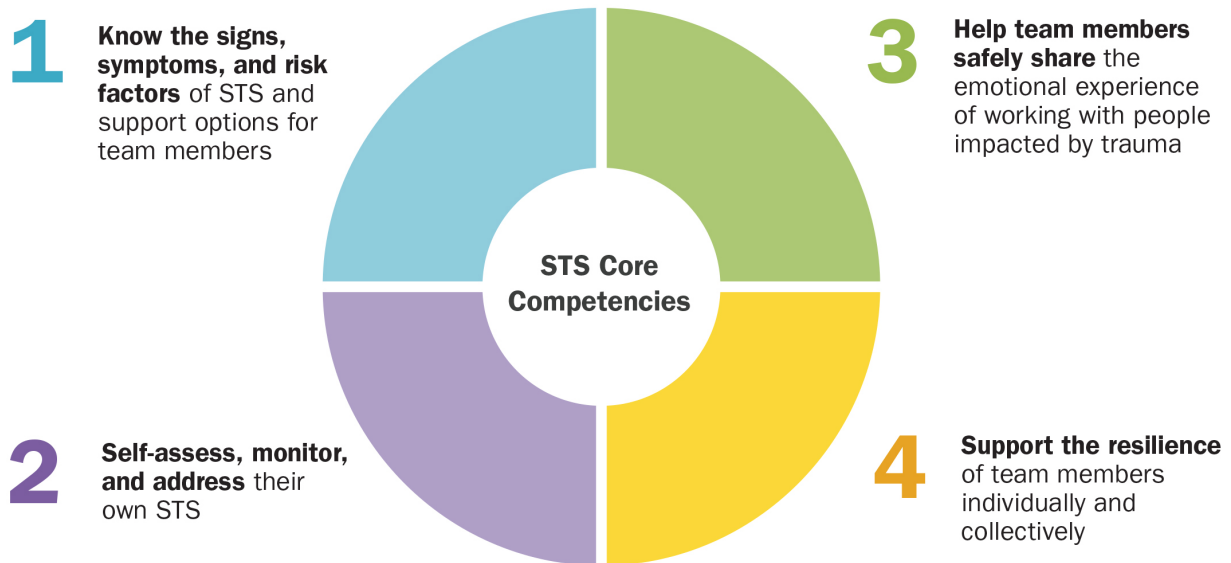
Strategies for mitigating secondary traumatic stress:

- Cultivate a safe and supportive organizational culture and team environment.
- Implement workplace policies, procedures, and programs that support holistic wellness of providers, teams, and organizations. Invest sufficient time and resources.
- Raise awareness of STS and build resiliency through periodic education, training, and supervision.
- Provide reflective supervision and support with designated time to address STS. Ensure supervisors are well-trained in STS core competencies for trauma-informed supervision and support.
- Promote a work culture that normalizes and validates trauma responses and enables open and honest conversations about STS.
- Ensure reasonable expectations for productivity, balance caseloads, and offer flex-time scheduling and breaks. Encourage healthy boundaries and work-life balance.



- Provide space for self-reflection and self-care. Encourage self-compassion.
- Teach emotional processing and regulation skills and coping strategies.
- Promote physical, cognitive, behavioural, relational, and spiritual self-care (e.g., nutritious meals, good sleep, exercise, leisure activities, exposure to nature, mindfulness, breaks).
- Provide opportunities for peer support, team debriefing, and group therapy. Ensure access to mental health support and wellness activities through employee assistance programs.
- Build support systems inside and outside of work. Avoid isolation.
- Attend carefully to team dynamics and negative group influences.
- Learn to identify STS risk factors and triggers in self and others. Use personal and organizational self-assessment tools to measure STS status and impairment.

Secondary traumatic stress-informed supervisors in any discipline will:



Source: [Secondary Traumatic Stress Core Competencies for Trauma-Informed Support and Supervision](#) (Haskell et al., 2022)

Secondary traumatic stress resources:

- [The Vicarious Trauma Toolkit](#)
- [Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals](#)
- [Secondary Traumatic Stress Core Competencies for Trauma-Informed Support and Supervision: Cross-Disciplinary Version](#)
- [Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision](#)
- [Taking Care of Yourself](#)
- [Secondary Traumatic Stress Consortium](#)
- [TEND Toolkit](#)

Examples of organizational and staff health and wellness screening and assessment tools:

- [Secondary Traumatic Stress Informed Organizational Assessment \(STSI-OA\)](#)
- [Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision Self-Rating Tool](#)
- [Secondary Traumatic Stress Scale \(STSS\)](#)
- [Professional Quality of Life Scale \(ProQOL\)](#)
- [Vicarious Resilience Scale \(VRS\)](#)

Refer to sections 3.2.7 and 3.2.10 of the protocol for additional secondary traumatic stress resources and tools.

2.10.3. Education, Training, and Supervision

Coinciding with national, provincial, and municipal government strategies to combat human trafficking, there has been a proliferation of awareness-raising campaigns, education and training initiatives, and cross-sector programming targeting human trafficking. An impetus of this community response protocol is to help to fill ongoing system-wide gaps in knowledge, values, and skills for effective and ethical CST service delivery. All service providers who interact with children who have experienced, or are at risk of, sex trafficking require access to standardized education and training to build competence in CST prevention, identification, assessment, and intervention. Anti-human trafficking organizations should strive to create a work environment where staff feel comfortable communicating their learning needs and asking questions without judgment. It is incumbent upon organizations to implement processes to assess staff education and training needs on a continual basis, monitor the type and level of education and training disseminated, and systematically evaluate uptake and application of learning. This requires commitment to an anti-human trafficking mandate, professional development, and sustainable funding.

“I had an experience with a therapist who had no idea what trafficking was. It was a weird experience to have to educate the therapist. It’s so important for them to have training. It wasn’t done in malice. She was nice, just very uneducated about this.” (Survivor)

Lived experience experts and populations most directly impacted by the problem should be engaged in the design and delivery of education and training. Combined interactive e-learning and in-person learning will have the greatest reach and impact. Incorporating a variety of multimedia platforms and teaching methods, including didactic and discussion-based approaches and experiential exercises such as client simulations, will tap into different learning styles and needs. Content and materials should be regularly reviewed, refined, and updated as needed. Tools such as the [Health Care and Human Trafficking Curriculum Assessment Tool](#) can assist with the design and evaluation of human trafficking training for health care professionals.

Interprofessional CST education and training curricula should centre on the guiding principles and core competencies outlined in section 1.2 of the protocol. This covers foundational concepts and promising practices grounded in the best available evidence. Level of education and training should correspond to baseline, intermediate, and advanced learning needs. To acquire and maintain core competencies, it is important for professional development opportunities to be offered episodically. More intensive training is required for specialized areas of practice, such as complex trauma therapy and substance use treatment.

Learning objectives based on core competencies:

- Use a child-centred, rights-based, trauma-informed approach.
- Apply anti-racist, anti-oppressive, culturally-responsive principles and practices.
- Understand the dynamics, scope, causes, and consequences of CST.
- Adopt legal and ethical standards relevant to discipline and setting.
- Collaborate with multidisciplinary service providers across sectors and systems.
- Engage survivors in meaningful input and apply survivor-informed practices.
- Evaluate and identify risk of CST.
- Assess multilevel needs and strengths.
- Provide developmentally-sensitive, relationship-focused, evidence-informed interventions.
- Integrate prevention and advocacy strategies into all levels of practice and systems of care.

Examples of Ontario government-funded anti-human trafficking training:

- [Online Training Initiative to Address Human Trafficking](#) (MCIS Language Solutions) is an online training program designed for multidisciplinary professionals working with survivors of human trafficking. It is comprised of four modules and additional resources covering both general and industry-specific topics. It takes approximately two to three hours to complete.
- [Understanding and Working With Sexually Exploited Youth](#) (Ontario Ministry of Children, Community and Social Services) is a six-day intensive training for select frontline service providers across multiple sectors working directly with child and youth victims of human trafficking and those at heightened risk of being trafficked. It is designed to equip participants with tools and knowledge to identify, appropriately respond, and support child and youth victims of human trafficking on their healing journeys. It is survivor-centred, as individuals with lived experience were integrally involved in leading the training through both development and delivery. Contact the Provincial Anti-Human Trafficking Coordination Office at aht.training@ontario.ca for training inquiries.
- [An Introduction to Human Trafficking](#) (Centre for Addiction and Mental Health) is an online course designed to help addiction and mental health service providers recognize and respond to the needs of human trafficking survivors. It consists of five modules and takes approximately two to three hours to complete.
- [Providing Care to Sex Trafficked Adolescents and Adults](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres & Women's College Hospital, Women's College Research Institute) is an e-learning curriculum designed to help forensic nurses understand domestic sex trafficking and provide acute and follow-up care to persons 16 years of age and older. It is currently available to health care professionals working in Sexual Assault/Domestic Violence Treatment Centres and takes approximately one hour to complete.

Refer to section 3.2.1 of the protocol for additional education and training resources.

Education and training should be supplemented with regular supervision, consultation, and team support. Effective supervision facilitates reflective practice, supports professional development, reduces secondary traumatic stress, increases job satisfaction, enhances work culture, ensures accountability, and improves client outcomes. Successful implementation of an individual or group supervision model requires shared understanding of the purpose, protected time and space, and mutual trust and respect.



2.10.4. Protocol Execution and Evaluation

In summary, the objectives of this community response protocol are to mobilize a system of care grounded in guiding principles and core competencies, enhance multisector collaboration and coordination, and integrate service and support pathways, with the goal of improving experiences and outcomes for children and families impacted by sex trafficking. Protocol implementation, in tandem with supplemental education and training, is recommended for child-serving anti-human trafficking organizations in Toronto. This requires sustained commitment to an anti-human trafficking agenda and community partnership.

Protocol content reflects the current state of knowledge derived from research, practice, and lived experience in CST prevention, identification, assessment, and intervention. It is intended to evolve with changing trends and community needs. The protocol should be updated at regular intervals with emerging empirical evidence, new community resources, and modified service pathways. The Hospital for Sick Children's Child Sex Trafficking Community Response Protocol Advisory Committee is the main forum for guiding protocol reviews and revisions, identifying barriers and facilitators to protocol uptake, monitoring service duplication and gaps, fostering new and existing partnerships, and integrating stakeholder input. Individual organizations are responsible for enabling and evaluating protocol adherence among their teams.

Continuous quality improvement efforts and evaluation of service effectiveness are encouraged. Research-informed self-assessment tools can help professionals and organizations to monitor and evaluate their capacity to effectively identify and respond to human trafficking. This includes application of principles and practice competencies. Evaluation results can help to identify gaps in knowledge and skill, inform the direction of training and service delivery, and guide the implementation of changes for improvement.

Examples of professional and organizational self-assessment tools:

- Service Assessment Tool in [Improving Physical and Mental Health Care for Those at Risk of, and Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#)
- [Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Organizations](#)
- [Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Professionals](#)

The human trafficking knowledge base can be moved forward by joining networks such as [Global Association of Human Trafficking Scholars](#) and conducting ethically-grounded, culturally-safe, trauma-informed research to guide practice, policy, and advocacy. Single-site and multisite data collection and program evaluation can help to determine whether CST services are achieving their intended impacts, demonstrate value to leaders and funders, support scaling up effective models, and advance the evidence base for the broader field. Transdisciplinary collaborations have the potential to strengthen research and evaluation efforts. Community-based agencies with limited research capacity can partner with universities, academic hospitals, and mental health centres with greater research capacity for mutual gains.

Individuals and communities with lived experience should be engaged in research design, implementation, and dissemination as advisors, collaborators, and partners. This should be done in a way that is trauma-informed, transparent, responsible, and accountable to those being studied and affected. This will promote equity, build trust, create opportunities for bidirectional learning, ensure relevance to those most impacted,

and improve uptake of findings. Barriers to engagement and mutually-beneficial relationships should be explored and addressed. The principles of [OCAP](#) (ownership, control, access, possession) and [EGAP](#) (engagement, governance, access, protection) for data governance in First Nations and Black communities should be upheld.

A combination of quantitative and qualitative methods can be used for quality improvement, program evaluation, and research in accordance with institutional research ethics protocols. Systematic measurement of service engagement and equity, diversity, and inclusion variables is important for identifying and reducing disparities in access and outcomes. There should be mechanisms in place for provider, stakeholder, and client feedback, such as surveys and focus groups. Multiagency case reviews can be useful forums for evaluating multidisciplinary processes, referral pathways, service coordination, collaborative impact, and application of trauma-informed care.

Data collection processes and outcome measures should be feasible, realistic, and meaningful. Standard evaluation methods may not be a good fit with the CST population due to their complex social circumstances, barriers to following through with care plans, unsuitability of some manualized interventions, lack of validated measures, added burden of self-administered tools, and atypical notions of success. Care should be taken to not overwhelm clients with numerous psychometrics that do not adequately reflect outcomes of importance to them. [Outcomes for Human Trafficking Survivors \(OHTS\)](#) is a low-burden instrument designed to address these challenges. OHTS outcome categories align with the comprehensive range of services found to be meaningful for human trafficking survivors, reflecting circumstances that can be realistically addressed through client efforts and program support across the domains of safety, well-being, social connectedness, and self-sufficiency (Cutbush et al., 2021). A [Gender-Based Analysis Plus](#) process can augment assessment of systemic inequalities and how people of different genders and intersecting identities experience government policies and programs.

Culture-based, community-engaged, and survivor-informed research and evaluation approaches can expand our ways of knowing and doing, balance power relations, and amplify the voices of those historically silenced. For greatest impact, knowledge mobilization efforts should consider multiple audiences, including diverse survivor groups, multidisciplinary service providers, organizational leaders, researchers, academics, policymakers, funders, and the general public. The social justice implications of findings should be leveraged to effect meaningful change in CST practice and policy that will promote the best possible outcomes for child health, safety, justice, and healing.

SECTION 3: RESOURCES AND MATERIALS

3.1. DIRECTORY OF ANTI-HUMAN TRAFFICKING RESOURCES

The Canadian Human Trafficking Hotline's [National Referral Directory](#) is a resource to connect victims and survivors of human trafficking to emergency, transitional, and long-term services in communities across Canada. The directory can be accessed online or by calling the hotline at **1-833-900-1010**.

The following list of Toronto and Greater Toronto Area resources is not exhaustive. Inclusion does not constitute an endorsement by The Hospital for Sick Children.

3.1.1. Toronto Region Services

Central Toronto, East York, North York, Scarborough, Etobicoke		
Organization	Phone/Email	Website
Action Ontarienne Contre la Violence Faite Aux Femmes (French)	communications@aocvf.ca	https://aocvf.ca
Anishnawbe Health Toronto	416-360-0486 (Queen Street) 416-920-2605 (Gerard Street) 416-657-0379 (Carlton Street)	https://aht.ca
Arab Community Centre of Toronto	416-231-7746 info@acctonline.ca	https://acctonline.ca/
Aura Freedom International	info@aurafreedom.org	https://aurafreedom.org
Aurora House	416-727-0299 aurora.safehouse@gmail.com	http://www.aurorahouse.ca
Barbra Schlifer Commemorative Clinic	416-323-9149	https://www.schliferclinic.com
Boost Child and Youth Advocacy Centre	416-515-1100 1-855-424-1100 info@boostforkids.org	https://www.boostforkids.org
Breakaway Community Services	416-537-9346 breakaway@breakawaycs.ca	https://breakawaycs.ca
Canadian Mental Health Association, Mental Health and Wellness Services for Indigenous Children and Youth	1-800-875-6213 info@ontario.cmha.ca	https://ontario.cmha.ca/documents/mental-health-and-wellness-services-for-indigenous-children-and-youth/
Caribbean African Canadian Social Services	416-740-1056 info@cafcan.org	https://cafcan.org
Catholic Children's Aid Society of Toronto	416-395-1500	https://torontoccas.ca
Centre for Addiction and Mental Health	416-535-8501 1-800-463-2338	https://www.camh.ca
Children at Risk of Exploitation Unit	Contact Child Welfare Agency or 416-808-4838 care.team@torontopolice.on.ca	https://www.htsurvivors.to/

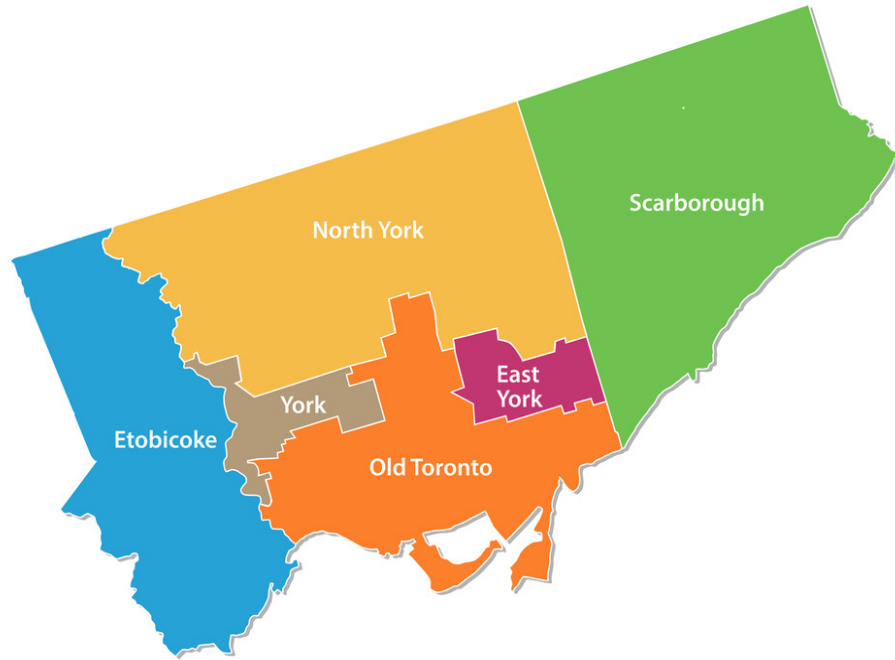
Children's Aid Society of Toronto	416-924-4646 1-866-527-0833	https://www.torontocas.ca
City of Toronto, My Access to Housing TO	416-338-8888	https://www.rentcafesocialhousing.com/onlineleasing/city-of-toronto-rent-geared-to-income-application/guestlogin.aspx
City of Toronto, Subsidized Housing, Special Priority Program	416-338-8888	https://www.toronto.ca/community-people/employment-social-support/housing-support/rent-geared-to-income-subsidy/survivors-of-domestic-abuse-or-human-trafficking/
Community Health Centres		https://www.health.gov.on.ca/en/common/system/services/chc/locations.aspx
Covenant House Toronto	General: 416-598-4898 1-800-435-7308 help@covenanthouse.ca Anti-Human Trafficking Team: 416-593-4849 1-800-435-7308 endht@covenanthouse.ca	https://covenanthousetoronto.ca
Dixon Hall	416-863-0499 x2028	https://dixonhall.org
Elizabeth Fry Toronto	416-924-3708 1-855-924-3708 info@efrytoronto.org	https://www.efrytoronto.org
Elsbeth Heyworth Centre for Women	416-663-2978 info@ehcw.ca	https://ehcw.ca
Family Health Teams		https://www.health.gov.on.ca/en/pro/programs/fht/fht_progress.aspx
FCJ Refugee Centre	416-469-9754 info@fcjrefugeecentre.org	https://www.fcjrefugeecentre.org
Fight4Freedom	admin@fight4freedom.ca	https://www.fight4freedom.ca
F.L.O.W Drop In	647-512-3996	https://flowdropin.com
George Hull Centre	416-622-8833 reachus@georgehullcentre.on.ca	https://georgehullcentre.ca
Healing in Colour		https://www.healingincolour.com
Jessie's: The June Callwood Centre for Young Women	416-365-1888 mail@jessiescentre.org	https://jessiescentre.org
Jewish Family and Child Service of Greater Toronto	416-638-7800 info@jfandcs.com	https://www.jfandcs.com
Justice for Children and Youth	416-920-1633 1-866-999-JFCY (5329) info@jfcy.org	https://jfcy.org/en/
Loft Community Services	416-979-1994 info@loftcs.org	https://www.loftcs.org
Lumenus Community Services	General: 416-222-1153 info@lumenus.ca Centralized Access to Residential Services: 416-482-7884 c.a.r.s@lumenus.ca	https://www.lumenus.ca

Mennonite New Life Centre	647-812-1332 info@mnlct.org	https://mnlct.org
Montage Support Services	416-780-9630	https://montagesupport.ca
Mulberry: Gender-Based Violence Services in Ontario		https://www.mulberryfinder.ca
Native Child and Family Services of Toronto	416-969-8510 info@nativechild.org	https://nativechild.org
Native Women's Resource Centre of Toronto	416-963-9963 info@nwrct.ca	https://nwrct.ca
Ontario Coalition of Rape Crisis Centres		https://sexualassaultsupport.ca
Ontario Ministry of the Attorney General, Free Legal Support Program for Victims of Human Trafficking	Contact Canadian Human Trafficking Hotline: 1-833-900-1010 Kelly.Beale@ontario.ca	https://www.ontario.ca/page/free-legal-support-survivors-human-trafficking
Ontario Ministry of the Attorney General, Human Trafficking Prosecution Team	416-326-2220 1-800-518-7901 HTProsecutionTeam@ontario.ca	https://www.ontario.ca/page/ministry-attorney-general
Ontario Ministry of the Attorney General, Victim/Witness Assistance Program	Contact Victim Support Line: 416-314-2447 1-888-579-2888	https://www.ontario.ca/page/victimwitness-assistance-program
Ontario Native Women's Association	1-800-667-0816 reception@onwa.ca	https://www.onwa.ca
Ontario Network of Sexual Assault/ Domestic Violence Treatment Centres	General: 416-323-7327 Navigation: 1-855-NAV-SADV (628-7238) info@sadvtreatmentcentres.ca	https://www.sadvtreatmentcentres.ca
Planned Parenthood Toronto, Teen Health Source	General: 416-961-0113 ppt@ppt.on.ca Teen Health: 416-961-3200 teenhealthsource@ppt.on.ca	https://ppt.on.ca https://teenhealthsource.com
Project iRise	rbruder@projectirise.org	https://www.projectirise.org/
Project Recover	647-302-3065	https://www.victimservicesutoronto.com/project-recover
Radius Child and Youth Services	416-744-9000 1-855-744-9001 info@radiuschild-youthservices.ca	https://radiuscys.ca
Removery, INK-initiative Program	care@removery.com	https://removery.com/en-ca/services/ink-initiative/
Scarborough Centre for Healthy Communities	416-642-9445 info@schcontario.ca	https://schcontario.ca
Scarborough Health Network, Sexual Assault and Domestic Violence Care Centre	416-495-2555	https://www.shn.ca/sexual-assault/
Scotiabank/Liechtenstein Initiative, Finance Against Slavery and Trafficking (FAST) Financial Access Program	financial.access@scotiabank.com	https://www.fastinitiative.org https://www.scotiabank.com/ca/en/personal/programs-services/financial-access-program.html
Stella's Place	416-461-2345 connect@stellasplace.ca	https://stellasplace.ca/
Strides Toronto, Gender-Based Violence Program	416-438-3697 contactus@stridestoronto.ca	https://stridestoronto.ca



Surrey Place	1-833-575-KIDS (5437)	https://www.surreyplace.ca
The 519	416-392-6874 Info@The519.org	https://www.the519.org
The Canadian Centre to End Human Trafficking	1-833-993-7867 info@CCTEHT.ca	https://www.canadiancentretoendhumantrafficking.ca
The Hospital for Sick Children, Lotus Health	437-226-3579 lotus.health@sickkids.ca	https://www.sickkids.ca/lotushealth
The Salvation Army	416-425-2111 1-800-725-2769	https://salvationarmy.ca
The Toronto Mental Health and Addictions Access Point	416-640-1934 1-888-640-1934 info@theaccesspoint.ca	https://theaccesspoint.ca/about/
Toronto Morgentaler Clinic	416-932-0446 1-800-556-6835 mclinic@passport.ca	http://www.morgentaler.ca
Toronto Police Service, Sex Crimes Unit, Human Trafficking Enforcement Team	416-808-4838 humantrafficking@torontopolice.on.ca	https://www.tps.ca/organizational-chart/specialized-operations-command/detective-operations/investigative-services/sex-crimes/human-trafficking/
Toronto Rape Crisis Centre	General: 416-597-1171 Crisis: 416-597-8808	https://trccmwar.ca
Urban Rez Solutions Social Enterprise	647-708-7226 rod@urbanrezsolutions.com	https://urbanrezsocialenterprise.com/
Uzima Women Relief Group International	647-748-8870 info@uzimawomeninternational.org	https://www.uzimawomeninternational.org/
Victim Crisis Assistance Ontario		https://www.ontario.ca/page/get-help-if-you-are-experiencing-violence
Victim Services Directory		https://ovss.findhelp.ca
Victim Services Toronto	416-808-7066 info@victimservicestoronto.com	https://victimservicestoronto.com
Women's College Hospital, Sexual Assault/Domestic Violence Treatment Centre	416-323-6040	https://www.womenscollegehospital.ca/care-programs/sexual-assault-domestic-violence-care-centre-sa-dccc/
Women's College Hospital, The Bay Centre	416-351-3700 bcbc@wchospital.ca	https://www.womenscollegehospital.ca/care-programs/the-bay-centre-sexual-health/
Yorktown Family Services	416-394-2424 info@yorktownfamilyservices.com	https://www.yorktownfamilyservices.com
Youthlink	416-967-1773 info@youthlink.ca	https://youthlink.ca
Youth Wellness Hubs Ontario	info@ywho.ca	https://youthhubs.ca/en/
YWCA Toronto	416-961-8100 info@ywcatoronto.org	https://www.ywcatoronto.org

TORONTO



GTA



3.1.2. Greater Toronto Area Services

Durham Region		
Organization	Phone/Email	Website
Catholic Family Services of Durham	905-725-3513 1-877-282-8932 info@cfsdurham.com	https://cfsdurham.com/english/
Cornerstone Community Association	905-433-0254 1-844-433-0254 GeneralInquiry@CornerstoneDurham.com	http://www.cornerstonedurham.com
Dnaagdawenmag Binnoojiiyag Child and Family Services	705-295-7135 1-844-523-2237 info@binnoojiiyag.ca	https://www.binnoojiiyag.ca
Durham Children's Aid Society	905-433-1551	https://durhamcas.ca
Durham Mental Health Services	905-666-0831 1-855-888-DMHS (3647) dmhsintake@lh.ca	https://dmhs.ca
Durham Rape Crisis Centre	General: 905-444-9672 Crisis: 905-668-9200 info@drcc.ca	https://drcc.ca
Durham Regional Police Service, Human Trafficking Unit/Children at Risk of Exploitation Unit	905-579-1520 x5600 Hotline: 905-579-1520 x4888	https://www.drps.ca/about-us/specialty-units/serious-organized-crime/
Family Services Durham	905-666-6239 1-888-721-0622 x5	
Kinark Children and Youth	1-888-454-6275 info@kinark.on.ca	https://www.kinark.on.ca
Lakeridge Health, Durham Region Domestic Violence/Sexual Assault Care Centre	905-576-8711	https://www.lakeridgehealth.on.ca/en/ourservices/domestic-violence-and-sexual-assault-care-centre.asp
Murray McKinnon Foundation, Lavender Hill Healing House	905-723-4677 mmf@murraymckinnon.ca	https://murraymckinnon.ca
Ontario Ministry of the Attorney General, Victim/Witness Assistance Program		https://www.ontario.ca/page/victimwitness-assistance-program
SafeHope Home	info@safehopehome.com referral@safehopehome.com intake@safehopehome.com	https://safehopehome.com
Victim Services of Durham Region	905-721-4226 1-888-579-1520 x3400 victimservices@drps.ca	https://www.victimservicesdurham.ca
YWCA Durham	General: 905-576-6356 Crisis: 905-576-2997 1-888-576-2997 info@ywcadurham.org	https://ywcadurham.org

Peel and Halton Region

Organization	Phone/Email	Website
African Community Services of Peel	905-460-9514 info@africancommunityservices.com	https://www.africancommunityservices.com
Catholic Family Services Peel-Dufferin	905-450-1608 x112 info@cfspd.com	https://cfspd.com
E Fry Hope and Help for Women Bonnie McPhee House	905-459-1315 efryhope@efryhope.com	https://www.efryhopehelp.com
Embrave: Agency to End Violence	905-403-9691	https://embrave.ca
Every Mind	905-795-3500 info@everymind.ca	https://everymind.ca
Family Services of Peel	905-453-5775 fsp@fspeel.org	https://fspeel.org
Family Transition Place	General: 519-942-4122 Support: 1-800-265-9178	https://familytransitionplace.ca
Halton Children's Aid Society	905-333-4441 1-866-607-KIDS (5437)	http://haltoncas.ca
Ontario Ministry of the Attorney General, Victim/Witness Assistance Program		https://www.ontario.ca/page/victimwitness-assistance-program
Our Place Peel	905-238-1383 info@ourplacepeel.org	https://ourplacepeel.org
Peel Children's Aid Society	905-363-6131 1-888-700-0996 mail@peelcas.org	https://www.peelcas.org
Peel Collaborative	905-795-3521	
Peel Regional Police, Specialized Enforcement Bureau, Vice and Human Trafficking	905-453-2121 x2133	https://www.peelpolice.ca/en/safety-tips/human-trafficking.aspx
Peel Youth Village	905-791-5576	https://shipshey.ca/housing/peel-youth-village/
Rape Crisis Centre of Peel	905-273-9442	
Restorations Second Stage Homes	905-962-REST (7378)	https://www.restorationscanada.org
Safe Centre of Peel	905-450-4650 scop@cfspd.com	https://scopeel.org
Sexual Assault and Violence Intervention Services of Halton	General: 905-825-3622 Crisis: 905-875-1555	https://www.savisofhalton.org
Thrive Counselling	1-866-457-0234 Burlington: 905-637-5256 Oakville: 905-845-3811 info@thrivecounselling.org	https://thrivecounselling.org
Trillium Health Partners, Chantel's Place	905-848-7580 x2548	https://www.thp.ca/patientservices/womens/Chantels-Place/Pages/default.aspx
Victim Services of Peel	General: 905-568-8800 Crisis: 905-568-1068 info@vspeel.org	https://vspeel.org



York Region

Organization	Phone/Email	Website
360° Kids	905-475-6694 info@360kids.ca	https://www.360kids.ca
BridgeNorth		https://bridgenorth.org
Cedar Centre	905-853-3040 1-800-263-2240 cedar@cedarcentre.ca	https://cedarcentre.ca
Dnaagdawenmag Binnoojiiyag Child and Family Services	705-295-7135 1-844-523-2237 info@binnoojiiyag.ca	https://www.binnoojiiyag.ca
Kinark Children and Youth	1-888-454-6275 info@kinark.on.ca	https://www.kinark.on.ca
Mackenzie Health, Domestic Abuse and Sexual Assault	905-883-2216 1-800-521-6004	https://www.mackenziehealth.ca/programs-services/domestic-abuse-and-sexual-assault-dasa
Ontario Ministry of the Attorney General, Victim/Witness Assistance Program		https://www.ontario.ca/page/victimwitness-assistance-program
Victim Services of York Region	905-953-5363 1-866-876-5423 x6790 victimservices@yrp.ca	https://www.victimservices-york.org
Women's Support Network of York Region	General: 905-895-3646 Crisis: 905-895-7313 info@womenssupportnetwork.ca	https://womenssupportnetwork.ca
York Hills Centre for Children, Youth and Families	905-503-9560 1-866-536-7608 yorkhills@yorkhills.ca	https://www.yorkhills.ca
York Regional Police, Special Victims Unit, Human Trafficking Section	1-866-876-5423 x6800 humantraffickingteam@yrp.ca	https://www.yrp.ca/en/about/Human-Trafficking.asp
York Region Children's Aid Society	905-895-2318 1-800-718-3850	https://www.yorkcas.org

3.1.3. Local and National Helplines

Helplines			
Organization	Phone	Text	Chat/Website
Assaulted Women's Helpline	416-863-0511 866-863-0511 TTY 1-866-863-7868	#SAFE (#7233)	https://www.awhl.org
Black Youth Helpline	416-285-9944 1-833-294-8650		https://blackyouth.ca
Canadian Human Trafficking Hotline	1-833-900-1010		https://www.canadianhumantraffickinghotline.ca/chat/



Distress Centres of Greater Toronto	416-408-HELP (4357)	416-741-741	https://www.dcoct.com
Emergency Services	911	T9-1-1 (deaf, deafened, hard of hearing, or speech impaired)	
Fem'aide (French)	1-877-FEMAIDE (336-2433)		https://femaide.ca
Good2Talk	1-866-925-5454	686868	https://good2talk.ca
Hope for Wellness Helpline (Indigenous)	1-855-242-3310		https://www.hopeforwellness.ca
Kids Help Phone	1-800-668-6868	686868	https://www.kidshelpline.ca/messenger
LGBT Youthline	1-800-268-9688	647-694-4275	https://www.youthline.ca
Male Survivors of Sexual Violence	1-866-887-0015		
Strides Toronto, Help Ahead	1-866-585-6486		https://stridestoronto.ca/program-service/help-ahead/
Suicide Crisis Helpline	988	988	https://988.ca
Talk 4 Healing Indigenous Women's Helpline	1-855-554-HEAL (4325)	1-855-554-HEAL (4325)	https://www.beendigen.com/programs/talk4healing/
Talk Suicide Canada	1-833-456-4566	45645	https://talksuicide.ca
Toronto Rape Crisis Centre Crisis Line	416-597-8808	647-424-1134	https://trccmwar.ca/crisis-line/
Trans Lifeline Hotline	1-877-330-6366		https://translifeline.org/hotline/
Victim Services Toronto Crisis Line	416-808-7066		https://www.victimservicestoronto.com
Victim Support Line	416-314-2447 1-888-579-2888		

3.2. DIRECTORY OF ANTI-HUMAN TRAFFICKING MATERIALS

3.2.1. Education, Training, and Prevention Resources

[Addressing Sex Trafficking Through Education and Research \(ASTER\)](#)

[A Guide for Human Trafficking Survivors](#) (Toronto Police Service, 2021a)

[All Party Parliamentary Group to End Modern Slavery and Human Trafficking](#)

[An Introduction to Human Trafficking: Online Course](#) (Centre for Addiction and Mental Health)

[Anti-Trafficking International](#)

[Aura Freedom International](#)

[BRAVE Education for Trafficking Prevention](#)

[Canadian Centre for Child Protection](#)

[Can You See Me?](#) (Toronto Police Service, 2021b)

[Child Sex Trafficking](#) (National Center for Missing & Exploited Children)

[Child Sex Trafficking: Experiences of Youth Who Have Been Trafficked](#) (Wozniak et al., 2021)

[Child Sex Trafficking Resource Toolkit](#) (National Children's Alliance Learning Center)

[Child Sex Trafficking: What You Might Not Know](#) (Garrett et al., 2021)

[Child Sex Trafficking: Who is Vulnerable to Being Trafficked?](#) (Kinnish et al., 2021)

[Chrysalis Anti-Human Trafficking Network](#)

[Coalition to Abolish Slavery and Trafficking](#)

[Courage for Freedom](#)

[Domestic Sex Trafficking of Youth Workshop](#) (Safeguards)

[ECPAT: Working Together to End the Sexual Exploitation of Children](#)

[Educators' Resources and Lesson Plans to End Child Sexual Exploitation](#) (White Ribbon Canada)

[Elevate Academy](#)

[Emancipation Nation Network](#)

[End Trafficking TO](#) (City of Toronto)

[Exposing Exploitation: Youth Curriculum](#) (Defend Dignity)

[ForUsGirls Foundation](#)

[Freedom Network USA](#)



[Girls Educational and Mentoring Services \(GEMS\)](#)

[Global Association of Human Trafficking Scholars](#)

[Health Care and Human Trafficking Curriculum Assessment Tool](#) (Human Trafficking Health Alliance of Canada, 2023)

[HEAL Trafficking](#)

[Human Trafficking](#) (Office for Victims of Crime)

[Human Trafficking](#) (Ontario Ministry of Children, Community and Social Services)

[Human Trafficking and Child Welfare](#) (Ontario Association of Children's Aid Societies)

[Human Trafficking and the Law](#) (Ontario Women's Justice Network & METRAC Action on Violence)

[Human Trafficking – Child Sex Trafficking](#) (EvidentialLearning)

[Human Trafficking Health Alliance of Canada](#)

[Human Trafficking Investigator's Course](#) (Canadian Police College)

[Human Trafficking Leadership Academy](#)

[Human Trafficking Learning and Resources](#) (Ontario Native Women's Association)

[Human Trafficking Lifecycle](#) (Ontario Native Women's Association)

[Human Trafficking Power and Control Wheel](#) (Polaris Project, 2010)

[Human Trafficking Training](#) (Polaris)

[Human Trafficking Training and Technical Assistance](#) (Office for Victims of Crime)

[I Am Little Red](#) (2017)

[Introduction to Human Trafficking Course](#) (Canadian Police Knowledge Network)

[Introduction to Labor and Sex Trafficking: A Health Care and Human Rights Challenge](#) (Futures Without Violence, 2016)

[Love 146](#)

[Mentari Human Trafficking Empowerment Program](#)

[Modern Slavery and Human Trafficking Response](#) (Salvation Army Justice)

[My Life My Choice](#)

[National Survivor Network](#)

[Not a Number: Interactive Child Trafficking and Exploitation Curriculum](#) (Love 146)

[OneChild](#)

[Online Training Initiative to Address Human Trafficking](#) (MCIS Language Solutions)



[Outcomes for Human Trafficking Survivors](#) (RTI International, 2020)

[Polaris](#)

[Preventing Human Trafficking: Global Issue, Calling Canada – Understanding, Identifying and Ending Trade in Human Lives](#) (Grant Thornton, 2017)

[Primary Prevention Framework for Child Trafficking: White Paper](#) (Global Alliance for Behavioral Health and Social Justice, 2020)

[Project iRISE](#)

[Providing Care to Sex Trafficked Adolescents and Adults: An E-Learning Curriculum for Forensic Nurses](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres & Women's College Hospital, Women's College Research Institute, 2023)

[Resources Library](#) (Canadian Human Trafficking Hotline)

[Sex Trafficking](#) (National Child Traumatic Stress Network)

[Sex Trafficking Prevention: A Guide for Caregivers](#) (Covenant House Toronto & Children's Aid Society of Toronto, 2019)

[Sex Trafficking: What is it?](#) (Amaze, 2019)

Sex Trafficking: Youth Guide (Children's Aid Foundation, Children's Aid Society of Toronto, & Covenant House Toronto, 2020)

[Sexual Exploitation and Trafficking of Children and Youth in Canada: A Prevention and Early Intervention Toolkit for Parents](#) (Children of the Street Society)

[Shared Hope International](#)

[Shining Light on the Commercial Sexual Exploitation of Children: A Toolkit to Build Understanding](#) (Youth Collaboratory)

[Speak Out: Stop Sex Trafficking – Addressing, Preventing and Ending the Sexual Exploitation of Indigenous Women and Youth](#)

[Speak Out: Stop Sex Trafficking – Discussion Guide for Facilitators: Addressing, Preventing and Ending Sex Trafficking](#)

[Starter Toolkit for Awareness-Raising on Trafficking in Persons](#) (Canadian Council for Refugees, 2013)

[Stop Sex Trafficking in Ontario](#) (Covenant House Toronto, 2015)

[Survivor Alliance](#)

[Take Action Against Trafficking of Black Girls](#) (Youth Collaboratory)

[TEDx Talks – Domestic Sex Trafficking: A Survivor's Perspective](#) (Church, 2020)

[TEDx Talks – Escaping the Pain of Human Trafficking](#) (Dell, 2019)

[TEDx Talks – I was Sex Trafficked for Years: Brothels are Hidden in Plain Sight](#) (Diamond, 2020)

TEDx Talks – Thriving After Trauma: The Power of Resilience (Bruder, 2020)

[The Impact of COVID-19 on Child Sex and Labor Trafficking](#) (National Child Traumatic Stress Network, Child Sex Trafficking Collaborative Group, 2020)



[The Trap: Human Trafficking Digital Education Tool](#) (Ontario Ministry of Children, Community and Social Services)

[Traffick Stop](#) (Covenant House Toronto)

[Traffick Stop: Educator Guide on Sex Trafficking Prevention](#) (Covenant House Toronto)

[Trauma-Informed Responses to Human Trafficking Webinar](#) (Western University, Centre for Research & Education on Violence Against Women & Children, Learning Network, 2019)

[Understanding and Addressing Trauma and Child Sex Trafficking: Policy Brief](#) (National Child Traumatic Stress Network, 2017)

Understanding and Working With Sexually Exploited Youth (Ontario Ministry of Children, Community and Social Services)

[Voice Found](#)

[What is Sex Trafficking?](#) (Bruder, 2020)

[What I've Been Through is Not Who I Am: Full Documentary](#) (ECPAT-USA, 2011)

[Youth Violence and Human Trafficking Prevention Program](#) (Ontario Ministry of Children, Community and Social Services)

3.2.2. Reports, Guides, and Toolkits

[Addressing Human Trafficking Through Health Systems: A Scoping Review](#) (World Health Organization, 2023)

[A Guide for Human Trafficking Survivors](#) (Toronto Police Service, 2021a)

[An Assessment of Sex Trafficking](#) (Barrett, 2013)

[Building a Child Welfare Response to Child Trafficking Handbook](#) (Walts et al., 2011)

[Building a Human Trafficking Program: Resource Guide](#) (Office for Victims of Crime, Human Trafficking Capacity Building Center)

[Building Trauma-Informed Practices for Anti-Trafficking Housing Programs](#) (Freedom Network USA, 2022)

[Caring for Trafficked Persons: Guidance for Health Providers](#) (International Organization for Migration, 2009)

[Child Sex Trafficking Resource Toolkit](#) (National Children's Alliance Learning Centre)

[Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States: A Guide for Providers of Victim and Support Services](#) (Institute of Medicine & National Research Council, 2014)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems](#) (National Human Trafficking Training and Technical Assistance Center, 2021a)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Organizations](#) (National Human Trafficking Training and Technical Assistance Center, 2021b)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Professionals](#) (National Human Trafficking Training and Technical Assistance Center, 2021c)



[Crisis Bed Program for Survivors of Sexual Exploitation and Trafficking](#) (Covenant House Toronto, 2017)

[Finding Our Voices: Lived Experiences in Human Trafficking](#) (Howarth, 2023)

[Getting Out: A National Framework for Escaping Human Trafficking for Sexual Exploitation in Canada](#) (Noble et al., 2020)

[Global Estimates of Modern Slavery: Forced Labour and Forced Marriage](#) (International Labour Organization & Walk Free Foundation, 2017)

[Global Report on Trafficking in Persons 2022](#) (United Nations Office on Drugs and Crime, 2023)

[Harm Reduction Series](#) (California Department of Social Services & Child Trafficking Response Unit, 2018)

[Homelessness, Survival Sex and Human Trafficking: As Experienced by the Youth of Covenant House New York](#) (Bigelsen & Vuotto, 2013)

[Human Trafficking Community Readiness Guide](#) (National Human Trafficking Training and Technical Assistance Center, 2021)

[Human Trafficking Corridors in Canada](#) (The Canadian Centre to End Human Trafficking, 2021b)

[Human Trafficking Prevalence and Child Welfare Risk Factors Among Homeless Youth](#) (Wolfe et al., 2018)

[Human Trafficking Response Program: Shared Learnings Manual](#) (CommonSpirit Health, 2021)

[Human Trafficking Trends in Canada \(2019 - 2020\)](#) (The Canadian Centre to End Human Trafficking, 2021a)

[Identifying Minors and Young People Exploited Through Sex Trafficking: A Resource Guide for Child Welfare Agencies](#) (Children's Bureau, Child Welfare Capacity Building Collaborative)

[Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#) (Greenbaum & Albright, 2022)

[Journey to Safe Spaces: Indigenous Anti-Human Trafficking Engagement Report \(2017 - 2018\)](#) (Ontario Native Women's Association, 2019)

[Justice in Their Own Words: Perceptions and Experiences of \(In\)Justice Among Human Trafficking Survivors](#) (Love et al., 2018)

[Modern Slavery Core Outcome Set](#)

[Multidisciplinary Collaborative Model for Anti-Human Trafficking Task Forces: Development and Operations Roadmap](#) (Albright et al., 2016)

[National Action Plan to Combat Human Trafficking \(2012 - 2016\)](#) (Public Safety Canada, 2012)

[National Forum on Human Trafficking: Summary Report](#) (Public Safety Canada, 2016)

[National Strategy to Combat Human Trafficking \(2019 - 2024\)](#) (Public Safety Canada, 2019)

["NO MORE" Ending Sex-Trafficking in Canada: Report of the National Task Force on Sex Trafficking of Women and Girls in Canada](#) (Canadian Women's Foundation, 2014)

[Ontario's Anti-Human Trafficking Strategy \(2020 - 2025\)](#) (Ontario Ministry of Children, Community and Social Services, 2020)

[PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings](#) (CommonSpirit Health, HEAL Trafficking, & Pacific Survivor Center, 2020)

[Practical Guide: Survivor-Informed Services](#) (Office for Victims of Crime, Human Trafficking Capacity Building Center)

[Preventing Human Trafficking: Global Issue, Calling Canada – Understanding, Identifying and Ending Trade in Human Lives](#) (Grant Thornton, 2017)

[Primary Prevention Framework for Child Trafficking: White Paper](#) (Global Alliance for Behavioral Health and Social Justice, 2020)

[Principles of Survivor Engagement in the Anti-Trafficking Field](#) (Office for Victims of Crime, 2016)

[Promising Practices: An Overview of Trauma-Informed Therapeutic Support for Survivors of Human Trafficking](#) (Polaris & Sanar, 2015)

[Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings](#) (Baldwin et al., 2017)

[Psychotherapy for Commercially Sexually Exploited Children: A Guide for Community-Based Behavioral Health Practitioners and Agencies](#) (Basson et al., 2018)

[Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls](#) (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

[Recognizing Human Trafficking Among Homeless Youth](#) (Chisolm-Straker et al., 2017)

[Reconciliation With Indigenous Women: Changing the Story of Missing and Murdered Indigenous Women and Girls](#) (Ontario Native Women's Association, 2020)

[Reconnecting With Your Child: Building Relationships After Sexual Exploitation](#) (National Center for Missing & Exploited Children)

[Responding to Sex Trafficking Victim-Offender Intersectionality: A Guide for Criminal Justice Stakeholders](#) (Shared Hope International, 2020)

[Sexual Exploitation and Trafficking of Aboriginal Women and Girls: Literature Review and Key Informant Interviews](#) (Native Women's Association of Canada, 2014)

[Shining Light on the Commercial Sexual Exploitation of Children: A Toolkit to Build Understanding](#) (Youth Collaboratory)

[Supporting Survivors of Human Trafficking: Counselling Guide](#) (Elizabeth Fry Toronto, 2019)

[Survivor-Informed Practice: Definition, Best Practices, and Recommendations](#) (National Human Trafficking Training and Technical Center, Human Trafficking Leadership Academy, 2017a)

[Survivor-Informed Practice: Self-Guided Assessment Tool](#) (National Human Trafficking Training and Technical Center, Human Trafficking Leadership Academy, 2017b)

[The 6 C's of Becoming an Advocate: Survivor's Lead](#) (Survivor Alliance)

[The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families Adapted for Youth Who Are Trafficked](#) (National Center for Child Traumatic Stress, 2019)

[The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment, and Treatment: APSAC Practice Guidelines](#) (APSAC Taskforce, 2013)

[The IOM Handbook on Direct Assistance for Victims of Trafficking](#) (International Organization for Migration, 2007)

[The Trauma-Informed Code of Conduct: For All Professionals Working With Survivors of Human Trafficking and Slavery](#) (Witkin & Robjant, 2018)



[Toolkit for Building Survivor-Informed Organizations](#) (National Human Trafficking Training and Technical Assistance Center, 2023)

[Toolkit to Combat Trafficking in Persons](#) (United Nations Office on Drugs and Crime, 2008)

[Trafficking at the Intersections: Racism, Colonialism, Sexism, and Exploitation in Canada](#) (Nonomura et al., 2020)

[Trafficking in Persons in Canada, 2020](#) (Conroy & Sutton, 2022)

[Trafficking of Indigenous Women and Girls in Canada: Submission to the Standing Committee on Justice and Human Rights](#) (Native Women's Association of Canada, 2018)

[Trauma-Focused Cognitive Behavioral Therapy for Commercially Sexually Exploited Youth](#) (Cohen et al., 2017)

[Understanding and Addressing Trauma and Child Sex Trafficking: Policy Brief](#) (National Child Traumatic Stress Network, 2017)

[What Works in Responding to Child Sexual Exploitation](#) (Scott et al., 2019)

3.2.3. Child Welfare and Legal Resources

[A Guide for Human Trafficking Survivors](#) (Toronto Police Service, 2021a)

[A Handbook for Criminal Justice Practitioners on Trafficking in Persons](#) (Department of Justice Canada, 2015)

[All Party Parliamentary Group to End Modern Slavery and Human Trafficking](#)

[An Anti-Oppression Framework for Child Welfare in Ontario](#) (Ontario Association of Children's Aid Societies, 2010)

[Anti-Human Trafficking Strategy Act \(2021\)](#)

[Association of Native Child and Family Services Agencies of Ontario](#)

[Building a Child Welfare Response to Child Trafficking Handbook](#) (Walts et al., 2011)

[Canadian Victims Bill of Rights \(2015\)](#)

[Can You See Me?](#) (Toronto Police Service, 2021b)

[Child and Family Services Review Board](#)

[Child Rights and Child Welfare](#) (Ontario Association of Children's Aid Societies)

[Child Welfare and Child Protection Services](#) (Government of Ontario)

[Child, Youth and Family Services Act \(2017\)](#)

[Combating Human Trafficking Act \(2021\)](#)

[Community Safety and Policing Act \(2019\)](#)

[Compensation for Victims of Crime Act \(1990\)](#)

[Courtprep.ca: A Site for Youth Preparing for Court](#)



[Criminal Code of Canada \(1985\)](#)

[Cybertip.ca](#) (Canadian Centre for Child Protection)

[Forensic Interviewing of Children: APSAC Practice Guidelines](#) (APSAC Taskforce, 2023)

[Health Care Consent Act \(1996\)](#)

[Health Protection and Promotion Act \(1990\)](#)

[Human Trafficking](#) (Ontario Provincial Police)

[Human Trafficking](#) (Royal Canadian Mounted Police)

[Human Trafficking and Child Welfare](#) (Ontario Association of Children's Aid Societies)

[Human Trafficking and the Law](#) (Ontario Women's Justice Network & METRAC Action on Violence)

[Human Trafficking in Ontario](#) (Ontario Provincial Police)

[Human Trafficking Investigator's Course](#) (Canadian Police College)

[Human Trafficking Prevalence and Child Welfare Risk Factors Among Homeless Youth](#) (Wolfe et al., 2018)

[Identifying Minors and Young People Exploited Through Sex Trafficking: A Resource Guide for Child Welfare Agencies](#) (Children's Bureau, Child Welfare Capacity Building Collaborative)

[Immigration and Refugee Protection Act \(2001\)](#)

[Indigenous Justice Program](#) (Department of Justice Canada)

[Introduction to Human Trafficking Course](#) (Canadian Police Knowledge Network)

[Legal Aid Ontario](#)

[My Court Case: An Interactive Workbook for Children and Youth Going to Court](#) (Boost Child and Youth Advocacy Centre)

[My Rights and Responsibilities](#) (Ontario Ministry of Children, Community and Social Services, Youth Justice Division)

[National Institute of Child Health and Human Development \(NICHD\) Protocol](#)

[Office of the Federal Ombudsperson for Victims of Crime](#)

[Office of the Independent Police Review Director](#)

[Ombudsman Ontario](#)

[Ontario Association of Children's Aid Societies](#)

[Ontario Child Protection Standards](#) (Ontario Ministry of Children and Youth Services, 2016)

[Ontario Child Welfare Eligibility Spectrum](#) (Ontario Association of Children's Aid Societies, 2021)

[Ontario Court of Justice](#)

[Ontario Human Rights Code \(1990\)](#)



[Ontario Victims Bill of Rights \(1995\)](#)

[Personal Health Information Protection Act \(2004\)](#)

[Policy/Program Memorandum 166 – Keeping Students Safe: Policy Framework for School Board Anti-Sex Trafficking Protocols](#) (Ontario Ministry of Education, 2021)

[Prevention of and Remedies for Human Trafficking Act \(2017\)](#)

[Publication Bans](#) (Ontario Ministry of the Attorney General)

[Reporting Child Abuse and Neglect: It's Your Duty](#) (Ontario Ministry of Children, Community and Social Services)

[Responding to Sex Trafficking Victim-Offender Intersectionality: A Guide for Criminal Justice Stakeholders](#) (Shared Hope International, 2020)

[Restorative Justice Programs](#) (City of Toronto)

[Sex Trafficking Prevention: A Guide for Caregivers](#) (Covenant House Toronto & Children's Aid Society of Toronto, 2019)

Sex Trafficking: Youth Guide (Children's Aid Foundation, Children's Aid Society of Toronto, & Covenant House Toronto, 2020)

[Superior Court of Justice](#)

[Ten-Step Investigative Interview Protocol](#) (Lyon, 2021)

[United Nations Convention on the Rights of the Child \(1989\)](#)

[United Nations Declaration on the Rights of Indigenous Peoples \(2007\)](#)

[United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children \(Palermo Protocol\) \(2000\)](#)

[Victim Impact Forms](#) (Ontario Ministry of the Attorney General)

[Victim Notification Services](#) (Ontario Ministry of the Solicitor General)

[Vulnerable Victims and Family Fund](#) (Ontario Ministry of the Attorney General)

[You Choose What to Do Next: A Guide for Navigating the Criminal Justice System, as a Sexual Assault Survivor](#) (Consent Comes First, 2021)

[Your Choice: A Guide for Sexual Assault Survivors](#) (Toronto Police Service, 2018)

[Your Rights: Children and Young Persons' Rights Resource](#) (Ontario Ministry of Children, Community and Social Services)

[Youth Criminal Justice Act \(2002\)](#)

[Youth in Transition: Pathways to Independence – A Resource Guide for Youth and Workers](#) (Association of Native Child and Family Services Agencies of Ontario, 2022)

[Youth Justice System](#) (Ontario Ministry of Children, Community and Social Services)



3.2.4. Traumatic Stress and Trauma-Informed Care Resources

[Academy on Violence and Abuse](#)

[Adolescent Trauma Training Center](#) (University of Southern California, Keck School of Medicine)

[Adverse Childhood Experiences](#) (Centers for Disease Control and Prevention)

[Adverse Childhood Experiences](#) (National Human Trafficking Training and Technical Assistance Center)

[A Guide to Toxic Stress](#) (Harvard University, Center on the Developing Child)

[Assessment of Complex Trauma by Mental Health Professionals](#) (National Child Traumatic Stress Network, 2018a)

[Assessment of Complex Trauma by Parents and Caregivers](#) (National Child Traumatic Stress Network, 2018)

[Assessment of Complex Trauma for Non-Mental Health Professionals](#) (National Child Traumatic Stress Network, 2018)

[A Trauma-Informed Guide for Working With Youth Involved in Multiple Systems](#) (Fehrenbach et al., 2022)

[Attachment, Regulation and Competency Framework](#)

[Being Anti-Racist is Central to Trauma-Informed Care: Principles of an Anti-Racist, Trauma-Informed Organization](#) (Powell et al., 2022)

[Building Trauma-Informed Practices for Anti-Trafficking Housing Programs](#) (Freedom Network USA, 2022)

[Canadian Consortium on Child and Youth Trauma](#)

[Center for Youth Wellness](#)

[Child Sex Trafficking: Experiences of Youth Who Have Been Trafficked](#) (Wozniak et al., 2021)

[Complex Trauma: Facts for Caregivers](#) (National Child Traumatic Stress Network, 2014)

[Complex Trauma Standardized Measures](#) (National Child Traumatic Stress Network, 2018b)

[Crisis and Trauma Resource Institute](#)

[Crosswalk: Youth Thrive and Healing Centered Engagement](#) (Soto-Aponte, 2021)

[Cultural Responsiveness to Racial Trauma](#) (St. Jean et al., 2020)

[Culture and Trauma](#) (National Child Traumatic Stress Network)

[Decolonizing Trauma Work: Indigenous Stories and Strategies](#) (Linklater, 2014)

[Dialectical Behavior Therapy](#)

[Eye Movement Desensitization and Reprocessing](#) (EMDR Institute, Inc.)

[Framework for Building Trauma-Informed Organizations and Systems](#) (American Institutes for Research, 2016)

[Gender-Affirming Care is Trauma-Informed Care](#) (Clarke et al., 2022)



[Guidelines for Planning and Facilitating Trauma- and Violence-Informed Meetings](#) (Western University, Centre for Research & Education on Violence Against Women & Children, Knowledge Hub, 2023)

[Helping Your Teen Cope With Traumatic Stress and Substance Abuse](#) (National Child Traumatic Stress Network, 2008a)

[How a Caregiver's Trauma Can Impact a Child's Development](#) (National Institute for the Clinical Application of Behavioral Medicine, 2019b)

[How Trauma Can Affect Your Window of Tolerance](#) (National Institute for the Clinical Application of Behavioral Medicine, 2019a)

[How Trauma Impacts Four Different Types of Memory](#) (National Institute for the Clinical Application of Behavioral Medicine, 2017b)

[Impact of Trauma on Youth With Intellectual and Developmental Disabilities: A Fact Sheet for Providers](#) (National Center for Child Traumatic Stress, Trauma and Intellectual/Developmental Disability Collaborative Group, 2020)

[Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#) (Greenbaum & Albright, 2022)

[Integrative Treatment of Complex Trauma for Adolescents](#) (University of Southern California, Keck School of Medicine, Adolescent Trauma Training Center)

[International Society for Traumatic Stress Studies](#)

[Mapping Your Nervous System's Response to Trauma](#) (National Institute for the Clinical Application of Behavioral Medicine, 2021)

[Mental Health Learning Hub](#) (SickKids, About Kids Health)

[National Child Traumatic Stress Network](#)

[National Institute for the Clinical Application of Behavioral Medicine](#)

[PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings](#) (CommonSpirit Health, HEAL Trafficking, & Pacific Survivor Center, 2020)

[Promising Practices: An Overview of Trauma-Informed Therapeutic Support for Survivors of Human Trafficking](#) (Polaris & Sanar, 2015)

[Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings](#) (Baldwin et al., 2017)

[Psychotherapy for Commercially Sexually Exploited Children: A Guide for Community-Based Behavioral Health Practitioners and Agencies](#) (Basson et al., 2018)

[Recommendations for Trauma- and Violence-Informed Physical Examinations for Patients](#) (CommonSpirit Health & HEAL Trafficking, 2022)

[Resource Library](#) (Harvard University, Center on the Developing Child)

[SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach](#) (Substance Abuse and Mental Health Services Administration, 2014)

[Seeking Safety](#) (Treatment Innovations)

[Sexual Health and Trauma](#) (National Child Traumatic Stress Network, 2019a)

[Supporting Survivors of Human Trafficking: Counselling Guide](#) (Elizabeth Fry Toronto, 2019)



[TEDx Talks – How Childhood Trauma Affects Health Across a Lifetime](#) (Harris, 2015)

[The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families](#) (National Center for Child Traumatic Stress, 2012)

[The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families Adapted for Youth Who Are Trafficked](#) (National Center for Child Traumatic Stress, 2019)

[The Trauma-Informed Code of Conduct: For All Professionals Working With Survivors of Human Trafficking and Slavery](#) (Witkin & Robjant, 2018)

[Trauma Affect Regulation: Guide for Education and Therapy](#) (Advanced Trauma Solutions Professionals)

[Trauma and the Brain](#) (NHS Lanarkshire, 2015)

[Trauma and Your Family](#) (National Child Traumatic Stress Network, 2011)

[Trauma- and Violence-Informed Approaches to Policy and Practice](#) (Public Health Agency of Canada)

[Trauma- and Violence-Informed Care: A Tool for Health and Social Service Organizations and Providers](#) (Wathen & Varcoe, 2021)

[Trauma- and Violence-Informed Care Toolkit for Reducing Stigma Related to Sexually Transmitted and Blood-Borne Infections](#) (Canadian Public Health Association, 2020)

[Trauma-Focused Cognitive Behavioral Therapy for Commercially Sexually Exploited Youth](#) (Cohen et al., 2017)

[Trauma-Focused Cognitive Behavioral Therapy: Therapist Certification Program](#)

[Trauma-Focused Cognitive Behavioral Therapy Web](#) (Medical University of South Carolina)

[Trauma-Informed Approach: Introductory Handbook](#) (Valgiusti, 2023)

[Trauma-Informed Care Implementation Center](#)

[Trauma-Informed Care in Youth Serving Settings: Organizational Self-Assessment](#) (Traumatic Stress Institute)

[Trauma-Informed Guiding Principles for Working With Transition Age Youth: Provider Fact Sheet](#) (Kisiel et al., 2021)

[Trauma-Informed Organizational Assessment \(TIOA\) Informational Packet](#) (National Child Traumatic Stress Network, 2020)

[Trauma-Informed Organizational Capacity \(TIC\) Scale](#)

[Trauma-Informed Physical Examinations and STBBI Testing: A Guide for Service Providers](#) (Canadian Public Health Association, 2021)

[Trauma-Informed Workplace Assessment](#)

[Trauma Teletherapy for Youth in the Era of the COVID-19 Pandemic: Adapting Evidence-Based Treatment Approaches](#) (Briere et al., 2020)

[Trauma Treatments](#) (National Child Traumatic Stress Network)

[Understanding and Addressing Trauma and Child Sex Trafficking: Policy Brief](#) (National Child Traumatic Stress Network, 2017)

[Understanding Child Traumatic Stress: A Guide for Parents](#) (National Child Traumatic Stress Network, 2008b)



[Understanding the Links Between Adolescent Trauma and Substance Abuse: A Toolkit for Providers \(2nd Ed.\)](#) (National Child Traumatic Stress Network, Adolescent Trauma and Substance Abuse Committee, 2008)

[What Happens in the Brain During a Potentially Traumatic Event](#) (National Institute for the Clinical Application of Behavioral Medicine, 2017a)

[What is a Trauma-Informed Child and Family Service System?](#) (National Child Traumatic Stress Network, 2016)

[What is Child Traumatic Stress?](#) (National Child Traumatic Stress Network, 2003)

[What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them](#) (Spinazzola et al., 2017)

[Women, Abuse and Trauma Therapy: An Information Guide for Women and Their Families](#) (Haskell, 2004)

3.2.5. Medical and Sexual Health Resources

[Addressing Human Trafficking Through Health Systems: A Scoping Review](#) (World Health Organization, 2023)

[A Guide to Taking a Sexual History](#) (Reno et al., 2022)

[Amaze](#)

[Amaze for Parents](#)

[Canadian Guideline on HIV Pre-Exposure Prophylaxis and Nonoccupational Postexposure Prophylaxis](#) (Tan et al., 2017)

[Canadian Immunization Guide](#) (Public Health Agency of Canada)

[Caring for Trafficked Persons: Guidance for Health Providers](#) (International Organization for Migration, 2009)

[Child Health Hub in Transition to Adult Healthcare](#) (Children's Healthcare Canada)

[Clinical Practice Guideline: Management of Acute Child and Adolescent Sexual Abuse and Assault](#) (The Hospital for Sick Children, 2020)

[Comprehensive Sexual Health Assessments for Adolescents](#) (Johnson, 2020)

[Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States: A Guide for Providers of Victim and Support Services](#) (Institute of Medicine & National Research Council, 2014)

[Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach](#) (World Health Organization, 2021)

[Contraceptive Care for Canadian Youth](#) (Di Meglio et al., 2018)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems](#) (National Human Trafficking Training and Technical Assistance Center, 2021a)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Organizations](#) (National Human Trafficking Training and Technical Assistance Center, 2021b)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Professionals](#) (National Human Trafficking Training and Technical Assistance Center, 2021c)



[Diagnosis and Management of Sexually Transmitted Infections in Adolescents](#) (Allen et al., 2019)

[Discussing Sexual Health, Substance Use and STBBIs: A Guide for Service Providers](#) (Canadian Public Health Association, 2017)

[Drug Facilitated Sexual Assault Information for First Responders](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2017a)

[Factsheets](#) (Planned Parenthood Toronto)

[Guidelines for Pediatric Concussion Care](#) (Reed et al., 2021)

[Guide to Taking HIV PEP](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2023)

[Health Care and Human Trafficking Curriculum Assessment Tool](#) (Human Trafficking Health Alliance of Canada, 2023)

[HEAL Trafficking](#)

[HIV Pre-Exposure Prophylaxis: It is Time to Consider Harm Reduction Care for Adolescents in Canada](#) (Leonard et al., 2023)

[Hospital Guidelines for the Treatment of Persons Who Have Been Sexually Assaulted \(3rd Ed.\)](#) (Ontario Hospital Association, 2019)

[How Racism Can Affect Child Development](#) (Harvard University, Center on the Developing Child)

[Human Trafficking – Child Sex Trafficking](#) (EvidentiaLearning)

[Human Trafficking Health Alliance of Canada](#)

[Human Trafficking Response Program: Shared Learnings Manual](#) (CommonSpirit Health, 2021)

[Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#) (Greenbaum & Albright, 2022)

[Interpretation of Medical Findings in Suspected Child Sexual Abuse: An Update for 2023](#) (Kellogg et al., 2023)

[Introduction to Labor and Sex Trafficking: A Health Care and Human Rights Challenge](#) (Futures Without Violence, 2016)

[Knowing Your Rights in a Health Care Setting](#) (SickKids, About Kids Health)

[Language Matters: Using Respectful Language in Relation to Sexual Health, Substance Use, STBBIs and Intersecting Sources of Stigma](#) (Canadian Public Health Association, 2019)

[Likely Story: The Game](#) (2021)

[Medical Assessment of Bruising in Suspected Child Maltreatment](#) (Ward et al., 2013)

[Medical Assessment of Fractures in Suspected Child Maltreatment](#) (Chauvin-Kimoff et al., 2018)

Medical Guidelines for HIV Post-Exposure Prophylaxis for Sexual Assault Victims/Survivors (Wong et al., 2011)

[National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach](#) (National Institute of Justice, 2017)

[National Protocol for Sexual Abuse Medical Forensic Examinations](#) (U.S. Department of Justice, Office on Violence Against Women, 2013)

[Not Just the Tip: Toolkit for Sexual Health Educators](#) (Canadian Centre for Gender and Sexual Diversity, 2023)

[Ontario Network of Sexual Assault/Domestic Violence Treatment Centres](#)

[PEARR Tool: Trauma-Informed Approach to Victim Assistance in Health Care Settings](#) (CommonSpirit Health, HEAL Trafficking, & Pacific Survivor Center, 2020)

[Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings](#) (Baldwin et al., 2017)

[Providing Care to Sex Trafficked Adolescents and Adults: An E-Learning Curriculum for Forensic Nurses](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres & Women's College Hospital, Women's College Research Institute, 2023)

[Recommendations for Trauma- and Violence-Informed Physical Examinations for Patients](#) (CommonSpirit Health & HEAL Trafficking, 2022)

[Safer Sex Tips](#) (Options for Sexual Health)

[Sex & U](#) (The Society of Obstetricians and Gynaecologists of Canada)

[Sexual Health and Trauma](#) (National Child Traumatic Stress Network, 2019a)

[Sexual Health Information Hub](#) (Action Canada for Sexual Health and Rights)

[Sexual Health Learning Hub](#) (SickKids, About Kids Health)

[Sexually Transmitted and Blood-Borne Infections: Guide for Health Professionals](#) (Public Health Agency of Canada, 2022)

[Sexually Transmitted Infections Treatment Guidelines, 2021](#) (Centers for Disease Control and Prevention, 2021b)

[Standards of Care \(2nd Ed.\)](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2019)

[Standards of Care for the Health of Transgender and Gender Diverse People, Version 8](#) (Coleman et al., 2022)

[Strangulation Aftercare Instructions](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2021)

[The Commercial Sexual Exploitation of Children: The Medical Provider's Role in Identification, Assessment, and Treatment: APSAC Practice Guidelines](#) (APSAC Taskforce, 2013)

[Transition to Adult Health Care Learning Hub](#) (SickKids, About Kids Health)

[Trauma- and Violence-Informed Care: A Tool for Health and Social Service Organizations and Providers](#) (Wathen & Varcoe, 2021)

[Trauma- and Violence-Informed Care Toolkit for Reducing Stigma Related to Sexually Transmitted and Blood-Borne Infections](#) (Canadian Public Health Association, 2020)

[Trauma-Informed Physical Examinations and STBBI Testing: A Guide for Service Providers](#) (Canadian Public Health Association, 2021)

[Was I Drugged and Sexually Assaulted? What You Should Know and Where You Can Go](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2017b)

[What is My Risk of Being Infected With HIV? What Can I Do About it?](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2017c)



3.2.6. Substance Use, Harm-Reduction, and Safety Planning Resources

[Best Practice Recommendations for Canadian Harm Reduction Programs](#) (Strike et al., 2021)

[Caring for Yourself](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2022)

[Discussing Sexual Health, Substance Use and STBBIs: A Guide for Service Providers](#) (Canadian Public Health Association, 2017)

[Harm Reduction International](#)

[Harm Reduction Series](#) (California Department of Social Services & Child Trafficking Response Unit, 2018)

[Helping Your Teen Cope With Traumatic Stress and Substance Abuse](#) (National Child Traumatic Stress Network, 2008a)

[Hope by CAMH: Suicide Prevention Mobile App](#) (Centre for Addiction and Mental Health, 2020)

[How to Talk With Your Teen About Drugs: Communication Tips for Parents](#) (Health Canada, 2010)

[Language Matters: Using Respectful Language in Relation to Sexual Health, Substance Use, STBBIs and Intersecting Sources of Stigma](#) (Canadian Public Health Association, 2019)

[My Safety Plan](#) (Children's Hospital of Eastern Ontario, 2019)

[Safety Planning](#) (Canadian Human Trafficking Hotline)

[Screening, Brief Intervention and Referral to Treatment \(SBIRT\)](#) (Substance Abuse and Mental Health Services Administration)

[Six Ways to Practice Self-Care](#) (Centre for Addiction and Mental Health, 2019)

[Stanley-Brown Safety Planning Intervention](#)

[Substance Use and Mental Health Services Administration](#)

[Substance Use and Substance Use Disorder: Overview](#) (SickKids, About Kids Health, 2019a)

[Substance Use Disorder: How to Help Your Teen at Home](#) (SickKids, About Kids Health, 2019b)

[Substance Use Spectrum](#) (Health Canada, 2022)

[Suicide Risk Assessment Toolkit: A Resource for Healthcare Workers and Organizations](#) (Mental Health Commission of Canada, 2021)

[Talking With Teens About Alcohol and Other Drugs](#) (Substance Abuse and Mental Health Services Administration, 2022)

[Understanding the Links Between Adolescent Trauma and Substance Abuse: A Toolkit for Providers \(2nd Ed.\)](#) (National Child Traumatic Stress Network, Adolescent Trauma and Substance Abuse Committee, 2008)

[Using Drugs to Deal With Stress and Trauma: A Reality Check for Teens](#) (National Child Traumatic Stress Network, 2008c)

[Using Grounding to Detach from Emotional Pain](#) (Najavits, 2002a)

[Was I Drugged and Sexually Assaulted? What You Should Know and Where You Can Go](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2017b)



3.2.7. Secondary Traumatic Stress Resources

[Figley Institute](#)

[Françoise Mathieu](#)

[Professional Quality of Life Scale \(ProQOL\)](#)

[Provider Self-Care Toolkit](#) (National Center for PTSD)

[Secondary Effects of Trauma](#) (National Human Trafficking Training and Technical Center)

[Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals](#) (National Center for Child Traumatic Stress, Secondary Traumatic Stress Committee, 2011)

[Secondary Traumatic Stress Consortium](#)

[Secondary Traumatic Stress Core Competencies for Trauma-Informed Support and Supervision: Cross-Disciplinary Version](#) (Haskell et al., 2022)

[Secondary Traumatic Stress Core Competencies for Trauma-Informed Support and Supervision: Cross-Disciplinary Version – Companion Document: Strategies and Resources to Support Implementation of Supervisor Competencies](#) (National Center for Child Traumatic Stress, 2022)

[Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision Self-Rating Tool](#) (Sprang, 2022)

[Secondary Traumatic Stress Informed Organizational Assessment \(STSI-OA\)](#) (University of Kentucky, Center on Trauma and Children)

[Secondary Traumatic Stress Scale \(STSS\)](#)

[Taking Care of Yourself](#) (National Child Traumatic Stress Network, 2018c)

[TEDx Talks – The Edge of Compassion](#) (Mathieu, 2018)

[TEND Toolkit](#) (TEND Academy LTD)

[The Compassion Fatigue Workbook: Creative Tools for Transforming Compassion Fatigue and Vicarious Traumatization](#) (Mathieu, 2012)

[The Vicarious Trauma Toolkit](#) (Office for Victims of Crime)

[Using the Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision](#) (National Center for Child Traumatic Stress, 2018d)

[Vicarious Resilience Scale \(VRS\)](#)

3.2.8. Survivor-Informed Practice and Peer Support Resources

[Canadian Mental Health Association, Centre for Excellence in Peer Support](#)

[Courage for Freedom](#)

[Elevate Academy](#)

[Finding Our Voices: Lived Experiences in Human Trafficking](#) (Howarth, 2023)



[ForUsGirls Foundation](#)

[Girls Educational and Mentoring Services \(GEMS\)](#)

[Guidelines for the Practice and Training of Peer Support](#) (Sunderland et al., 2013)

[Human Trafficking Leadership Academy](#)

[Justice in Their Own Words: Perceptions and Experiences of \(In\)Justice Among Human Trafficking Survivors](#) (Love et al., 2018)

[Making the Case for Peer Support: Report to the Mental Health Commission of Canada](#) (Cyr et al., 2016)

[Mentari Human Trafficking Empowerment Program](#)

[My Life My Choice](#)

[National Survivor Network](#)

[OneChild](#)

[Peer Support Canada](#)

[Peer Support Code of Conduct](#) (Peer Support Canada, 2019)

[Peer Support Core Values](#) (Peer Support Canada, 2019a)

[Peer Support: What is it and Does it Work?](#) (National Voices & Nesta, 2015)

[Peer Supporter Competencies](#) (Peer Support Canada, 2019b)

[Practical Guide: Survivor-Informed Services](#) (Office for Victims of Crime, Human Trafficking Capacity Building Center)

[Principles of Survivor Engagement in the Anti-Trafficking Field](#) (Office for Victims of Crime, 2016)

[Project iRISE](#)

[Reflexive Practice Guidelines and Tools for Peer Supporters](#) (Read, 2020)

[Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Substance Use/Addiction Organizations](#) (Phillips et al., 2018)

[Support House, Centre for Innovation in Peer Support](#)

[Survivor Alliance](#)

[Survivor-Informed Practice: Definition, Best Practices, and Recommendations](#) (National Human Trafficking Training and Technical Center, Human Trafficking Leadership Academy, 2017)

[Survivor-Informed Practice: Self-Guided Assessment Tool](#) (National Human Trafficking Training and Technical Center, Human Trafficking Leadership Academy, 2017)

[The 6 C's of Becoming an Advocate: Survivor's Lead](#) (Survivor Alliance)

[Toolkit for Building Survivor-Informed Organizations](#) (National Human Trafficking Training and Technical Assistance Center, 2023)

[Voice Found](#)



3.2.9. Culture-Based and Anti-Oppressive Practice Resources

[2-Spirited People of the 1st Nations](#)

[Africentric Social Work](#) (Mullings et al., 2021)

[An Anti-Oppression Framework for Child Welfare in Ontario](#) (Ontario Association of Children's Aid Societies, 2010)

[Being Anti-Racist is Central to Trauma-Informed Care: Principles of an Anti-Racist, Trauma-Informed Organization](#) (Powell et al., 2022)

[Black Girls Matter: Pushed Out, Overpoliced and Underprotected](#) (Crenshaw, 2015)

[Canadian Centre for Diversity and Inclusion](#)

[Canadian Centre for Gender and Sexual Diversity](#)

[Caring for LGBTQ2S People: A Clinical Guide \(2nd Ed.\)](#) (Bourns & Kucharski, 2022)

[Critically Infused Social Work: Anti-Oppressive Practice](#)

[Cultural Resources for Families](#) (Association of Native Child and Family Services Agencies of Ontario)

[Cultural Responsiveness to Racial Trauma](#) (St. Jean et al., 2020)

[Culture and Trauma](#) (National Child Traumatic Stress Network)

[Decolonizing Trauma Work: Indigenous Stories and Strategies](#) (Linklater, 2014)

[EGAP Framework](#) (Black Health Equity Working Group, 2021)

[Equity, Inclusion, Diversity and Anti-Racism Framework](#) (Ontario Health)

[Everyone Belongs: A Toolkit for Applying Intersectionality](#) (Simpson, 2009)

[First Nations Mental Wellness Continuum Framework](#) (Health Canada, 2015)

[First Nations Principles of OCAP](#) (First Nations Information Governance Centre)

[Gender-Affirming Care is Trauma-Informed Care](#) (Clarke et al., 2022)

[Gender and Identity Learning Hub](#) (SickKids, About Kids Health)

[Global Accountability Framework on Gender Equality and Women's Empowerment](#) (United Nations Sustainable Development Group, 2019)

[GLMA: Health Professionals Advancing LGBTQ+ Equality](#)

[Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada](#) (Truth and Reconciliation Commission of Canada, 2015)

[How Racism Can Affect Child Development](#) (Harvard University, Center on the Developing Child)

[How to Talk Effectively About Racism](#) (Hardy, 2015)

[Human Trafficking Learning and Resources](#) (Ontario Native Women's Association)



[Human Trafficking Lifecycle](#) (Ontario Native Women's Association)

[Impact of Trauma on Youth With Intellectual and Developmental Disabilities: A Fact Sheet for Providers](#) (National Center for Child Traumatic Stress, Trauma and Intellectual/Developmental Disability Collaborative Group, 2020)

[Journey to Safe Spaces: Indigenous Anti-Human Trafficking Engagement Report \(2017 - 2018\)](#) (Ontario Native Women's Association, 2019)

[Key Health Inequalities in Canada: A National Portrait](#) (Public Health Agency of Canada, 2018)

[Learning for Justice](#) (Southern Poverty Law Center)

[LGBTQ2S Inclusion Playbook: A Series of Best Practices for Healthcare Environments](#) (Liss, 2020)

[LGBTQ2S Toolkit](#) (National Learning Community on Youth Homelessness, 2015)

[Measuring Cultural Safety in Health Systems](#) (Canadian Institute for Health Information, 2021)

[Ontario Human Rights Commission](#)

[Psychology's Response to the Truth and Reconciliation Commission of Canada's Report](#) (Canadian Psychological Association & The Psychology Foundation of Canada, 2018)

[Rainbow Health Ontario](#)

[Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls](#) (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019)

[Reconciliation With Indigenous Women: Changing the Story of Missing and Murdered Indigenous Women and Girls](#) (Ontario Native Women's Association, 2020)

[Self-Assessment of Culture in Regard to Privilege: Hot Spots, Hidden Spots, and Soft Spots](#) (Cuellar et al., 2022)

[Sexual Exploitation and Trafficking of Aboriginal Women and Girls: Literature Review and Key Informant Interviews](#) (Native Women's Association of Canada, 2014)

[Sexual Orientation, Gender Identity and Gender Expression \(SOGIE\): Safer Places Toolkit](#) (Alberta Health Services, 2019)

[Social Determinants and Inequities in Health for Black Canadians: A Snapshot](#) (Public Health Agency of Canada, 2020)

[Speak Out: Stop Sex Trafficking – Addressing, Preventing and Ending the Sexual Exploitation of Indigenous Women and Youth](#)

[Speak Out: Stop Sex Trafficking – Discussion Guide for Facilitators: Addressing, Preventing and Ending Sex Trafficking](#)

[Standards of Care for the Health of Transgender and Gender Diverse People, Version 8](#) (Coleman et al., 2022)

[Tips on How to Practice 2SLGBTQI Allyship](#) (Egale)

[Trafficking at the Intersections: Racism, Colonialism, Sexism, and Exploitation in Canada](#) (Nonomura et al., 2020)

[Trafficking of Indigenous Women and Girls in Canada: Submission to the Standing Committee on Justice and Human Rights](#) (Native Women's Association of Canada, 2018)

[Truth and Reconciliation Commission of Canada: Calls to Action](#) (Truth and Reconciliation Commission of Canada, 2015)

[United Nations Convention on the Rights of the Child \(1989\)](#)



[United Nations Declaration on the Rights of Indigenous Peoples \(2007\)](#)

[Wisdom2Action](#)

3.2.10. Screening and Assessment Tools

Human trafficking and commercial sexual exploitation tools:

[Asian Health Services & Banteay Srei Commercial Sexual Exploitation of Children \(CSEC\) Screening Protocol](#)

[Child and Adolescent Needs and Strengths - Commercial Sexual Exploitation \(CANS-CSE\)](#)

[Child Protective Services and Risk Assessment: Human Trafficking Screening Tools](#)

[Commercial Sexual Exploitation - Identification Tool \(CSE-IT\)](#)

[Comprehensive Human Trafficking Assessment](#)

[Human Trafficking Assessment for Runaway and Homeless Youth](#)

[Human Trafficking Interview and Assessment Measure \(HTIAM-14\)](#)

[Human Trafficking Screening Tool Short Form \(HTST-SF\)](#)

[Memorandum Summarizing the Available Screening Tools to Identify Commercial Sexually Exploited Children and Matrix of Screening Tools](#)

[National Human Trafficking Assessment Tool](#)

[Operational Indicators of Trafficking in Human Beings](#)

[Quick Youth Indicators for Trafficking \(QYIT\)](#)

[Rapid Appraisal for Trafficking \(RAFT\)](#)

[Rapid Screening Tool \(RST\) for Child Trafficking and Comprehensive Screening and Safety Tool \(CSST\) for Child Trafficking](#)

[SEXual Health Identification Tool \(SEXIT\)](#)

[Sexually Exploited Youth \(SEY\) Risk Assessment Tool](#)

[Screening and Universal Education: Choosing Your Approach](#)

[Short Screen for Child Sex Trafficking \(SSCST\)](#)

[Trafficking Screening Tools](#)

[Trafficking Victim Identification Tool \(TVIT\)](#)

Trauma, mental health, suicide, and substance use tools:

[Acute Stress Checklist for Children \(ASC-Kids\)](#)

[Ask Suicide-Screening Questions \(ASQ\)](#)



[Beck Depression Inventory \(BDI-II\)](#)

[Behavior Assessment System for Children \(BASC-3\)](#)

[Child and Adolescent Trauma Screen \(CATS\) - Youth Report and Caregiver Report](#)

[Child Behavior Checklist \(CBCL\)](#)

[Childhood Trauma Questionnaire \(CTQ\)](#)

[Child PTSD Symptom Scale for DSM-5 \(CPSS-5\)](#)

[Children's Reaction to Traumatic Events Scale - Revised \(CRTES-R\)](#)

[Child Trauma Screen \(CTS\)](#)

[Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#)

[Complex Trauma Standardized Measures](#)

[CRAFFT](#)

[CYW Adverse Childhood Experiences Questionnaire \(ACE-Q\)](#)

[Mental Health: Screening Tools and Rating Scales](#)

[Multidimensional Anxiety Scale for Children \(MASC 2\)](#)

[Pediatric ACEs and Related Life-Events Screener \(PEARLS\)](#)

[Pediatric Traumatic Stress Screening Tool \(PTSST\)](#)

[Screen for Child Anxiety Related Emotional Disorders \(SCARED\)](#)

[Screening to Brief Intervention \(S2BI\)](#)

[Suicide Risk Assessment Toolkit: A Resource for Healthcare Workers and Organizations](#)

[Trauma Symptom Checklist for Children \(TSCC\)](#)

[Traumatic Events Screening Inventory - Child Report Form \(TESI-CRF\) and Parent Report Revised \(TESI-PRR\)](#)

[UCLA Posttraumatic Stress Disorder - Reaction Index \(UCLA PTSD-RI\)](#)

Secondary traumatic stress tools:

[Professional Quality of Life Scale \(ProQOL\)](#)

[Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision Self-Rating Tool](#)

[Secondary Traumatic Stress Informed Organizational Assessment \(STSI-OA\)](#)

[Secondary Traumatic Stress Scale \(STSS\)](#)

[Vicarious Resilience Scale \(VRS\)](#)



Human trafficking response, trauma-informed care, and cultural safety tools:

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Organizations](#)

[Core Competencies for Human Trafficking Response in Health Care and Behavioral Health Systems: Self-Assessment Tool for Health Care and Behavioral Health Professionals](#)

[Health Care and Human Trafficking Curriculum Assessment Tool](#)

[Measuring Cultural Safety in Health Systems](#)

[Self-Assessment of Culture in Regard to Privilege: Hot Spots, Hidden Spots, and Soft Spots](#)

[Service Assessment Tool in Improving Physical and Mental Health Care for Those at Risk of, and Experiencing Human Trafficking and Exploitation: The Complete Toolkit \(2nd Ed.\)](#)

[Survivor-Informed Practice: Self-Guided Assessment Tool](#)

[Trauma-Informed Care in Youth Serving Settings: Organizational Self-Assessment](#)

[Trauma-Informed Organizational Assessment \(TIOA\) Informational Packet](#)

[Trauma-Informed Organizational Capacity \(TIC\) Scale](#)

[Trauma-Informed Workplace Assessment](#)

3.2.11. Psychoeducational Resources for Children and Families

[A Guide for Human Trafficking Survivors](#) (Toronto Police Service, 2021a)

[A Guide for Trusted Adults: Practical Tips and Tools for Supporting Girls and Young Women Navigating Life Online](#) (YWCA Canada, Project Shift, 2017)

[A Guide to Toxic Stress](#) (Harvard University, Center on the Developing Child)

[Amaze](#)

[Amaze for Parents](#)

[A Quick Guide on Sexual Image Based Abuse](#) (YWCA Canada)

[Assessment of Complex Trauma by Parents and Caregivers](#) (National Child Traumatic Stress Network, 2018)

[BRAVE Education for Trafficking Prevention](#)

[Canadian Consortium on Child and Youth Trauma](#)

[Can You See Me?](#) (Toronto Police Service, 2021b)

[Caring for Yourself](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2022)

[Complex Trauma: Facts for Caregivers](#) (National Child Traumatic Stress Network, 2014)

[Courtprep.ca: A Site for Youth Preparing for Court](#)



[Cybertip.ca: Online Harms](#) (Canadian Centre for Child Protection)

[Domestic Sex Trafficking of Youth Workshop](#) (Safeguards)

[Exposing Exploitation: Youth Curriculum](#) (Defend Dignity)

[Factsheets](#) (Planned Parenthood Toronto)

[Gender and Identity Learning Hub](#) (SickKids, About Kids Health)

[Get Cyber Safe](#) (Government of Canada)

[Helping Your Teen Cope With Traumatic Stress and Substance Abuse](#) (National Child Traumatic Stress Network, 2008a)

[Hope by CAMH: Suicide Prevention Mobile App](#) (Centre for Addiction and Mental Health, 2020)

[How a Caregiver's Trauma Can Impact a Child's Development](#) (National Institute for the Clinical Application of Behavioral Medicine, 2019b)

[How to Talk With Your Teen About Drugs: Communication Tips for Parents](#) (Health Canada, 2010)

[How Trauma Can Affect Your Window of Tolerance](#) (National Institute for the Clinical Application of Behavioral Medicine, 2019a)

[How Trauma Impacts Four Different Types of Memory](#) (National Institute for the Clinical Application of Behavioral Medicine, 2017b)

[Human Trafficking Info Hub](#) (Aura Freedom International, 2021)

[Human Trafficking Power and Control Wheel](#) (Polaris Project, 2010)

[I Am Little Red](#) (2017)

[Knowing Your Rights in a Health Care Setting](#) (SickKids, About Kids Health)

[Likely Story: The Game](#) (2021)

[Love is Respect](#) (National Domestic Violence Hotline)

[Mapping Your Nervous System's Response to Trauma](#) (National Institute for the Clinical Application of Behavioral Medicine, 2021)

[MediaSmarts](#)

[Mental Health Learning Hub](#) (SickKids, About Kids Health)

[My Court Case: An Interactive Workbook for Children and Youth Going to Court](#) (Boost Child and Youth Advocacy Centre)

[My Rights and Responsibilities](#) (Ontario Ministry of Children, Community and Social Services, Youth Justice Division)

[My Safety Plan](#) (Children's Hospital of Eastern Ontario, 2019)

[National Child Traumatic Stress Network](#)

[NetSmartz](#) (National Center for Missing & Exploited Children)



[OneChild](#)

[Protect Kids Online](#) (Canadian Centre for Child Protection)

[Reconnecting With Your Child: Building Relationships After Sexual Exploitation](#) (National Center for Missing & Exploited Children)

[Resource Library](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres)

[Resources Library](#) (Canadian Human Trafficking Hotline)

[Safer Sex Tips](#) (Options for Sexual Health)

[Safety Planning](#) (Canadian Human Trafficking Hotline)

[Sex & U](#) (The Society of Obstetricians and Gynaecologists of Canada)

[Sex Trafficking](#) (National Child Traumatic Stress Network)

[Sex Trafficking Prevention: A Guide for Caregivers](#) (Covenant House Toronto & Children's Aid Society of Toronto, 2019)

[Sex Trafficking: What is it?](#) (Amaze, 2019)

Sex Trafficking: Youth Guide (Children's Aid Foundation, Children's Aid Society of Toronto, & Covenant House Toronto, 2020)

[Sexual Exploitation and Trafficking of Children and Youth in Canada: A Prevention and Early Intervention Toolkit for Parents](#) (Children of the Street Society)

[Sexual Health Information Hub](#) (Action Canada for Sexual Health and Rights)

[Sexual Health Learning Hub](#) (SickKids, About Kids Health)

[Six Ways to Practice Self-Care](#) (Centre for Addiction and Mental Health, 2019)

[Speak Out: Stop Sex Trafficking – Addressing, Preventing and Ending the Sexual Exploitation of Indigenous Women and Youth](#)

[Staying Safe While Staying Connected: Facts and Tips for Teens](#) (National Child Traumatic Stress Network, Child Sexual Abuse Collaborative Group, 2010)

[Staying Safe While Staying Connected: Tips for Caregivers](#) (National Child Traumatic Stress Network, 2015)

[Stop Non-Consensual Intimate Image Abuse](#)

[Stop Sex Trafficking in Ontario](#) (Covenant House Toronto, 2015)

[Substance Use and Substance Use Disorder: Overview](#) (SickKids, About Kids Health, 2019a)

[Substance Use Disorder: How to Help Your Teen at Home](#) (SickKids, About Kids Health, 2019b)

[Talking With Teens About Alcohol and Other Drugs](#) (Substance Abuse and Mental Health Services Administration, 2022)

[Tech Safety Canada](#) (Women's Shelters Canada)

[The Trap: Human Trafficking Digital Education Tool](#) (Ontario Ministry of Children, Community and Social Services)



[Traffick Stop for Caregivers](#) (Covenant House Toronto)

[Traffick Stop: Sex Trafficking 101](#) (Covenant House Toronto)

[Transition to Adult Health Care Learning Hub](#) (SickKids, About Kids Health)

[Trauma and Your Family](#) (National Child Traumatic Stress Network, 2011)

[Understanding Child Traumatic Stress: A Guide for Parents](#) (National Child Traumatic Stress Network, 2008b)

[Using Drugs to Deal With Stress and Trauma: A Reality Check for Teens](#) (National Child Traumatic Stress Network, 2008c)

[Using Grounding to Detach from Emotional Pain](#) (Najavits, 2002a)

[Was I Drugged and Sexually Assaulted? What You Should Know and Where You Can Go](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2017b)

[What Happens in the Brain During a Potentially Traumatic Event](#) (National Institute for the Clinical Application of Behavioral Medicine, 2017a)

[What is Child Traumatic Stress?](#) (National Child Traumatic Stress Network, 2003)

[What is Complex Trauma? A Resource Guide for Youth and Those Who Care About Them](#) (Spinazzola et al., 2017)

[What is My Risk of Being Infected With HIV? What Can I Do About it?](#) (Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, 2017c)

[What is Sex Trafficking?](#) (Bruder, 2020)

[You Choose What to Do Next: A Guide for Navigating the Criminal Justice System, as a Sexual Assault Survivor](#) (Consent Comes First, 2021)

[Your Choice: A Guide for Sexual Assault Survivors](#) (Toronto Police Service, 2018)

[Your Rights: Children and Young Persons' Rights Resource](#) (Ontario Ministry of Children, Community and Social Services)

[Youth in Transition: Pathways to Independence – A Resource Guide for Youth and Workers](#) (Association of Native Child and Family Services Agencies of Ontario, 2022)



SECTION 4: TERMS AND REFERENCES

4.1. AGENCY ACRONYMS AND ABBREVIATIONS

Boost Child and Youth Advocacy Centre	Boost CYAC
Boost Child Victim Witness Support Program.....	Boost CVWSP
Catholic Children’s Aid Society of Toronto	CCAS
Centre for Addiction and Mental Health.....	CAMH
Centre of Forensic Sciences	CFS
Children at Risk of Exploitation Unit.....	CARE
Children’s Aid Society of Toronto.....	CAST
Community Health Centre	CHC
Covenant House Toronto.....	CHT
Emergency Department	ED
Human Trafficking Enforcement Team.....	HTET
Human Trafficking Prosecution Team.....	HTPT
Indigenous Anti-Human Trafficking Liaison Program	IAHTL
Intelligence-Led Joint Forces Strategy.....	IJFS
Jewish Child and Family Service of Greater Toronto	JFCS
Native Child and Family Services of Toronto.....	NCFST
Native Women’s Resource Centre of Toronto.....	NWRCT
Ontario Association of Children’s Aid Societies	OACAS
Ontario Ministry of Children, Community and Social Services.....	MCCSS
Ontario Ministry of the Attorney General.....	MAG
Ontario Native Women’s Association	ONWA
Ontario Network of Sexual Assault/Domestic Violence Treatment Centres	ONSADVTC
Ontario Provincial Police.....	OPP
Provincial Anti-Human Trafficking Coordination Office	PATCO
Royal Canadian Mounted Police.....	RCMP
Sexual Assault/Domestic Violence Treatment Centres	SA/DVTCs
Suspected Child Abuse and Neglect Program	SCAN
The Canadian Centre to End Human Trafficking.....	CCTEHT
The Hospital for Sick Children	SickKids
Toronto Police Service.....	TPS
Victim Quick Response Program	VQRP
Victim Services Toronto	VST
Victim/Witness Assistance Program	V/WAP

4.2. GLOSSARY OF TERMS

Child: Individual under 18 years of age. The term child is inclusive of children and youth.

Child sex trafficking: Use of a child in a sex act in exchange for something of perceived value. This is a form of human trafficking, encompasses commercial sexual exploitation, and constitutes child maltreatment.

Coercive control: Pattern of physical and/or non-physical behaviours used to control, dominate, and hold power over another person in a relationship.

Commercial sex: Any type of sex act for which something of perceived value is given, promised, or received, directly or indirectly.

Grooming: Tactics used to prepare a child for being sex trafficked. This typically involves manipulation and coercion to gain the child's trust and form an emotional bond.

Debt bondage: Coercive tool used by traffickers to force victims to engage in commercial sex as a means of repaying imposed financial debt.

Human trafficking: Recruitment, transportation, transferring, holding, concealing, harbouring, or exercising control, direction, or influence over a person for the purpose of exploitation, generally through sexual exploitation or forced labour.

Lived experience expert: Individual who has personally experienced sex trafficking and is working in a professional capacity in the anti-human trafficking sector. Lived experience experts are survivors.

Luring: Deliberate communication with a child for the purpose of committing sex trafficking.

Recruiting: Act of selecting and enlisting individuals to be sex trafficked.

Survivor: Individual who was previously sex trafficked and may be engaged in a healing process.

The game/life: Street terms referring to sex trade subculture.

Trafficker: Individual or group responsible for committing the offence of child sex trafficking. Also known as exploiters, offenders, perpetrators, or pimps.

Trauma: Lasting adverse effects resulting from a distressing event, or series of events or circumstances, that is experienced as frightening, harmful, or life-threatening.

Trauma-informed care: Approach to care that realizes the widespread prevalence and impact of trauma, recognizes the signs and symptoms of trauma, responds by fully integrating knowledge about trauma in policies and practices, and seeks to actively resist re-traumatization and promote recovery.

Victim: Individual who is currently being sex trafficked or has experienced harm or injustice and is in need of protection and support. This term is commonly used in child welfare and criminal justice contexts.

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