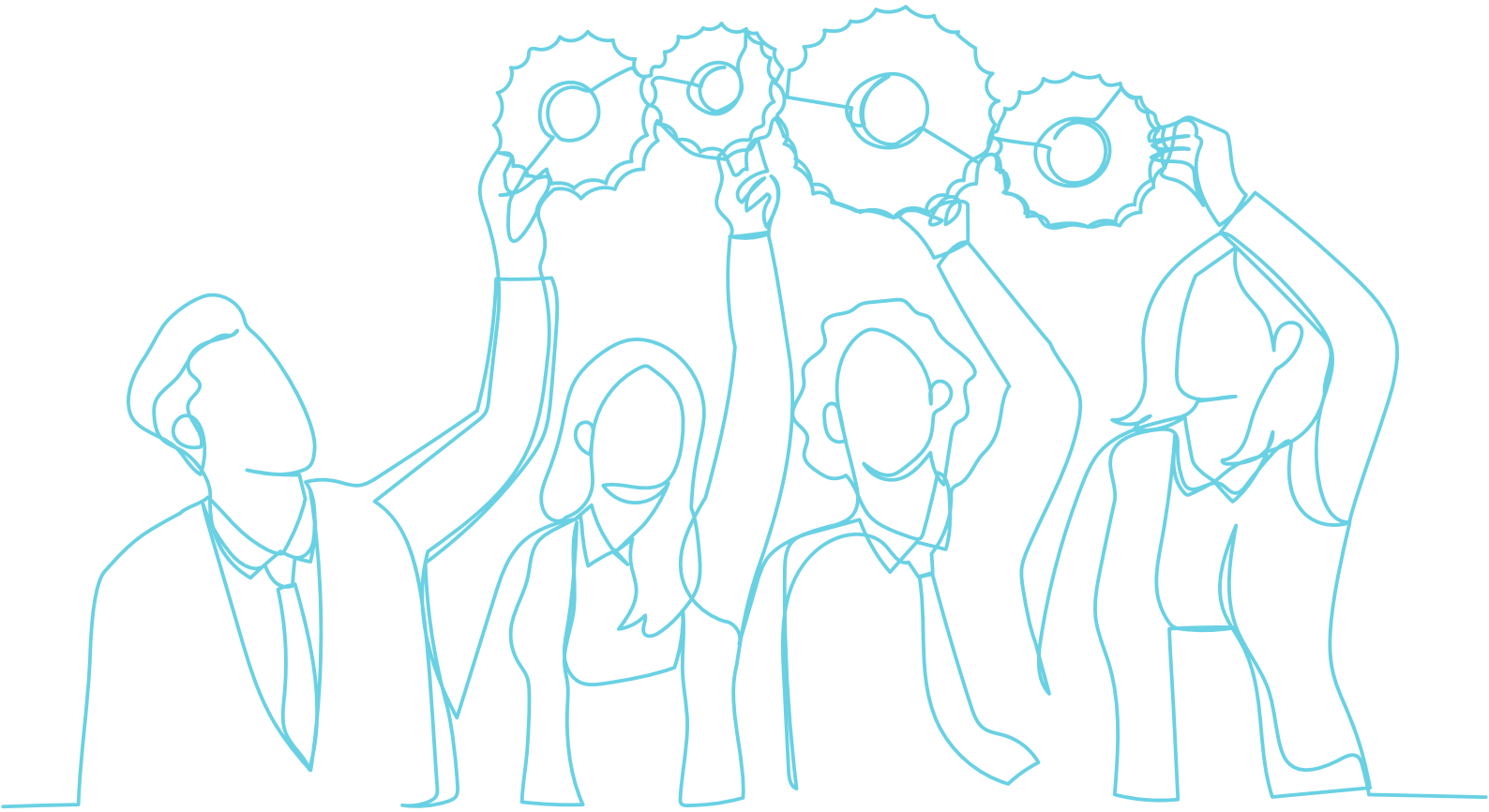
The Multidisciplinary Team Framework

for Addressing Child Sexual Abuse, Exploitation and Trafficking



International Centre™
FOR MISSING & EXPLOITED CHILDREN

HEROES

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Introduction

THB/CSA/CSE are major global public health problems. As per the International Labour Organisation (ILO), approximately 1.7 million children were involved in commercial sexual exploitation on any given day in 2021.[3] In a global systematic review and meta-analysis of child sexual abuse, CSA prevalence estimates ranged from 8 to 31 % for girls and 3 to 17 % for boys.[4] Individuals subjected to THB/CSA/CSE may experience a plethora of emotional, behavioural and physical adverse consequences. Impacts include increased risk for post-traumatic stress disorder, major depression, anxiety disorders, sexually transmitted infections and other sexual health and reproductive problems, HIV/AIDS, physical injury, and early pregnancy.[5-8]

Beyond health and mental health care, children experiencing THB/CSA/CSE often have myriad other needs including housing (if the current home is not safe for the child, there is severe stigma in the community, or the child/family have no home); education; job skills training; immigration relief, interpretation services, crisis intervention and financial resources.

THB/CSA/CSE as gendered crimes

Crimes and abuse of a sexual nature are gendered no matter the country, context or individuals involved. Indeed, the largest majority of known victims of crimes of a sexual nature such as THB for sexual exploitation, CSA and CSE, are women and girls. This also means that the gender of the victim(s) and/or perpetrator(s) will have an impact on the crime, its purposes, and impact, including on the ability to report the crime and be believed.

Especially, gender roles influence victimization, disclosure rates, responses by those who learn of the THB/CSA/CSE and responses by victims to their experiences. One of the most typical gender role encountered in most cultures is the 'machismo' gender role, which encourages dominance and sexual prowess amongst boys and men, which in a sense condones sexual aggression toward women and girls, who are expected to be sexually objectified, submissive and weak. Gender roles also demand that men and boys be seen as 'protectors' and able to resist victimization. They are not allowed to be victims and if they are, they may be seen as 'weak', 'unmanly' and/or 'homosexual.' This presents a significant barrier to disclosure by victimized boys, but it also drives those who learn of the abuse to 1) not view the boy child as a victim (e.g., when the offender is an older woman); 2) blame the victim for not preventing the abuse/trafficking; 3) assign agency to the child victim, seeing him as a criminal (THB). Gender roles of weakness and an inability to protect oneself make women and girls victims more likely to be treated as victims, and given assistance. It is seen as easier for them to disclose because they are not violating an assigned gender role, although other factors and roles assigned to them (such as holding the family's honour through their "purity" / virginity) will impact this disclosure differently – or prevent it entirely.

Male victims, especially boys, may have a harder time coping with the THB/CSA/CSE if they internalise these gender roles and expectations, as they may view themselves as weak, unmanly, etc. The fact that gender expectations are that boys should take care of themselves rather than reach out for help will further push them to silence. Indeed, male victims have been shown to respond to trauma like CSA with more externalizing behaviours, such as violence, than girls, who tend to respond with more internalizing symptoms (e.g., depression).

Having a nonbinary sexual identity – not fitting within traditional gender roles – is another factor of victimisation: an American study[153] has found that transgender people (over 16 years of age) are over four times more likely than cisgender people to be victims of violent crime, including rape and sexual assault. There is no difference between transgender men and women. The study does not focus on children – only those between 16 and 18, but we can expect conclusions to be similar for transgender children.

Multidisciplinary Teams as one of the solutions to better care for victims

For many children and families, healing and recovery occurs alongside criminal investigations and prosecutions. The sheer number of stakeholders involved in providing services and pursuing criminal justice may be overwhelming to affected children and their caregivers, and this may lead to their confusion, distress, and distrust of authorities, as well as to very limited access to appropriate services. In many areas of the world, child-serving professionals and their organisations work in relative isolation in response to THB/CSA/CSE.9 Information is not shared; resources are not organised; service efforts are not coordinated, and the family must assume responsibility for orchestrating their own healing. As a result, social, psychosocial, health and legal outcomes suffer.

To promote child and family healing, minimise re-traumatisation and optimise criminal justice efforts in response to THB/CSA/CSE, many countries and regions have developed strategies to facilitate cross-agency, multidisciplinary collaboration among the professionals engaged in prevention, identification, protection, service provision, investigation, criminal prosecution and legal redress.[10-16] Utilising the varied expertise and resources of multidisciplinary professionals ensures input from multiple perspectives regarding a case and facilitates better-informed decisions. Strategies may take the form of national referral mechanisms (NRMs) or transnational referral mechanisms (TRMs) to address THB, or state/regional/local child protection multidisciplinary teams that tend to focus on child sexual abuse. In the framework outlined in this document, these strategies will be referred to as ‘multidisciplinary teams’ (MDTs), regardless of whether they define discrete ‘teams’ of professionals or simply emphasise collaborative activities between staff of relevant agencies/organisations. There is no prototype for optimal MDT collaboration and a variety of models have been developed across the globe,[11] including but not limited to Thuthuzela Centres in South Africa,[17] One-Stop Centres in India, Malawi, and many low- and middle-resource countries,[18-20] integrated service centres within hospitals,[11,21] a Multiagency Investigation and Support Team (MIST) in Australia,[22] Barnahaus centres in Europe,[23] child advocacy centres in the United States,[24] and child and youth advocacy centres in Canada. Most countries have formal or informal NRMs for suspected THB and some have TRMs, which standardise the process for interagency collaboration on the response to THB within and across borders, respectively.[15,25,26] Within these categories of MDT organisation there is additional variation,[11,27] often regarding the number and type of partners involved, services offered and overall goals of the team. A relatively large MDT typically involves a private/public partnership between government agencies, NGOs, INGOs and other private institutions who serve children experiencing or at risk for THB/CSA/CSE.

MDTs may function at a community, regional, national or even international level covering one or more counties/parishes/jurisdictions/states/provinces/countries. Their composition varies according to community needs and resources but generally includes professionals from organisations/agencies involved in preventing, identifying, assessing, investigating and prosecuting cases of suspected/confirmed THB/CSA/CSE, and in serving impacted children and their families.24,27 Typically these include the agencies/stakeholders listed below (See Section I, â€œMDT Compositionâ€).

Teams may also seek membership from organisations that serve children at particular risk for THB/CSA/CSE, such as asylum/refugee assistance centres, NGOs serving street-based children, organisations serving LGBTQ+ youth, organisations providing legal immigration assistance, and organisations serving marginalised ethnic, racial or religious groups.[24] For MDTs that focus primarily on systemic issues related to the response to THB/CSA/CSE, it is important to include adults with lived experience of childhood exploitation and abuse, and caregivers of victimised children, as these perspectives are critical in developing policy, programs and systems change.[28]

Some MDT models involve actual physical co-location of MDT members, including representatives from the government agency providing child protective services, and law enforcement.[22] Some have a specific location where children and families are brought to meet with multiple MDT members for combined services (e.g., a Chikwanekwane).[18,21,29] Still others have no specific building that hosts collaborative services and no co-location of MDT members. For example, MDTs may involve a network of representatives from varied organisations and agencies, that simply communicate online, by phone or with regular in-person meetings, to discuss individual cases of THB/CSA/CSE, or to discuss broad, systemic issues related to MDT collaboration. These may involve groups of professionals within a given city or county, or within a province, country or groups of countries.30 The nature of the MDT model in any given community must be consistent with cultural, geographic, social, and economic factors in the region, as well as the needs of the population served.

One-Stop Service Model[20,22,24,27,29]

In some jurisdictions, the MDT will provide multiple services and engage in collaborative practices at a specific location, such as a One Stop Centre. This strategy is aimed at increasing MDT communication, facilitating a team approach, and simplifying the referral process so that children/families are more likely to receive needed services.[27] There is significant variation among centres such as the nature of services provided, whether there is actual co-location of agency representatives at the site of the centre, and whether key roles such as the forensic interviewer or child advocate are filled by members of staff belonging to the centre, or by representatives from other MDT agencies (e.g. law enforcement).[27] To date, evidence is limited in determining which characteristics of one-stop-centres are most important in improving outcomes for children.[27]

Important considerations for the centre include, but are not limited to, the following:

- Ensure a child-friendly and safe environment suitable for all ages, for children of all genders and sexual orientations including lesbian/gay/bisexual/transgender/queer/questioning/other (LGBTQ+) youth, for clients from varied cultures and for children with disabilities. Input from those with lived experience may be very useful when designing the centre. (NOTE: Existing laws may limit efforts to optimally serve children identifying as LGBTQ+, although respect for their basic human rights as outlined in the UN Convention on the Rights of the Child must remain the highest priority.)[2]
- Ensure that the site of services is not associated with social stigma
- Install ramps, lifts and other aids to ensure access for children, caregivers and MDT members with mobility challenges and other forms of disability.
- Implement child safeguarding policies, including strategies to monitor adherence and address issues that may arise
- Establish the location near public transportation or arrange transportation assistance for families
- Ensure privacy and confidentiality through effective policies and procedures and by making necessary alterations in the physical environment. This may include establishing non-disclosure agreements with the staff, implementing a policy of keeping the child/family separated from a suspected perpetrator, and installing sound-proofing materials in the interview rooms.

- Ensure adequate safety measures are in place to manage stressful situations and or emergencies; ensure staff are trained in these procedures and aware of safety measures
- Provide adequate space and equipment for team meetings, forensic interviews (FI), team observation of FIs, etc.
- Establish a safe, secure system for storing client data
- Establish policies and procedures that allow video recording of FIs, as permitted by law. Policies should include provisions for appropriate access to, and safe storage of recordings so as to ensure confidentiality and privacy. It should outline steps to be taken to ensure children and caregivers are aware of the recording and provide informed consent/assent.
- Address information-sharing restrictions and codify system of sharing client information among MDT members as appropriate, consistent with existing laws and policies (e.g., establish policy/guidelines or advocate for legislation allowing information-sharing; establish a clear plan for obtaining informed consent and release-of-information from guardians; address the issue in MDT member MOUs or other similar but binding agreements) (see Appendix A).
- Build and maintain an efficient case-tracking system
- Ensure staff are trained in trauma-informed, rights-based, culturally sensitive, child-centred care
- Provide client/family information materials on THB/CSA/CSE in appropriate languages and have professional interpreters available during visits

Successful multidisciplinary collaboration entails:[9,11,19,20,24,25,29,31-41]

Leadership and General Structure:

- An MDT addressing THB/CSA/CSE cannot be effective without demonstrated commitment from top-level leaders of organisations participating in the collaboration. It is important for these leaders to fully understand and to support the provisions of the MDT, including:
    - providing experienced staff who can fulfil the roles and responsibilities required by the team,
    - committing to support MDT goals,
    - guaranteeing staff are allowed time to carry out MDT activities during work hours
    - providing critical resources including necessary technology and financial support.
    - A memorandum of understanding (MOU) is helpful in facilitating consensus and commitment among partners. While cultural, social, and legal factors will influence the content of the MOU and structure of the MDT, the elements contained in the sample MOU included in this framework are relevant in many contexts (see Appendix A).
- Leaders should ensure that agency/organisation standard operating procedures include a statement that at least one staff member participate in the MDT and all staff members receive training on the MDT and on THB/CSA/CSE
- Formal recognition of the MDT by state/province/national government with appropriate infrastructure in place, and accompanying MDT funding included in the government budget, along with provisions that authorise interagency collaboration and information sharing
- Strong leadership within the MDT, itself in the form of a steering committee (comprised of decision-makers) and MDT coordinator (neutral party)
- Broad professional representation on the MDT
- Representation on the MDT that reflects the population served (e.g., cultural inclusion)
- Engagement in serious preplanning for MDT development. This may include hosting a roundtable of agency/organisation leaders to discuss the merits and challenges associated with the multidisciplinary process and begin planning the MDT developmental process

Standardised policies and procedures in the form of a protocol that:

- Is supported by a memorandum of understanding (MOU) signed by leaders of organisations and agencies participating in the MDT (see Appendix A)
- Clearly defines the goals and objectives of the MDT (e.g., focus mainly on investigation/prosecution vs. provision of child services vs. focus on both). Ideally, the MDT prioritises both child/family services, which are virtually always needed, and criminal investigation/prosecution, which is pursued in some but not all cases.
- Clearly establishes that the child's best interest is, and should always be, the highest priority for the MDT. The rights of the child outlined in the CRC2 are embraced, including but not limited to, providing the child/family with relevant information about their case; empowering the child/family to voice their opinions in all decisions related to them and to have an active role in safety planning and service provision consistent with age and development; ensuring the rights of the child/family to confidentiality and privacy, as well as cultural responsivity and care that is free of bias/discrimination related to race/ethnicity, nationality, gender identity, sexual orientation, disability, religion or other factors.
- Is founded on the concept that the needs and desires of every impacted child/family are unique so that services and assistance must be tailored to meet the specific needs in each case.
- Recognises that when the age of a child is not clear, the dangers of falsely assuming the individual is an adult exceed those of erroneously assuming they are a child, and that the individual should be given the benefit of the doubt and treated as a minor until age can be determined.
- Clearly describes the roles/responsibilities of MDT members, as well as limitations inherent in their work
- Codifies strategies for appropriate information-sharing and collaborative teamwork (including what information can/should be shared and procedures to follow to allow sharing). It is critical to have prompt, consistent, open communication between members, with tactical information sharing in the context of privacy and confidentiality laws and policies; existing challenges to cross-agency information sharing must be addressed. See section VII.
- Outlines the step-by-step procedure to be followed when managing a case of suspected THB/CSA/CSE, from initial referral of the case to provision of child/family services that extends beyond the period of criminal investigation, to case closure (including local integration, return to country of origin or resettlement in a 3rd country for foreign-born children).
- Establishes multiple pathways in which a child may come to the attention of MDT members and receive services. Multiple reporting channels helps ensure vulnerable children are recognized and served.
- Outlines the trauma-informed, child-centred, rights-based and culturally responsive approach to working with children who may have experienced THB/CSA/CSE and their families
- Clearly establishes guidelines on appropriate documentation by MDT members
- Establishes procedures to address and resolve conflicts within the MDT
- Provides information regarding risk factors and possible indicators of THB/CSA/CSE and a standardised, validated screening measure(s) to screen for risk (if available).
- Provides a directory of available child/family services and prevention programs, as well as MDT member agency/organisation contact information.
- Actively seeks out organisations that serve marginalised populations at risk for THB/CSA/CSE.
- Ensures equity and inclusivity for all children and families throughout all phases of identification, assessment, investigation, prosecution and service provision. This includes free access to health and mental health care services, waiving fees to file police reports and elimination of other economic and social barriers to service access for all children regardless of citizenship status.

- Establishes formal agreements with key service providers, such as an organisation offering paediatric mental health services, and a children's hospital forensic institute and/or medical clinic where staff are trained in treating paediatric trauma and sexual violence. This helps to ensure standardised reliable services for children and families.
- Addresses vicarious trauma/secondary traumatic stress
- Outlines process for ongoing monitoring and evaluation of the MDT process and impact, with evaluation results used to make necessary changes to MDT
- Creates a steering committee to oversee MDT function, resolve conflicts, make changes to the MDT and to ensure sustainability.
- Establishes an MDT coordinator to address day-to-day details of MDT function and ensure ongoing collaboration and compliance with the protocol; ideally this person is viewed as a neutral party
- Establishes a system for anonymous feedback by MDT members, children, families and other stakeholders regarding MDT functioning, with regular review of feedback and implementation of necessary changes to protocol and practices
- Describes process for effective dissemination of the protocol to stakeholders, including education on use of the protocol

Training

- Initial and regular supplementary training of child-serving professionals is critical in establishing a thorough understanding of THB/CSA/CSE dynamics, the experiences, health impacts, and psychosocial needs of children, as well as the requirements for criminal investigation. Training includes:
  - Annual, cross-professional training of **MDT members** on the protocol; the definitions and dynamics of THB/CSA/CSE (including similarities and differences); online CSE as a form of abuse; and the trauma-informed, rights-based, child-centred and culturally responsive approach to child/family interactions. The training should cover updates to laws and policies; a review of available child/family services; specific training on the negative impact of stigma; and strategies to increase cultural responsiveness.
  - Training on cultural responsiveness, as well as implicit and explicit bias and discrimination, including its negative impact on children and families. Training should address strategies for recognizing and responding to one's own biases and those of others in the workplace.
  - Training for **all mental health providers serving affected children and families** on the impact of trauma and traumatic stress, the child-centred, trauma-informed approach to working with clients, and basic strategies needed to provide psychoeducation and teach techniques for stress management. Where resources are available, children needing specialty care should be referred to mental health clinicians trained specifically on child trauma and evidence-based therapies for children who have experienced sexual violence. Clinicians should be aware of the similarities and unique challenges in serving children who have experienced THB vs CSE vs CSA.
  - **Specialised training for MDT staff** regarding professional practices within their specific field that are needed to successfully address THB/CSA/CSE. Examples include training forprosecutors on building and trying cases, for law enforcement on evidence collection and investigation strategies, for healthcare professionals on obtaining relevant patient history and conducting forensic medical evaluations, etc.
  - Training for frontline professionals who, while not part of the MDT, may be first responders in the recognition of children exposed to THB/CSA/CSE. This includes, but is not limited to some police officers, lawyers, teachers, labour inspectors, religious leaders and health professionals, among others. Consider creating 'checklists' or short manuals that outline professional responsibilities when THB/CSA/CSE is suspected.

- Training for **aspiring professionals** in police academies, and programs in law, medicine, nursing, psychology, education and social work

MDT Member Values and Commitments

To function appropriately, the MDT should also be based on:

- A negotiated, shared vision and goals that are valued and accepted by all MDT members and their organisations.
- Understanding of the cultures defining each MDT agency/organisation
- Thorough understanding of members' roles and responsibilities, as well as their organisations' limitations
- Attention to 'turf' issues (potentially opposing views of roles/responsibilities of MDT members with disagreements over control)
- Interdependence, shared power and mutual gain of participants and their organisations
- Commitment by members to engage in clear, open-minded communication, with prompt responses to questions and requests by other members
- Commitment by each member to appropriately protect the private information of children and families

Successful Functioning of the MDT Includes:

- Collaborative networking to develop and maintain professional relationships with all members feeling equally valued and respected.
- Use of standardised definitions that are harmonised with international standards and national laws
- Use of standardised screening tools when feasible, or use of evidence-informed and standardised questions assessing risk of THB/CSA/CSE appropriate for the local population.
- Awareness of MDT members of existing resources for children and families. This may involve conducting a 'community mapping' exercise to identify public and private organisations that provide resources to address vulnerability factors as well as those facilitating trauma healing.
- Implementation of effective strategies for cross-agency referrals within and external to the MDT.
- Integration of community-based organisations into the MDT, to help facilitate service provision
- Ensuring that a case manager is assigned to each family to advocate for the rights of the child/ caregiver and to ensure their service needs are met during and after the investigation.
- Regular team meetings to facilitate information sharing and maintain critical relationships among members. Meetings may vary in goals, from focusing on individual case reviews to provide case updates and facilitate service provision, to broad, high-level discussions of systemic issues regarding MDT function and sustainability. Training sessions and respectful peer review discussions may be incorporated into meetings.
- Participation in primary prevention activities to raise awareness of THB/CSA/CSE, reduce risk within the community and address social stigmas related to THB/CSA/CSE. Such efforts may include school education programs, town hall sessions for parents, and media campaigns.
- Working with the media to educate on the child-centred, trauma-informed approach to reporting THB/CSA/CSE, the need to avoid stigmatising, victim-blaming language and a respect for the privacy of affected children and families.
- Working with the media to advocate for the rights of children and their families.

Common Challenge to MDT Implementation

Countries and communities functioning in low resource settings, those experiencing extensive corruption, and/or limited governmental support may face serious challenges in developing and implementing the comprehensive MDT described in this framework. Even communities and states characterised as 'high resource' may experience limited access to resources due to allocation restrictions, political climate, legislative limitations and other factors.

It is critical to consider that full implementation of an all-inclusive protocol may be accomplished in a step-wise fashion, introducing changes in small increments, according to opportunities that arise over time. In fact, even in the best of conditions, designing and implementing a comprehensive protocol is a time- and labour-intensive project that should be piloted before full implementation. Thereafter it requires monitoring and continuous adjustment to reflect ongoing changes in the dynamics of the community and of THB/CSA/CSE.

In some states and communities, it may not be feasible for a relatively small number of dedicated child-serving professionals to instigate sweeping changes in the legal and/or social welfare infrastructure that will pave the way for an effective MDT response. For example, widespread corruption within the criminal justice system, or extremely limited and suboptimally organised social welfare responses may severely limit the development of a fully functional MDT. Significant changes may require a lengthy period of time, substantial and sustained political and social will and major cultural shifts. However, in these instances, alternative shorter-term goals may be considered while working for long-term change. For example, the MDT may choose to focus efforts on assisting parents, other caregivers and frontline professionals (e.g., teachers, and healthcare personnel) to keep children safe in the absence of an effective law enforcement or government social welfare response. That is, efforts are directed toward child safety rather than holding offenders accountable in the criminal justice system; to grass roots support rather than government-run social service interventions. In addition to THB/CSA/CSE primary prevention initiatives, adults may be trained on harm reduction strategies to maximise the safety of a child who is at high risk for, or who has experienced THB/CSA/CSE.90,92 For example, teachers may be taught how to assist parents in creating safety plans to protect the child from harm or to minimise harm that cannot be avoided. Healthcare providers may be trained to provide psychoeducation to traumatised children and their caregivers, so healing may begin even in the absence of trained mental health professionals. Examples of psychoeducation include explanations of the traumatic stress response, strategies for re-interpreting a child's behaviours as an adaptation to prior trauma, and training on simple but effective stress management techniques. Training and support may be provided by community NGO's. Parent/caregiver and child support may be provided by hotlines and helplines. Adult survivors of THB/CSA/CSE and caregivers of survivors may provide critical input on the effective design and implementation of these harm reduction and psychoeducation initiatives.

Primary prevention efforts are also critical and may be a major focus if major barriers prevent an effective criminal justice response and provision of government-run child protective services. These may focus on initiatives addressing CSA, online sexual victimisation and THB, targeting children of varying age, parents/caregivers and professionals. Again, involvement of adult survivors of THB/CSA/CSE and caregivers of survivors is important, as is cultural adaptation of existing programs. Prevention messages should be relevant to the target audience and their daily lives, especially when addressing online safety concerns. Please also see Section VIII.

Structure of the Template for a MDT Protocol

The framework includes a template for the development of a MDT protocol that is tailored to meet the specific needs of a given community/region/country. The template outlines the basic components of a protocol and indicates areas that must be specifically adapted to local conditions. In addition, there are multiple appendices that provide further resources. The resulting protocol created by stakeholders may or may not include the Introduction section of this framework.

The template begins by outlining the foundations of a MDT, then provides relevant definitions for terms related to THB/CSA/CSE. It includes sections on providing trauma-informed, child-centred, culturally responsive, and rights-based care, and on strategies for working with children of varying age and developmental abilities. The framework outlines procedures for multidisciplinary collaboration among team members, describes roles and responsibilities of members, and outlines key services relevant to the MDT. Finally, the framework addresses THB/CSA/CSE prevention, and discusses secondary traumatic stress/vicarious trauma that may be experienced by MDT members. The appendices include a sample MOU, a list of potential indicators of THB/CSA/CSE, additional resources for MDT members, an international framework for THB/CSA/CSE, additional ethical issues to consider and a template for a directory of community resources. A summary of the evidence base for multidisciplinary collaboration in the field of child protection is also included.

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

Moreover, for some jurisdictions that have more advanced legal frameworks, e.g.: EU Member States, the use of this Framework **does not in any way exempt** countries and organisations from adherence to their binding legal instruments. On the contrary, this Framework should be used to complement them, and aspects of this document that are below the standards of the current legislative state of the art can be removed.

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

Methodology of the Framework as part of the HEROES project

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

Template

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

NOTE: This template, *with or without the above introduction,* should be adapted to create a protocol that meets specific environmental conditions and population needs of the target community/region/country.

I. Foundations of the MDT Protocol

Why a protocol is important

Purpose:

The purpose of an MDT protocol is to outline general principles and strategies for building and maintaining a comprehensive, multidisciplinary collaborative approach to the prevention, identification, assessment, intervention (including protection and child/family service provision), investigation and criminal prosecution of THB/CSA/CSE.
An MDT protocol serves as a guideline and is not intended as legal evidence of a standard of care. Compliance or noncompliance with the document is not intended for use in trial or court as relevant evidence. In case of any interpretation or conflict, or for requirements not addressed herein, the law will always take precedence. In addition, case specific conditions may require that certain components of the protocol are not followed; this should be determined on a case-by-case basis.

Goals: *[Modify goals below to reflect specific needs of community.]*

The protocol aims to:

1. Ensure that children who have experienced THB/CSA/CSE, and those at risk receive services that meet their holistic needs, in ways that respect child rights, empower the child and caregiver, promote healing, minimise risk of re-victimization, and minimise emotional distress during the intervention process.

2. Improve the quality of criminal investigations of THB/CSA/CSE and promote successful prosecution of offenders.

3. Enhance the quality of evidence identified/gathered for civil litigation.

4. Increase public awareness of THB/CSA/CSE and appropriate strategies for seeking victim assistance

Objectives:[9,24,29]: *[Modify objectives below to reflect specific needs of community.]*

The objectives of this Protocol are to:

1. Establish a multidisciplinary, standardised, collaborative process for the investigation and response to suspected THB/CSA/CSE, that embodies a child-centred, trauma-informed, rights-based and culturally responsive approach.

2. Define, implement and monitor appropriate information-sharing practices between MDT members

3. Ensure continuous monitoring and evaluation of MDT functioning, with use of data to improve processes and practices

4. Facilitate the education of community professionals, families and the public on THB/CSA/CSE prevention, recognition and response, emphasising the harm associated with bias and stigmatisation.

Guiding Principles:

The following guiding principles, which are essential for child justice as stated under the United Nations Convention on the Rights of the Child[2] and United Nations Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime,[42] must be observed by all professionals during their work with children/families who have experienced THB/CSA/CSE:

- Prioritise the best interest of the child in all matters impacting that child
- Ensure children and families are treated with respect and are protected from discrimination
- Ensure the child and family receive relevant information and are empowered to participate in decisions impacting them, as developmentally appropriate
- Respect the child and family's right to dignity
- Treat children and families with sensitivity, empathy and care at all times

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

1. Conduct a comprehensive child protection investigation that minimises trauma to the child/family.
2. Assess the safety of the child, immediately and over the longer term.
3. Determine the strengths and needs of the child and family.
4. Provide holistic services to assist the child's recovery and improve family functioning.
5. In cases of transnational THB/CSA/CSE, provide assistance in local integration, return or resettlement as indicated.
6. Successfully investigate and prosecute offenders, holding them accountable for their crimes.
7. Assist the family in obtaining proper compensation, as possible
8. Raise awareness of THB/CSA/CSE within the community.

Activities of the THB/CSA/CSE Multidisciplinary Team: (See also, Section VII) *[Modify below to reflect specific needs of community.]*

In order to efficiently support children who have experienced THB/CSA/CSE and their families, MDT members need to implement:

1. A written MDT protocol that describes the roles and responsibilities of each MDT member and outlines a process that allows multiple recognized points of entry to services for children who have experienced THB/CSA/CSE.

2. Consistent communication between members with timely information-sharing as appropriate.

3. Cross-reporting of allegations between law enforcement, child protection/child welfare service workers and others involved in the immediate response.

4. Collaboration during child forensic interviews, preferably with video recording of the interviews.
5. Referrals for child and family services to organisations within the MDT and to outside organisations, with consistent follow up during and after the criminal investigation to ensure continuity of care and social inclusion. This includes services for local integration, return, or resettlement of children experiencing transnational THB/CSA/CSE in their destination-, origin-or third country, respectively.

6. Regularly scheduled multi-disciplinary case review meetings that help ensure every child/family receives needed services as is possible within the bounds of laws/policies. New legislation may be required to allow this activity. Attendance in-person or via videoconferencing is strongly advised.

7. Data tracking with ongoing monitoring and periodic evaluation of MDT activities and functioning , as well as trends in the dynamics of THB/CSA/CSE.

8. Regular meetings of leaders of MDT organisations/agencies to discuss systemic issues related to the MDT process and protocol, as well as the results and recommendations of the periodic evaluation.

9. Participation in prevention initiatives to raise awareness of THB/CSA/CSE within the community, address stigma surrounding sexual violence, educate the public about victimization of boys and decrease the risk of child victimization.

Target Audience: *[Modify below to reflect specific needs of community.]*

This protocol is relevant to all MDT members, as well as other community professionals working with children experiencing THB/CSA/CSE and those at risk. Professionals who are not members of the MDT will benefit from knowing the structure and function of the collaborative approach so that they may more easily work with team members to prevent, report, and respond to THB/CSA/CSE.

MDT composition [1,15,24,25,27,29,35]: *[Modify below to reflect specific needs of community.]*

According to best practices, MDT's are composed of the following individuals:

1. Coordinator of MDT (may have dual role with one of the MDT organisations)

2. Government child protective service workers

3. Law enforcement personnel

4. Prosecutors

5. Forensic interviewers (these individuals may be part of other MDT organisations, such as law enforcement)

6. Representative from Child Ombudsman office (or equivalent)

7. Other legal professionals (ex., free legal-aid lawyer, a former judge, a lawyer who represents children, or legal professionals otherwise involved in THB/CSA/CSE), depending on laws and on the structure of the MDT

8. Medical/forensic professionals, ideally with experience working with children exposed to trauma, abuse, and exploitation

9. Mental health professionals, ideally with experience working with traumatised children and their families

10. Representatives from agencies working with children in conflict with the law (for example, a juvenile liaison officer in the Republic of Ireland, who works with underage offenders)
11. Victim and/or family advocates

12. Staff from nongovernmental organisations (NGOs) that provide services to individuals who have experienced or are at risk of THB/CSA/CSE, or offer prevention programs and outreach related to THB/CSA/CSE

13. Representatives from congregate care centres/rescue centres that provide housing to children who have experienced THB/CSA/CSE

Additional members may be added, as appropriate. Some may be invited to attend meetings on an ad hoc basis to provide input on particular cases. For example, it may be useful to consider the following:

1. Border police

2. Representative from the Ministry of Foreign Affairs/Interior/Home Affairs (or equivalent), to assist with return of individuals experiencing THB/CSA/CSE abroad.

3. NRM/TRM coordinator

4. Educators and/or representatives of the Ministry of Education

5. Representative from the Ministry of Labour

6. Hotline/Helpline staff (Child, THB, Gender-Based Violence hotline/helplines)

7. Staff from organisations that provide services to vulnerable populations (e.g., women's shelters, migrant/refugee assistance organisations, minority support organisations)

8. Religious leaders, as appropriate for a given case

9. Cultural mediator/cultural-linguistic mediator (see section V)

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

1. Caregiver of a child who experienced THB/CSA/CSE, or the survivor, themselves (provided the survivor is developmentally and emotionally able to participate without sustaining harm)

2. Leaders of child-serving community organisations

3. Leaders of organisations that provide housing to vulnerable populations

4. Other community leaders, as appropriate

5. Members of academia who are well informed on THB/CSE/CSE and can add insight to MDT discussions

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

Geographic Scope:

[Insert description of target area of MDT coverage, for example, a given city, region or country. Initially, this may involve a relatively small region as the MDT is piloted, with subsequent expansion to larger areas.]

II. Definitions of Common Terms

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

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

Child sexual abuse (CSA):

The World Health Organisation defines CSA as follows, “The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performances and materials.”[43]

Child sexual exploitation (CSE):

Per the Luxembourg Guidelines, CSE involves engaging a child in a sexual activity in exchange for something (or the promise of such).44 According to the United Nations, the term refers to “Actual or attempted abuse of a position of vulnerability, power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another.”45

Trafficking in human beings (THB):

Per the Palermo Protocol, trafficking in persons involves, “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.”[46] Importantly, the protocol indicates that when the definition is applied to children (<18 years of age), the ‘means’ described are not required.

Trauma:

Trauma occurs when an individual experiences one or more events or conditions they perceive as physically or emotionally harmful or life threatening to themselves or others. See below for a discussion of ‘traumatic stress’ a response to the trauma that significantly disrupts a person’s functioning and well-being, including mental, physical, social, emotional, or spiritual dimensions.47,48

Vicarious traumatization (VT):

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

Secondary traumatic stress (STS):

The emotional, behavioural, and physical signs/symptoms of post-traumatic stress that affect a person who learns about the trauma and adversity of another individual.

Traumatic stress:

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

Post-Traumatic Stress Disorder (PTSD):

A psychiatric disorder that may develop in response to a major traumatic event (actual or threatened), and which includes symptoms in 4 major categories (intrusion symptoms; avoidance of stimuli associated with the trauma; negative alterations in cognitions and mood; and significant changes in arousal and reactivity associated with the trauma event). Symptoms must cause clinically significant distress or impairment in functioning and persist more than 1 month.[49]

Rights-based, child-centred approach (also called, 'victim-centred' approach):

An approach to working with children and families that is based on the basic human rights outlined in the Convention on the Rights of the Child2 (ex., right to voice, information, confidentiality, respect, dignity, etc.) and care that prioritises the child's best interests in all decisions and actions involving that individual.

Trauma-informed approach:

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

Culturally responsive:

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

Mandated reporter:

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

First responder:

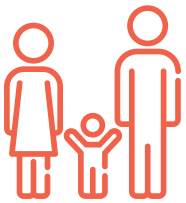
This term may have a variety of meanings but in the current context it refers to individuals (often adults interacting with children) who learn of possible THB/CSA/CSE and are in a position to offer assistance and/or report their concerns to authorities.
Common first responders are pedagogues/teachers,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

Forensic/Investigative interview:

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

Extended forensic evaluation:

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



III. The child-centred, rights-based, trauma-informed and culturally responsive approach to interacting with children and families[2,11,34,47,50-52]

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

Whether speaking to a child about upcoming court procedures or working with a caregiver to create a safety plan, professionals should be cognizant of, and respect, the basic human rights outlined in the United Nations Convention on the Rights of the Child (CRC)[2] and national laws and protocols supporting the CRC. Table 1 lists some particularly relevant rights that apply to children who have experienced THB/CSE/CSA *and their adult caregivers.*

Table 1: Basic Rights of Children (and Adults) in Cases of THB/CSE/CSA (for full list refer to UN CRC2)[41]

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

Right to the enjoyment of the **highest attainable standard of healt**h and to facilities for the treatment of illness
Right to effective assistance
Right to be protected from hardship during the justice process
Right to safety
Right to special preventive measures
Right to reparation

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

[Insert specific details of measures to be taken to prevent and respond to bias and discrimination in the activities of the MDT. This may include a relevant code of conduct, which may be designed specifically for the MDT and based on professional ethical standards and/or codes of conduct already in place for agencies/organisations participating on the MDT.]

When THB/CSE/CSA occurs, the associated trauma not only involves the child (primary victim) but also those close to the child (e.g., caregivers). The latter may sustain considerable secondary trauma when they learn of the child's experiences and may respond with a range of distressing emotions such as guilt, anger and intense sadness. Their child's traumatic experiences may reawaken trauma they, themselves, endured earlier in their lives, trauma that may have remained unresolved for years. MDT members working with children and families thus may interact with multiple traumatised individuals.

Affected children and their non-offending caregivers may experience prominent symptoms associated with their trauma; this is known as 'traumatic stress'. These symptoms may reflect the body's efforts to cope with the anxiety, fear and other negative emotions associated with the trauma. For example, extreme anxiety may preclude a caregiver from paying attention to the person attempting to assist them, may impede a child's memory of event details, may lead to transient dissociation whereby the individual seems to distance themselves from their immediate surroundings. Somatic complaints such as seemingly unexplained head, back and stomach aches may signal emotional distress, as may sudden mood swings. Anxiety, feelings of guilt, and fear may hinder a non-offending caregiver from managing simple tasks in daily life and make it difficult for them to support their traumatised child. Significant trauma of any sort--be it the THB/CSE/CSA events being addressed in the investigation, or another major traumatic event experienced earlier in an individual's life (e.g., prior death of a loved one, or physical assault)--may negatively impact the traumatised child/caregiver's views of themselves and the world around them.[47] They may come to view themselves as powerless, worthless, and undeserving of respect. They may view the world as a dangerous place, and the people they encounter (including MDT professionals) as threatening and potentially harmful. As a result, they may adopt behaviours, views and attitudes that reflect these beliefs and serve to protect them from a hostile or threatening situation. Some of these attitudes and behaviours may be maladaptive in situations outside of the trauma setting (e.g., substance use, aggression, suspiciousness, paranoia, marked social withdrawal). They may also negatively impact others who interact directly or indirectly with the individual, including MDT professionals.

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

Table 2: Concepts of a Trauma-Informed Approach[1,41,47,50,58]

CONCEPT	ATTITUDES & BEHAVIOURS OF PROFESSIONAL
SCREEN FOR TRAUMA (THB/CSE/CSA)	The professional is aware of vulnerability factors and potential indicators of THB/CSE/CSA and asks questions to assess the level of risk.
ENSURE SAFETY	The professional actively works to increase the child/caregiver's physical comfort (meets with individual in a warm, private, child-friendly, quiet environment; addresses basic physical needs) and decreases stress and anxiety. The professional follows a protocol to maximise the safety of the child, family and staff; and speaks with the child outside the presence of those who accompany them to the visit, as developmentally appropriate for the child and when allowed by law/policy. When discussing sensitive issues, a child/adolescent may feel safer and more comfortable having the non-offending caregiver or other companion outside the room. And in some instances, the professional may not know with certainty that the person(s) accompanying a child to the visit is prioritising the safety and best interest of the child. In some jurisdictions, a trained mental health professional may need to be present during a formal investigative forensic interview. In any conversation, a professional interpreter is used when there are concerns of language fluency (family members or companions are NOT used to interpret). No action is undertaken that will jeopardize the safety of the child.
DEMONSTRATE RESPECT	The professional explains the purpose of the visit and the reasons behind each step (for example, the reason for asking personal questions; the function of the physical exam or the purpose of the psychological assessment) and answers the child's/caregiver's questions before seeking assent/consent for each step (consistent with the child's developmental capacities). The provider seeks and accepts the individual's perspective and respects their decisions as feasible and appropriate[A]. They actively listen and remain non-judgmental and open.
BUILD TRUST	The professional takes time to build rapport with the child/caregiver; demonstrates an interest in learning about who they are and their situation; avoids making assumptions. The professional demonstrates empathy and concern for the individual's well-being.
ENGAGE AND EMPOWER	The professional is interested in, and actively encourages the individual's questions and opinions, facilitates a 2-way discussion, and asks the child/caregiver for their thoughts about their situation/condition and the best way to address it. The provider recognises the individual's self-agency and encourages them to use it to make choices and take control whenever possible throughout the visit.
USE A STRENGTH-BASED APPROACH	The professional recognises, respects and emphasises the child/caregiver's strengths and resiliency and acknowledges that the individual is the expert on his/her/their life.
MAINTAIN TRANSPARENCY	Before asking personal questions, the professional explains any limits of confidentiality in a way the child/caregiver understands. They review who may have access to information obtained during the visit (e.g., access to documentation), and under what circumstances. They explain what will happen during the visit and keep the individual updated on activities occurring during the visit.

DEMONSTRATE SENSITIVITY TO DIVERSITY	The professional is aware of, sensitive to, and respectful of, differences that may exist between themselves and the child/caregiver (e.g., differences in culture, nationality, race, ethnicity, religion, gender, or sexual orientation). They actively seek to understand the individual's beliefs and perspectives as these pertain to their physical and mental health, their life, and their situation. The professional accommodates the individual's preferences whenever these are safe for the person, possible and feasible, and when they represent the best interest of the child. They respect the desire of the child/caregiver to be served by a professional of a specific gender when possible.
MINIMISE RE-TRAUMATIZATION	The professional limits their questions to those needed to perform their duties, assess safety, and promote the child's well-being. They avoid questions that are irrelevant and that may trigger anxiety and distress. The professional monitors the individual for verbal and nonverbal signs of emotional distress throughout the visit. They provide reassurance and support and have resources available to manage major psychological distress. They implement procedures to ensure that the child/caregiver does not have to repeat her/his/their information multiple times. In many jurisdictions this includes audio video recording of a formal forensic interview. Some experts advocate for recording other interviews, as well, although the latter is not uniformly recommended, and ramifications should be carefully considered by the MDT.
PROVIDE RESOURCES/ REFERRALS	The professional or designee creates and regularly updates a list of community, regional, and national resources for the myriad needs of children and families who experience THB/CSE/CSA or are at risk for abuse and exploitation. Ideally, the professional establishes relationships with community service agencies and uses a 'warm hand-off approach''B to a referral agency when possible. Community referral information is provided to the child/caregiver in a way they understand, considering language, literacy, age and cultural factors.
ENSURE PRIVACY AND CONFIDENTIALITY	The professional and the facility maintain strict protocols on documentation and release of information that respect the child's right to privacy and confidentiality (while facilitating trauma-informed, rights-based MDT collaboration). Procedures are in place for taking appropriate and prompt action if confidentiality is breached; adherence to the procedure is monitored. Staff receive training on maximising confidentiality and are held accountable for maintaining high standards. If media are involved, the professional does not release the child/family name or photograph, caregiver occupation or address without the child/family's permission and does not discuss specifics of the case that may violate the confidentiality of the child/family. The professional avoids sensationalising the case and does not make derogatory, victim-blaming, or stigmatising statements about the child or family.

A: Respecting a child/caregiver's decision about evaluation and treatment assumes there are no health or safety issues that require emergent care, such as uncontrolled bleeding or suicidal behaviour that place the child's wellbeing in jeopardy. It includes due consideration of the child's developmental capabilities.
B: "Warm hand-off" refers to the professional directly contacting the service agency to discuss and arrange the referral or assisting the child/caregiver with making contact before leaving the professional's facility.

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

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

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

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

- Child factors:
    - Age/developmental status
    - Temperament (impacts how child attends to, and interprets event)
    - Understanding of event(s) in question
    - Coping skills for managing stress
    - Intelligence
    - Information-processing skills
    - Language skills
- Factors related to the conversation:
    - Format of questions asked
    - Demeanour of professional
    - Content and quality of the preparation preceding sensitive questions (e.g., rapport-building, discussing expectations)
    - Pre-conversation factors (number of times child has been questioned/interviewed and how they have been questioned)
    - Availability of appropriate communication modalities for children who are not able to easily express themselves verbally (e.g., play therapy (toys), drawing or writing materials)
- Event factors:
    - Time between event(s) and conversation with professional
    - Number and type of events
    - Child as witness to the trauma of another vs child directly experiencing the event
    - Impact of event on the child

Acknowledging tremendous variation between children of similar age, and the variation in a given skill demonstrated by a child under different conditions, the following outline may be helpful to MDT professionals

(see **Table 3**). Conversations with children with mild ID should generally be targeted at their 'developmental age' while those with more severe disabilities may benefit from questions appropriate for levels lower than their developmental age. (For more information on speaking with children with ID, see Lamb, et al., 2018; pp137-160).[62]

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

YOUNG CHILDREN		
Often are able to….	**Usually cannot…**	**They may….**
Answer open-ended questions (broad, and cued invitations), although they may give relatively few details per question	Report how many times an event occurred (although may be able to distinguish between 'one time' and 'more than one time')	Be reluctant to admit they do not know an answer or do not understand
Answer 'who' and 'what' questions, using their own words/terms	Provide a reliable sequence of events (e.g., timeline)	Try to guess if they don't know the answer
Interpret and answer questions very concretely	Tell *when* something happened or *why* it happened	Be suggestible to leading questions
	Collect things into adult-like categories ("Has anything like this ever happened to you?")	
	Keep track of pronouns easily	
	Pay attention for extended periods (keep conversation to <20 minutes)	

SCHOOL-AGED CHILDREN		
Often are able to….	**Often or Usually cannot…**	**They may….**
Provide idiosyncratic details (e.g., smells, visual details in environment, bodily sensations)	Reliably provide the time of day and month of year or the season when event occurred	Remain relatively concrete, although some abstract thinking is emerging
Provide narratives that are better organised	Give reliable report of frequency of events.	Have a strong sense of responsibility and shame for what happened
Report the age abuse started/ stopped		Be reluctant to admit they do not know an answer or do not understand
Correct mistakes introduced by misleading questions		Try to guess if they don't know the answer

		Still make errors with pronoun references
		Become confused when questions include double negatives
		Be very concerned about family's reaction to events, and whether they are believed

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

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

- Try to obtain information about the THB/CSA/CSE from reliable adult sources, which may help minimise the number and type of sensitive questions posed to children.
- Introduce yourself and describe your role; ask the child/adult what name they would like you to use (some experts also advise querying the individual about preferred pronouns).
- Be aware of possible concerns the child/adult may have regarding the gender of the professional asking questions and try to accommodate their requests as feasible. If the child/adult and the professional are of differing genders, ensure extra safeguarding measures are in place, such as the presence of a neutral chaperone of the same gender as the child/adult, having the conversation in a place where involved parties may be visualised (e.g., window on the door of an office) or videorecording of the conversation. (NOTE: While some experts advocate for the presence of a child's caregiver during an interview about THB/CSA/CSE events, it is important to note that the chaperone is a caregiver or someone else well known to the child, this may negatively influence the child's willingness to disclose sensitive information and may limit the usefulness of the interview.)

- Take time to build rapport before asking sensitive questions. This stage allows the professional to build trust with the child/caregiver, assess the ability of the child/caregiver to provide a narrative, and to assess conversational skills and vocabulary. In addition, it allows the child/caregiver to 'practice' providing narratives and answering open-ended questions.
- In your conversations with older children/adolescents, and caregivers, provide an explanation for why you need to ask questions, make it clear that participation by the individual is voluntary and that they may decline to answer questions or stop the conversation at any time without repercussions. Explain who will have access to information they provide and how it will be used. Obtain informed consent/ assent.
- Discuss the importance of the child/caregiver:
    - Letting the professional know if they
        - do not understand a question
        - do not know the answer to a question
        - feel uncomfortable with a question or want to stop or take a break
    - Talking only about events that the child/caregiver knows actually happened, not about those that may have happened
- Listen more than speak. Demonstrate active listening by maintaining eye contact (as is culturally appropriate and comfortable for the child), avoiding multitasking (e.g., taking notes, studying forms, glancing at texts or computer screens), taking time to briefly summarise what the individual has said to show you are listening and to ensure you understand. Use occasional words/phrases or sounds to encourage continued narrative (e.g., "um-hm, ", "I see,").
- Consider the use of nonverbal methods of providing information, such as drawing, or writing.
- Use open-ended questions (broad questions and cued invitations) as much as possible. Even very young children and children with ID are able to answer questions in this format. (See below for discussion of question format.)
- Frame your questions so the child is aware of the topic to be discussed; announce topic changes with a new frame ("We've been talking about your day in the park. Now I'd like to talk about what you did this morning.")
- Clarify terms (e.g., 'had sex'; terms used to describe genitals) and then use the child's terms.
- Make questions short, simple, and inclusive of only one idea. Avoid strings of clauses.
- If the answer given by the child appears odd or nonsensical, think about how the question was phrased. It may have been an abstract question that the child interpreted very concretely.
- Remain objective and neutral; avoid asking only the questions that will affirm your assumptions or showing approval/disapproval for certain answers.
- Be aware of nonverbal communication, including your own. Do not show surprise, anger, disgust, or other reactions that may be construed by the individual as shaming or blaming. Avoid questions implying blame (e.g., "Why didn't you tell anyone?")
- Monitor for verbal and nonverbal signs of emotional distress so that you can respond in a way that minimises anxiety, fear and distress. For example, you may acknowledge the individual's feelings and normalise them; ask if the person wants to pause or take a break, help the individual manage distress with strategies such as breathing or relaxation exercises, or switch to a less emotionally charged topic.
- Remember that a narrative may be incomplete. Initially children may provide limited detail as they assess your reaction. Stress experienced at the time of the event and the time of the interview may also impact memory retrieval and disclosures. If abuse has been chronic a child may not recall details of all episodes during an interview but retrieve memories at a later time and describe them in subsequent conversations.
- Young children may begin to use words before they truly understand their meaning, particularly prepositions (for example, before, after; inside, between).
- End the session on a neutral or positive note. Ask the child/caregiver if they have any questions or concerns.

- Try to avoid:
    - phrasing questions in the negative, and especially using double negatives (“He didn’t tell you not to .
    - frequent use of pronouns; instead repeat the name of the person in question (this is especially important for young and school-aged children)
    - anticipating the answers to questions or starting to plan the next query before the child/caregiver has completed the answer to the prior question.
    - rushing to fill a silence. This pause may be helpful for the child/adult to gather their thoughts, or necessary for them to process their emotions.
    - correcting or interrupting the individual during a narrative. You can return to the issue later when the child/caregiver has finished their answer.
    - correcting nervous behaviour, although the professional may acknowledge and normalise the individual’s nervousness.

Question Format

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

One may obtain a great deal of information from a child simply relying on a sequence of open-ended questions. However, in many cases (with adults and children), narratives prompted by open-ended questions will lack some details and the professional may need to ask **more focused/direct questions**. These still rely on free recall, but provide direction to a child, *using information already mentioned by the individual.* Examples include “who”, “what” and “where” questions.

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

V. Roles and Responsibilities of MDT Members Speaking with Children

Roles and responsibilities of core MDT members are outlined below. This list should be supplemented with descriptions of additional members who are included in the MDT being developed.

Mandated Reporter/First Responder

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

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

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

- The best interests of the child must be the highest priority.
- While interacting with the child, minimise questions about the THB/CSA/CSE, limiting your focus to obtaining information **critical for your role as a first responder. Your role entails**
    - Assessing if there is reasonable suspicion for THB/CSA/CSE (remember, a mandated reporter does NOT need to be certain THB/CSA/CSE has occurred, but only have a reasonable suspicion/concern)
    - Assessing the immediate and short-term safety of the child (and other children who may be affected)
    - ⚬ Assessing the immediate need for medical or psychiatric evaluation/care. Indications for immediate care include bleeding, pain, injury, complaint of a discharge from the genitals,

obvious physical distress, change in mental status, suicidal ideation, evidence of psychosis, etc.). Emergency medical services should be contacted.

- Consider the safety of the child when deciding to report to authorities, and when deciding if it is appropriate to notify the caregiver that a report is being made.
- Consider the intended and unintended consequences of making a report to authorities and take steps to mitigate negative outcomes and ensure the safety of the child.
- Do not discuss the case with or reveal the identity of the child to anyone who does not have a role in managing the case. Maintain strict privacy and confidentiality practices according to agency/ organisation policies and professional standards.
- A major role for the mandatory reporter is to provide support and reassurance to the child and non-offending caregiver. See **Table 4** and **Sections III and IV** for additional guidance.

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

HELPFUL STRATEGIES	STRATEGIES TO AVOID….
Thank the child for telling you what happened	Implying shame or blame
Assure child they are not in trouble	Denigrating the reported abuser/exploiter
Validate their feelings	Assuming the child's perspective matches yours
Assure child the abuse/exploitation is not their fault	Imposing your views of the situation onto the child
Demonstrate to the child (verbally and nonverbally) that you take the allegation very seriously and are here to help (ex., active listening, supportive statements, non-judgmental demeanour)	Asking irrelevant, traumatising questions
Be transparent about the need for a report to authorities; explain next steps	Making promises you cannot keep
Empower child to share their feelings, concerns	Challenging the child's statement, implying disbelief
Remain empathic and open	Allowing pre-conceived notions, stereotypes, and biases to affect your reaction to the allegation

Law enforcement AND Government Child Protective Service Workers (CPS)

[Insert additional roles/responsibilities and edit below as indicated.]

The roles of law enforcement personnel (LE) are to 1) determine if a crime has been committed, 2) conduct an investigation to identify and apprehend the offender and build a criminal case, and 3) file appropriate criminal charges. (NOTE: A description of specific duties of LE personnel in conducting a criminal investigation for suspected THB/CSA/CSE is beyond the scope of this protocol. Guidance should be sought from agency standard operating procedures, policies and protocols. Additional resources are available.[36,70-72])

Government child protective service workers (CPS) are responsible for 1) determining if the child (and potentially other children) have experienced THB/CSA/CSE, 2) assessing risk and ensuring the safety of the child(ren) (an ongoing process), 3) determining the needs of the child(ren) and famil(ies), and 4) connecting them to appropriate services. The terms used for this position vary with the country; staff are typically government employees. Some of these responsibilities may be shared with the case manager, who may be a CPS worker. (See below).

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

Children who have experienced THB/CSA/CSE may have sustained one or more physical adverse consequences and should be offered a medical evaluation by a health worker with training on THB/CSA/CSE. This is important for all children, even if the last contact with an offender was weeks or months prior, and even if it is not clear there was sexual contact with the alleged offender(s). Please see “Medical Evaluation” in Section VII for additional information on the reasons for prompt medical attention.
A designated member of the MDT (often LE, CPS, case manager or the MDT coordinator) should be responsible for arranging the medical evaluation and communicating with medical staff regarding results and recommendations. In some cases, a child or caregiver may refuse a medical evaluation. After gently exploring the concerns of the individual and explaining the benefits of an evaluation, the child/caregiver’s request should be respected unless a medical or psychiatric emergency is present (e.g., significant pain, injury, acute symptoms of chronic disease, life-threatening conditions, aggression, psychosis, suicidality, or other extreme emotional distress), or the request may not represent the best interest of the child. It may be feasible, and preferable, to have the child come back for a medical evaluation at another time, if and when they change their mind.

If available, the CPS worker, case manager or other designated MDT member should offer to connect the child/family to a trained mental health professional with experience in treating traumatised children. This will allow the child to be screened for traumatic stress symptoms, and for the child and caregiver to receive important psychoeducation that can assist in the healing process. In many cultures, mental health symptoms and mental health care are heavily stigmatised so it is important for the worker to approach the subject with care and discretion. For example, rather than using the word ‘trauma’, which children and caregivers may associate with ‘craziness’ or long term ‘damage’, it may be helpful to refer to prior events as ‘difficult experiences’ or ‘scary events’, etc. Emphasising that signs and symptoms of emotional distress are normal reactions to abnormal situations helps to establish that a child’s difficulties are common among individuals who experience THB/CSA/CSE and are often transient, without progression to long term problems. The worker may refer to ‘counsellors’ or ‘professionals who know how to talk with children who have been through experiences similar to yours (or your child’s)’ rather than using terms such as ‘psychotherapist’ or ‘psychiatrist’. When specially trained mental health professionals are not available, the worker should provide the child and family with basic psychoeducation to help manage acute stress related to the trauma. Please see Section VII, “Emotional and Psychological Support of Children and Their Families.”

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

Other potential service needs include ongoing primary medical care; substance misuse assessment and treatment; housing (if child is not safe at home, or family requires relocation due to community stigma), education, job skills training, financial resources, immigration legal advice; interpreter services, assistance with acculturation or repatriation, etc. MDT collaboration for identifying and obtaining services is essential for the CPS worker; referrals may be made to service organisations inside and outside the MDT. Many countries have child helplines available and these are good sources of information regarding community service referrals. When discussing and planning possible services, child and family safety, confidentiality and preferences must be prioritised, with risk management and safety planning underlying all activities.

Case Manager

[Insert additional roles/responsibilities and edit below as indicated.]

Each child/family should be assigned a case manager to assist them in obtaining services and attending appointments and court hearings related to the criminal investigation/prosecution. This person may be a CPS worker (see above), victim or family advocate or other professional. The case manager helps to ensure continued inter-agency collaboration and a child-centred approach throughout the course of the case, including the time after the investigation has ended when the child/family remain in need of services. They work closely with the child and family to monitor service implementation and success, foster resilience and empowerment, ensure safety and address potential challenges related to stigmatisation. They may help organise transfer of a foreign-born child back to their home country or to a 3rd country as indicated and arrange appropriate services for re-integration or resettlement. Central to their role and their effectiveness is the rights-based, trauma-informed approach that empowers the child and caregiver to actively engage in service planning, ask questions, express opinions and concerns, and practice self-agency. The case manager must be familiar with relevant service agencies and establish relationships with service providers so as to facilitate a smooth connection between the child/family and the organisation. Initiation of services with an organisation may be facilitated through use of ‘bridging letters’.73 The manager should maintain close contact with professionals involved in the case and provide updates on case status at MDT case review meetings.

Prosecutor's Office
[Insert additional roles/responsibilities and edit below as indicated.]

Prosecuting attorneys are responsible for determining if a case can be charged and for managing the prosecution. They work closely with law enforcement (LE) and government child protection workers (CPS), and with other MDT members as indicated. They collaborate with investigation officers to ensure cases presented to court are strong and properly investigated. Prosecuting attorneys conduct pretrial interviews to prepare the child, family, and other witnesses for court procedures. They present all the evidence and facts of the case in court.

The prosecutor and legal team work to reduce the child and family's trauma related to the criminal prosecution process, minimising child testimony and contact with the alleged offender(s). The prosecutor uses all available MDT information on the case and minimises the number of times a child is questioned; when questioning occurs, they use a trauma-informed, developmentally appropriate, and rights-based approach (see Sections III and IV). They empower the child and caregiver to express opinions and ask questions during the trial preparation process, and when considering plans for case disposition. The child's views and opinions are given due weight in accordance with their age and maturity.

Criminal and Civil Court Judges
[Insert additional roles/responsibilities and edit below as indicated.]

Judges may or may not be members of the MDT but they play a critical role in the community response to THB/CSE/CSE. They preside over the trial proceedings, maintain order, provide jury instructions (as applicable), determine facts, and make a ruling on a case (bench trial). They decide on the punishment of convicted offenders. They may play a key role in creating a trauma-informed, child-centred, rights-based and culturally responsive legal process. In cases of alleged THB/CSA/CSE, it is desirable for the court to strive for the following, within the bounds of laws and regulations, and the rights of the defendant(s):

- Minimise trauma to the child victim (ex., make efforts to reduce the time the child must be in the presence of the alleged offender; take steps to make the courtroom as child friendly as feasible; allow child to testify online or otherwise outside the presence of the alleged offender, etc., depending on local laws and policies)
- Make the child's best interest and safety a high priority in pre-trial, trial, and post-trial proceedings
- Minimise opportunities for child and family intimidation by others
- Use a trauma-informed, rights-based, child-centric, culturally responsive and developmentally appropriate approach when speaking with the child
- Take steps to ensure that the child and family receive services that assist in the healing process and help prevent re-victimization
- Minimise delays in court proceedings

MDT Coordinator

[Insert additional roles/responsibilities and edit below as indicated.]

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

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

Forensic Interviewer

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

Depending on laws, practices and infrastructure, forensic interviewers may serve a dual role within the MDT (e.g., be a law enforcement officer) or they may function purely in the capacity of an interviewer employed by a one-stop centre such as a child advocacy centre. They are responsible for conducting formal, objective, developmentally appropriate and legally admissible interviews of children who may have experienced THB/CSA/CSE. They should have specialised training and ongoing supervision (the latter may be obtained on-site or via videoconference with an expert forensic interviewer); they should follow an evidence-based or evidence-informed forensic interview (FI) protocol. (Please see Appendix C for resources.) Interviewers must stay informed of current relevant legislation regarding THB/CSA/CSE, and new research on forensic interviewing practices. Specific requirements for continuing education of interviewers should be included in the MDT protocol and tracked to ensure ongoing improvement in skills and fidelity with FI protocol standards.

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

Victim Advocate

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

(Note: Depending on the structure of the MDT, the role of the victim advocate may be subsumed under that of the case manager, NGO staff or other MDT member.)

Victim advocates work directly with children and families to assist them in understanding the roles of MDT members and in communicating with service providers and other professionals as needed. They ensure families understand the investigation and prosecution processes, are oriented to the courtroom and familiar with the roles of court staff. They assist families in navigating the court system. They work closely with the families to obtain necessary services and may accompany them to appointments.

Nongovernmental Service Organisation Staff

[Insert additional roles/responsibilities and edit below as indicated.]

Staff at nongovernmental service organisations have varied roles corresponding to the mission of their organisation. They may serve children and families experiencing THB/CSE/CSA, and/or those experiencing conditions that render them at risk of THB/CSE/CSA (e.g., staff at migrant/refugee service organisations, domestic violence shelters, specialist counselling and psychotherapy service organisations). Many staff at NGO's provide practical, emotional, psychological, legal and social support. For example, they may be called upon to accompany the child to court. They collaborate with the case manager and other MDT members in ensuring that families have access to needed services. Staff also assist in the dissemination of the MDT protocol through training and resource mobilisation.

Interpreters[66,74]

[Insert additional roles/responsibilities and edit below as indicated.]

When there are concerns about a child or caregiver's language fluency, a professional interpreter should be used. Family members, other family companions, and staff without professional interpreter credentials should not serve as interpreters. The interpreter's role is to provide a linguistic connection between the MDT professional and the child/caregiver. They may also play a critical role during court proceedings, ensuring the child/caregiver's testimony is accurately represented in the dominant language. They translate exactly what is said from one language to another, without omitting, editing, or revising content.

Interpreters may also fulfil a role as cultural mediators (see below), clarifying cultural meanings to avoid or resolve misunderstandings that arise during a child/family's conversation with an MDT member. They may provide information to the professional about the child/caregiver's level of understanding during a conversation, and/or cultural nuances that are noted during a conversation. Their knowledge of cultural beliefs and practices can be very helpful in building trust with families, understanding child/caregiver perspectives and needs, and ensuring those needs are met appropriately.

The MDT must ensure access to interpreters (in-person vs by telephone vs by videoconference) for languages common among the local population and for deaf/hard-of-hearing children/caregivers. Ideally, an interpreter should speak the same dialect as the child/family. These interpreters need to have received training on THB/CSA/CSE, as well as the trauma-informed, culturally responsive, rights-based approach, and on child development. They should have experience working with children. Interpreters should not be familiar with the child or family or be from the same village/town. When possible, the gender of the interpreter should follow the preference of the child/caregiver to be interviewed. Interpreters should follow professional standards. They should remain impartial, provide accuracy in interpretation of statements made by the professional and child/caregiver, and strive to minimise cultural misunderstandings that may arise during the interview.74

Cultural mediators/Cultural-linguistic mediators[15]

[Insert additional roles/responsibilities and edit below as indicated.]

Cultural mediators foster communication and bridge cultural gaps that may be present between MDT professionals and a child/caregiver. They facilitate an understanding of the needs, values and beliefs of each party, and ensure that roles and responsibilities (with associated limitations) are understood. They may accompany children/families to services, translate documents for the MDT and assist in creating culturally appropriate written materials for families. They may provide cultural input to MDT members regarding potential services needed by children/families from a nondominant culture. They may assist in facilitating safe transfer of the child back to their home country or to a 3rd country with connections to appropriate services.

Health Care Professional/Forensic Medicine Professional

[Insert additional roles/responsibilities and edit below as indicated.]

Depending on country laws and procedures, the initial forensic medical evaluation may be provided by a paediatrician or other primary care medical practitioner (often in a hospital), or a forensic medicine physician (often at a designated forensic institute). In some jurisdictions the services may be divided among professionals with the child receiving general medical care, sexually transmitted infection (STI) testing, HIV prophylaxis and emergency contraception at a nearby hospital, and forensic evaluation with trace evidence collection and injury documentation at a forensic institute. In the latter case, communication among providers is critical, to ensure the child promptly receives all services that are needed.

THB/CSA/CSE is associated with a variety of adverse physical consequences, including injury, infection, unwanted pregnancy, complications of substance misuse, delay in seeking medical care for acute conditions and exacerbation of chronic diseases.[6,53,75-78] Children experiencing THB/CSA/CSE may have had limited access to health care, so it is important to arrange a forensic medical evaluation as soon as is feasible. The evaluation should be completed by a health worker with training on THB/CSA/CSE.[79] A forensic medical evaluation is important for all children with allegations of THB/CSA/CSE, even if the last reported contact with an offender was weeks or months prior, and even if it is not clear there was sexual contact with the alleged offender(s).[80] Some infections (e.g., HIV, syphilis, hepatitis) may have few and subtle symptoms and signs yet have very serious health consequences and persist for years. There may be important physical sequelae that need to be documented (e.g., scarring, disfigurement), and acute or chronic medical conditions that need to be treated (e.g., poorly managed diabetes mellitus). In some cases, initial investigation may suggest only non-contact sexual abuse, with episodes of genital-to-genital contact only being discovered later in the investigation. If this sexual contact between child and alleged offender occurred shortly before authorities became involved and a forensic medical evaluation was not sought, an opportunity for forensic evidence collection will have been missed.

The exact timing of the forensic medical evaluation depends on the circumstances of the case but should always prioritise the best interest of the child. An evaluation should be obtained as soon as possible if any of the following is present:[81]

- Child has signs/symptoms of injury and/or infection (e.g., genital discharge, genital pain, itching, pelvic pain, fever), acute illness, suicidal ideation, psychosis, pain, bleeding, or other significant distress

- The last sexual contact may have occurred within 120 hours. The child may benefit from HIV post-exposure prophylaxis (if administered within 72 hours of sexual contact); emergency contraception (if given within 96 hours), and collection of traced evidence (if event occurred within 96-120 hours depending on laws/policies).

- There are concerns regarding the safety of the child

- However, it must be stressed that in some cases, immediate evaluation may NOT be in the child's best interest and accommodation should be made. For example, if a child is extremely emotionally distressed and resistant to having a genital exam with trace evidence collection, the exam should be delayed until the child can tolerate it, assuming there is no medical emergency or other complication. This prevents re-traumatisation of the child.

If the above criteria are not present, the forensic medical evaluation may be postponed until the child has had some sleep and is less stressed. For example, if authorities make contact with a victimised child at night, it may be more appropriate to conduct the forensic medical evaluation the next afternoon. The examination should be conducted when an experienced clinician is available, preferably in a child-friendly setting. Siblings of the affected child and children who may have been exposed to an alleged offender should be offered a medical evaluation, given their risk of victimisation.

The initial forensic medical evaluation seeks to address immediate medical and mental health needs and safety issues, as well as evaluating overall health and nutrition, addressing untreated medical or traumatic conditions, documenting injuries, obtaining forensic evidence if indicated, testing for infections and pregnancy, offering treatment and emergency contraception as indicated, offering community service referrals and assisting in safety planning.[50,82,83] It may also assist in the healing process by allowing a child to discuss health concerns and fears, and obtain reassurance from a health care provider.[84] Any and all steps of the evaluation are completed only with the assent/consent of the child and guardian unless a medical emergency is present. While specific guidance on the medical management of THB/CSA/CSE is[82,85] available,[50,59,65,83,84,86,87] the general process is outlined below. The medical professional will:

- Obtain a medical, social and reproductive history using a trauma-informed, rights based, culturally responsive and developmentally appropriate approach that respects the privacy and confidentiality of the child
- Explain the forensic medical examination to the child and caregiver, and address any questions they may have about the examination
- Conduct a physical examination to assess general health and acute / chronic medical conditions
- Assess dental health and care
- Evaluate, treat, and document traumatic injuries
- Gather trace forensic evidence if indicated
- Obtain appropriate diagnostic testing (e.g., sexually transmitted infections, HIV, pregnancy)
- Offer appropriate treatment for STIs, HIV PEP or ARV, tetanus prophylaxis, HBV immunisation, and emergency contraception (as indicated)
- Discuss any concerns the child may have regarding their body or health, answer questions
- Discuss results with the child and caregiver, and offer resources and referrals (e.g., victim-serving organisations, HIV clinic, mental health service). Referrals for services should be made only with assent/ consent of the child/family. The medical professional should call the referral organisation or facilitate caregiver contact with referral staff prior to the family leaving the health facility, to maximise the likelihood of follow up.

o Summarise, interpret, document and communicate the results of the evaluation in a way that MDT members can understand. A standardised form for documentation may be used, specific for cases of suspected THB/CSA/CSE.

● Medical professionals also provide follow up and ongoing care to address a child's primary and special health care needs. Primary care involves immunizations, periodic sexually transmitted infection testing, HIV testing, preventive health services and counselling, reproductive health services, and other testing and treatment as indicated. Providers also make referrals to medical/surgical specialists as needed.

● Medical assessment and treatment of a child who has experienced THB/CSA/CSE is best accomplished when the health facility has a protocol/guidance in place that outlines roles/responsibilities for each staff member, and describes the process for obtaining a history, conducting an appropriate physical/genital exam, gathering forensic evidence, testing for HIV and sexually transmitted infections as well as pregnancy, and offering appropriate treatment (syndromic vs in response to positive testing, vs prophylactic/ presumptive), HIV PEP/ARV and emergency contraception). Links to sample protocols and guidance, as well as an online resource to assist in creating an organisational protocol may be found in Appendix C, "Medical Management of THB/CSA/CSE".

Mental Health Professional

[Insert additional roles/responsibilities and edit below as indicated.]

Mental health professionals on the MDT may have varied titles and levels of training, but all should have experience working with children and have training in the trauma-informed, rights-based, developmentally appropriate and culturally responsive approach. The role of the mental health professional is to

- Assess and manage psychiatric emergencies (e.g., suicidal ideation, psychosis)

- Assess trauma-related symptoms and offer culturally appropriate, trauma-focused treatment if indicated (including for example, conducting a court-ordered assessment on the impact of the THB/CSA/CSE, providing individual therapy, support groups, psychoeducation)

- Provide or refer for assessment/treatment of other mental health disorders (e.g., schizophrenia, bipolar disorder) or for substance misuse disorder.

- In some cases, mental health professionals also may be asked to provide developmental assessments.

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

Emotional and Psychological Support of Children and Their Families

[Insert additional roles/responsibilities and edit below as indicated.]

Many children are very resilient, even after experiencing major traumatic events.[88,89] Some children who have experienced THB/CSA/CSE will develop symptoms of traumatic stress (see Table 5).[90] These symptoms represent normal reactions to highly abnormal situations. They may vary in severity, expression and duration, since no two children experience and react to trauma in the same way.48 Many children will not go on to develop severe mental health problems such as post-traumatic stress disorder (PTSD) and major depression, but a proportion of children will have persistent symptoms that disrupt daily life and may meet diagnostic criteria for these and other disorders.[91] Some may benefit from a range of psychosocial supports including psychoeducation, support groups, family therapy and/or individual psychotherapy.

Table 5: Common (and Nonspecific) Reactions to Trauma[92]

TRAUMA REACTION	COMMENTS
Abrupt changes in behaviour; new fears, or resurgence of prior fears	
Avoidance	Of situations, people, conversation topics
Social withdrawal	e.g., peer difficulties
Difficulty regulating emotions	e.g., rapid changes in emotions; anger; hostility
Irritability	
Acting out	e.g., inappropriate sexual behaviour, anti-social behaviour, aggression
Distrust of others, especially adults	
Regression in milestones	Especially younger children; ex., new bedwetting
Generalised fears	Very young children may have difficulty describing their fears
Recreating aspects of the trauma	In drawings, stories, sexualized behaviour, etc.
Sexual behaviours or use of sexual language not consistent with age/developmental stage	
Hyperarousal, hypervigilance	
Difficulty paying attention	May mimic attention deficit hyperactivity disorder
Anxiety/panic	May be exacerbated by memories of trauma
Hopelessness, sadness	
Physical symptoms	Nightmares, change in appetite, sleep problems, pain without apparent cause (e.g., somatic symptoms); bowel symptoms
Guilt, self-blame, shame	
Numbness, dissociation	
Refusal to separate from caregiver	Young children
Intrusive thoughts about trauma experience	
High-risk behaviour (e.g., substance use, running away; self-injurious behaviour, suicidal tendencies)	Often seen in adolescents
Concerns of being perceived as abnormal	Especially in adolescents

MDT members play a key role in providing psychoeducation to the child and caregiver and referring children with persistent and significant symptoms for further assessment by a mental health professional (see **Role**

of Mental Health Professional in **Section V**) and/or victim-service organisation providing psychosocial support. Psychoeducation may include:

- Providing the child and the caregiver basic information about how children typically respond to trauma
    - See **Table 5**
    - These are **normal reactions to abnormal circumstances**
    - Traumatic stress symptoms are **not** unusual
    - They do not mean the child is 'crazy,' 'bad' or 'damaged'
    - They often self-resolve but if not, treatment may be available
- Discuss the concept that trauma impacts the way a child views themselves, others, and the world around them, and influences their behaviours and attitudes. Caregivers are advised to look beyond the child's behaviours (e.g., hostility, anxiety) to the potential underlying functions of the behaviours (e.g., self-protection, a reaction to a memory of the trauma event(s)) and respond with empathy and support, realising that negative behaviours and attitudes likely reflect the child's trauma rather than being a sign of negativity toward the caregiver.
- Discuss the concept of trauma triggers (sounds, smells, sights, etc. that remind the child of trauma, and often lead to anxiety, fear, or other distress). Discuss ways caregivers can help the child identify trauma triggers and develop strategies to avoid the triggers or mitigate their impact.
- Teach the child and caregiver strategies for emotion regulation (e.g., relaxation techniques, mindfulness, yoga, specific cultural practices).
- Additional messages for the caregiver include:
- The abuse/exploitation/trafficking is not the fault of the child (or their fault as caregivers). It is the responsibility of the offender.
- The child needs increased support and acceptance, especially during times of acute exacerbation of stress
- Establishing routines and maintaining a sense of 'normalcy' can help a child feel safe
- It is helpful to offer the child choices and control whenever possible
- MDT members and other service providers should use a strength-based approach to empower the child and the caregiver to identify healing strategies they feel would be most effective, encourage the child and caregiver to offer their opinions in planning services and to actively engage in those services.

Mental health support for children and adults is not common practice in some regions of the world. If psychologists and other highly trained mental health specialists are scarce or unavailable in the community, MDT members should consider exploring the possibility of telemental health services provided by experts from other regions/countries. Any mental health therapy that is offered should be culturally appropriate and acceptable to the child and family. Often this involves a combination of therapeutic strategies that incorporate cultural values, beliefs, and practices into trauma-focused therapeutic modalities. Services designed to improve child and family well-being vary and may be provided by a number of organisations. For example, music or art therapy, peer support groups, group counselling, yoga classes and meditation sessions may be offered at organisations within the community. Community mapping of the available resources is important in order to facilitate appropriate referrals for care.

VI. Forensic Interview and Forensic Evaluation

Forensic Interview (FI)

Forensic interviews (FI) are designed to obtain a statement from a child regarding possible THB/CSE/CSA, using objective, legally defensible techniques that are child-centred, rights-based, culturally responsive, and developmentally appropriate. The interview is conducted using an evidence-based or evidence-informed structured protocol.66,68,69,93-95 FI's should be scheduled to attend to the needs of the child (highest priority), maximise MDT collaboration, ensure that information needed by all MDT members is obtained, and minimise the need for repeat interviews.24,29 The location of the interview should be child/adolescent-friendly (although not distracting), quiet, neutral, private and (ideally) equipped with technology that allows simultaneous observation by MDT members and videorecording of the interview. MDT members not able to attend the live interview may review the recording and/or other documentation as codified in the information-sharing section of the protocol.

The process for scheduling and conducting interviews is as follows:

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

There are a number of evidence-based or evidence-informed interview protocols that are suitable for children who may have experienced THB/CSA/CSE.[68,69,93-95] In general, structured interview protocols consist of several phases to the interview, including[62]

- An introduction that includes an explanation of the purpose of the FI and establishes expectations for the child.
- Rapport-building phase in which trust is built between child and interviewer.
- Narrative training phase, in which the child 'practices' responding to open-ended questions by describing a neutral event. This affords the interviewer an opportunity to assess the child's linguistic and conversational abilities.
- Substantive phase that includes the child's narrative of the events involving THB/CSA/CSE. This begins with the forensic interviewer using open-ended prompts and is followed by more directive questions as needed. In general, information is sought related to details of what happened, who was involved, where and when events occurred (if child developmentally able to address these issues), and if other victims may have been involved.
- Conclusion phase when the interviewer asks the child if they have anything else they would like to add, then introduces a neutral topic to discuss. The interviewer answers any questions, then thanks the child and the session ends.

Forensic evaluation (FE)

A forensic evaluation (FE) extends the forensic interview over multiple sessions (typically 2-6) and is sometimes used when the initial interview is inconclusive, and issues remain unresolved.[96] Some children may have difficulty establishing trust with the interviewer during the initial session and need more time (e.g., additional sessions) to feel comfortable discussing sensitive issues. Others may require additional time due to physical or developmental disabilities, and at times cultural factors require extended interview time. The decision to bring a child back for additional forensic interviews must be made on a case-by-case basis and involve MDT discussion, review of established criteria for FEs, consideration of the judicial process and careful analysis of the risks and benefits of the FE.

VII. Procedures for Responding to THB/CSA/CSE

Strategies for Information Sharing and Data Protection:

It is extremely important for MDT members to establish an agreed upon safe, secure method of sharing case information with one another on and offline, and storing case data. A policy should outline these procedures in detail, fully respecting the confidentiality and privacy rights of the child and family. The policy should be reviewed regularly and updated as needed. There should be a system in place to monitor compliance and address any breaches of confidentiality. Information-sharing procedures must be consistent with legal, ethical, and professional standards of practice, the UN Convention on the Rights of the Child,[2] and existing laws regarding data protection. These strategies may require legislation that specifically recognizes the authority of the MDT and permits data-sharing between MDT organisations, or establishment of a formal data protection protocol and agreement.

Information sharing may or may not involve a shared database with MDT members entering case data as it is obtained, and accessing data entered by others as needed (various members may have differing access to information according to their roles). Potential strategies for data protection may entail online password protected databases located on a secure server; encrypted email; etc. The exact strategies used will depend on the resources, relevant laws, and other local factors.

Regardless of the specific method of sharing data, a signed release of information should be sought from the caregiver, with explanations of the nature of the MDT; who will have access to what information; and how that information will be used and protected. The release should have a specific time limit. The information sharing and data protection procedures should be explained to the child (as developmentally appropriate) and caregiver in a way they can understand. This should be done by a professional thoroughly trained in trauma-informed care, THB/CSA/CSE and issues of confidentiality and privacy, using professional interpreters as needed. Caregivers/children should be encouraged to ask questions and voice concerns. The professional should not pressure individuals to consent and should respect their wishes whenever possible There may be exceptions to the practice of obtaining informed consent to share information (e.g., related to laws of mandatory reporting), and these should be specifically addressed in the policy on information sharing and confidentiality.

Children who have experienced THB/CSA/CSE, and their caregivers understandably have deep concerns about privacy and confidentiality regarding the very sensitive information they share. Consistent with their basic right to obtain information, they need to be aware of information-sharing strategies and limits of confidentiality early on in conversations so that they can decide what information to disclose. MDT members should consider very carefully what information must be shared with others, confining it to data that is directly relevant to the case and to the safety/wellbeing of the child.

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

Cross-reporting:

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

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

Joint response:

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

- Two or more members co-participating in or observing an interview of witnesses and stakeholders.
- MDT members observing another member conduct a forensic interview of the child.
- Members sharing information about interviews previously conducted by one party (e.g., the child protection worker shares with law enforcement relevant information obtained during a conversation with the non-offending caregiver).
- Discussion among MDT members prior to an interview to determine relevant questions to be asked.
- An MDT member reviewing their report with one or more other members to explain the content and conclusions, discuss next steps and facilitate referrals for services (e.g., healthcare provider discussing results of forensic examination with law enforcement and communicating with NGO staff regarding child/family service needs identified during the medical visit).
- Sharing other information relevant to the case, such as photographs, and information from records regarding prior assessments/investigations involving the child, family, or alleged offender.
- Communicating among MDT members to follow up on earlier activities, referrals, etc., as well as to manage misinformation and disinformation that may arise during an investigation.

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

Flow Diagram of Entire Investigation/Service Provision Process

The MDT should establish and implement a formal step-by-step- process for receiving reports of suspected THB/CSA/CSE, conducting criminal investigations and psychosocial assessments, obtaining necessary child/family services, prosecuting the criminal case and ensuring appropriate post-investigative follow up of holistic child/family services. This should be outlined in one or more flow diagrams.

Multidisciplinary Case review

(NOTE: Case review meetings may be prohibited by law/policy and new legislation or other measures may be required to engage in this very important activity.)

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

The purposes of the case review meetings are to:

1. Ensure MDT members are aware of relevant information to help guide the investigation and plan appropriate child/family services for active cases
2. Discuss potential harm to children, including risk of re-victimisation, and plan steps to promote safety
3. Foster appropriate referrals to meet the needs of the child and family
4. Ensure child/family services are delivered
5. Ensure that child centred, rights based, trauma informed, and culturally responsive strategies are used whenever MDT members interact with children and caregivers
6. Clarify apparent discrepancies, resolve issues, and answer questions to facilitate the investigation and service provision
7. Continue to cross-train on roles/responsibilities of MDT members
8. Foster networking and collaboration between MDT members
9. Discuss emerging and evolving trends in Crimes Against Children
10. Conduct analyses of mitigation processes and procedures to examine Strengths; Weaknesses; Opportunities; Threats related to MDT functioning (SWOT analysis)
11. In some jurisdictions, meetings may also serve as venues for short continuing education opportunities (invited speakers) and for representatives from new NGOs to describe their services. They may also provide the opportunity for respectful peer review to increase MDT member knowledge and improve skills.
12. **[Insert additional purposes for case review meetings.]**

Feedback System and Conflict Resolution:

To ensure optimal care for vulnerable children and their families, it is important to have in place a formal system for receiving and appropriately responding to positive and negative input regarding MDT functioning. This system should be available and easily accessible to all stakeholders, including children, family members, MDT members and other professionals. The feedback submitted should be reviewed by the MDT coordinator and relevant MDT members, with involvement of the steering committee as indicated. An MDT code of conduct, professional ethical standards, and/or relevant agency code of conduct should be used to assess and manage issues. If a complaint involves the MDT coordinator, a member of the steering committee should provide the initial review, with subsequent evaluation by the committee. If a complaint involves a steering committee member, that individual should recuse themselves from the evaluation process. Feedback obtained through the system should be evaluated regularly and used to modify and improve the protocol and the MDT process.

In the course of collaborating on difficult and highly stressful cases of THB/CSA/CSE, conflict among MDT members is inevitable. While many conflicts may be resolved informally, or with involvement of MDT agency supervisors, some may be relatively complicated and may require involvement by leadership of the MDT. It is important to have a formal conflict resolution process in place that is familiar to all team members and rigorously followed. This process should describe the activities, roles, and responsibilities of relevant members as they review, discuss, resolve, and document conflicts. Periodic review of documentation regarding MDT conflicts will assist the steering committee in initiating important systems change to improve the overall collaboration process and the efficiency of the MDT.

Documentation of anonymous feedback and instances of conflict between MDT members, including steps taken to address the issues, should be stored securely, and with rigorous protection of confidentiality.

[Insert a description of the specific strategies to be used for stakeholder feedback and conflict resolution. Examples of strategies for anonymous feedback include suggestion boxes available at sites where children and caregivers interact with MDT professionals; an online form available on the MDT agency websites to submit anonymous feedback, or surveys distributed to stakeholders. An example of conflict resolution may include the following: The MDT coordinator is notified of the conflict by another MDT member or by the members involved in the conflict. The coordinator interviews the involved parties and gathers relevant information. They present this information to the steering committee, who discuss the information and decide on an appropriate course of action. The coordinator summarises the conflict in a confidential log with appropriate redaction of identifying information, and outlines the outcome of the process, including recommendations for change. The log of MDT conflict management is reviewed periodically by the steering committee to help drive MDT evaluation and improvement.]

VIII. Prevention of THB/CSA/CSE

Actions to prevent THB/CSA/CSE may occur at the primary, secondary and tertiary levels.[97]

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

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

Capacity-building for all 3 levels of prevention is central to success.[98] The MDT can facilitate training and awareness of THB/CSA/CSE prevention strategies among its members and their associated agencies/organisations, in addition to working with other professionals within law enforcement, medical and mental health, education, public health and social services. They can educate families and children about THB/CSA/CSE and refer families for services that address vulnerabilities and help minimise the risk of abuse/exploitation. They can provide critical information to professionals and the public regarding the harm associated with social stigma, bias and discrimination that often impact children and families experiencing THB/CSA/CSE. They can educate the public about victimisation of boys and address harmful cultural attitudes surrounding gender roles and expectations that inhibit boys from disclosing THB/CSA/CST and lead to stigmatisation and alienation of males who experience victimisation.

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

IX. Monitoring and Evaluation (M and E) of the MDT[29]

Monitoring and evaluation are critical to the success of a multidisciplinary team.[11] Continuous data collection and periodic analysis identify strengths and weaknesses in MDT collaboration and inform quality improvement strategies that will maximise efficiency and improve outcomes. Data analysis also identifies important trends in THB/CSA/CSE which, when shared with key stakeholders, may inform legislative initiatives and policy decisions. Data from the MDT can help drive prevention initiatives and increase awareness of child abuse and exploitation in the region. Any information that is shared outside the MDT is anonymous, consisting of compiled, de-identified data.

Possible M and E strategies include:

- A secure database of cases that includes demographic data, information regarding the THB/CSA/CSE allegations, MDT members involved, results of specialty evaluations (e.g., medical; forensic laboratory); investigation and prosecution outcomes, child/family services recommended; and services obtained by the family
- Qualitative surveys of MDT members regarding their perceptions of the successes and challenges in the collaboration process, and suggestions for improvement
- Feedback from children/families who have been served by the MDT. This may take the form of surveys, interviews, etc. that occur immediately after a service is delivered, as well as after a fixed follow-up period.
- Feedback from professionals who interact with MDT members but who do not belong to the team.

A detailed list of potential monitoring and evaluation variables is available.[11]

X. Secondary traumatic stress among professionals

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

When working with children and families who have experienced THB/CSA/CSE, MDT members are exposed to graphic descriptions of abuse, exploitation, and cruelty. This can result in professionals developing 'secondary traumatic stress' (e.g., symptoms of post-traumatic stress disorder that occur as a result of learning about trauma experienced by others) (STS) and/or 'vicarious trauma' (e.g., changes in a person's views of the world in response to learning of trauma experienced by others) (VT).[99,100] Individuals respond differently to adversity (our own or someone else's), depending on a variety of factors such as temperament, coping style, work habits, prior history of trauma, and social support. STS and VT can be distressing and disruptive to those who experience it, impacting their personal and professional lives.

Some potential signs of STS/VT include:[99]

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

Strategies for preventing and reducing STS/VT may be implemented at the personal, professional and organisational levels:[101] See **Table 6**.

Table 6: Strategies for Addressing Secondary Traumatic Stress and Vicarious Trauma.[102,103]

Personal Strategies	Professional Strategies	Organisational Strategies
Identify one or more supportive individuals who understand STS/VT	Respect boundaries (yours and others')	Encourage a culture that acknowledges work-related stress and fosters support and recovery
Engage in regular exercise	Know and accept your limitations; have reasonable expectations	Organise staff debriefing sessions after very stressful events
Work on hobbies, engage in enjoyable activities	Avoid assuming responsibility for other people's problems	Ensure supervisors are aware of STS/VT and of strategies to support staff
Examine and adjust work/life balance	Share with others (de-brief, but do not traumatise peers)	Accommodate staff with STS/VT (ex., time off; reorganisation of activities, of schedules)
Do not bring work home with you	Obtain ongoing professional training (general topics or training relating to STS/VT)	Provide psychological support for those with STS/VT symptoms
Maintain a healthy diet	Prepare/plan for stressful aspects of work (ex., arrange schedule to perform stressful work when you have maximum energy)	Organise well-being activities for staff
Practice relaxation, mindfulness exercises	Monitor yourself for signs of stress	Ensure hiring process is transparent about stress encountered in work
	Be aware of your own emotional reactions and distress when confronting others' traumatic experiences and know what traumatic material may trigger you	Provide staff training on STS/VT recognition and management, including self-assessment strategies and stress management techniques

XI. Dissemination and Maintenance of Protocol

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

- Translation of the MDT protocol to other languages used in the community/region/country.
- Regular training on THB/CSA/CSE and the protocol (stand-alone training and/or inclusion at agency/organisation staff meetings)
- Regular email or social media notifications regarding the MDT, with links to the protocol
- Online self-paced module describing the MDT protocol, available for new employees as well as established staff (annual supplementary training)
- Checklist and pocket manuals for quick reference to MDT processes and procedures

[Insert additional strategies for dissemination as indicated.]

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

Conclusions

This Multidisciplinary Teams (MDTs) Framework provides a template for development of a MDT protocol addressing THB/CSA/CSE at the community, regional or national level. It assists professionals in caring for affected children and their families in ways that minimise emotional distress and re-traumatisation during the intervention process. The framework offers advice and space to tailor a protocol that is relevant to local and national needs and conditions.

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

Appendix A: Sample Memorandum of Understanding (MOU)

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

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

MDT members will:

a. Adhere to the protocol to the extent possible unless special circumstances dictate an alternative approach that supports the best interest of the child.
b. Make the best interest of the child the highest priority in any decision or action impacting the child/family.
c. Receive training regarding:
    i. **The MDT protocol**: All members of the MDT will receive training on the purpose and appropriate use of the protocol, strategies for effective communication and collaboration, and cross-training between team members, so professionals fully understand the roles, responsibilities and limitations of each agency involved. Training will be repeated regularly, to educate new members and remind existing members of key concepts and updates to laws and policies.
    ii. **THB/CSA/CSE**: Training will include the definitions, scope, and dynamics of THB/CSA/CSE, with an emphasis on local and national conditions. Risk factors, potential indicators, and challenges to identification will be discussed, as well as strategies for recognizing children experiencing or at risk of THB/CSA/CSE. Characteristics of offenders, as well as strategies used for recruitment and control of targeted children will be described. Training will address the impact of traumatic experiences on child physical and mental health, and ways MDT professionals may support the child and family in recovery. Available community services will be reviewed. Training will involve discussion of the negative impact of stigma as well as strategies to increase cultural responsiveness. The recognition of, and appropriate response to one's own biases and the discriminatory behaviour of others will be discussed.
    iii. **Additional training specific to the professional roles of MDT members** is also indicated, per agency/organisation protocol (e.g., investigative techniques related to cybercrime for use by law enforcement; skills for mental health professionals when working with children who experience THB/CSA/CSE).
    iv. **The child-centred, rights-based, trauma-informed, and culturally responsive** approach to working with children of varying developmental capacities and ages, and with families. See **Section III**.

d. Attend scheduled continued educational sessions throughout the year (this may entail guest speakers presenting at MDT meetings on issues related to THB/CSA/CSE).
e. Ensure that any action taken on the case does not place the child or family at increased risk of harm, or minimises potential harm.
f. Practise a child-centred, rights-based, trauma-informed, and culturally responsive approach to working with children and families.
g. Share case information appropriately with the child and non-offending caregiver (respecting their rights to access information while obeying laws and policies. surrounding privacy/confidentiality, respecting ethical and professional standards of practice, and protecting the integrity of criminal investigations). Verbal and written information should be conveyed in the preferred language of the child/family in a way that both child and caregiver can understand. Questions should be encouraged and answered with all possible transparency.
h. Respect the child and family's rights to a voice in decisions affecting them by actively seeking their input throughout the duration of the case. Information provided to the child, and consideration of their requests should be consistent with their developmental stage and cognitive abilities.
i. Take steps to minimise repetitive questioning of children and non-offending caregivers by sharing information, co-attending forensic interviews, and collaborating on activities related to the assessment and investigation of the case.
j. Take steps to ensure that all the adults around the child are protective and will not pressure the child to disclose, withhold or retract information.
k. Prioritise family preservation when in the best interest of the child; when not feasible, consider providing specialised care outside the child's home/family. (e.g., temporary measures in organisations or specialised care centres serving children who have experienced THB/CSA/CSE).
l. Treat other professionals, children, and families with dignity, respect and compassion.
m. Provide services that are free of bias and discrimination against families, children, and other professionals. MDT members will take action if bias/discrimination is exhibited by others in the workplace, consistent with agency/organisation policies and procedures.
n. Collaborate and coordinate with other involved MDT agencies, sharing relevant information, decisions and actions consistent with privacy and confidentiality laws and policies. Maintain open communication with others involved in the case, as much as possible.
o. Participate in regular MDT meetings to discuss collaboration/coordination efforts and current cases. These meetings should be closed to the public.
p. Participate in, and abide by, the MDT conflict resolution process as needed (see protocol).
q. Designate a professional to serve as MDT coordinator, and provide adequate funding to cover this position.
r Create a protocol steering committee that oversees protocol implementation and meets at least annually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying its provisions.
s. If communicating with the media, will rigorously follow ethical and professional standards that protect child/family confidentiality and privacy, and avoid victim-blaming, bias, and discrimination. An example of ethical guidelines is available (https://sahil.org/).

Participating agencies and any MDT coordinating body/agency commit to:

1. Providing adequate resources for staff to engage in MDT practices (e.g., staff to attend meetings, engage in joint response activities, etc.).
2. Contributing resources to the steering committee, and MDT coordinator as indicated ***[insert details here]*** .
3. Ensuring that staff participating on the MDT have relevant experience, knowledge and skills working

with children who have experienced THB/CSE/CSA, and receive support engaging in continued professional development.

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

This MOU is valid for ***[insert number]*** years.

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

Appendix B: Risk Factors & Potential Indicators of THB/CSA/CSE

There are a variety of factors that may increase the risk for THB/CSA/CSE, and these exist at the individual, relationship, community and societal levels.104 However, it is important to note that some victimised children may lack obvious risk factors, while others may have a few or many.105 Similarly, the presence of one or more risk factors does not guarantee that a child has experienced THB/CSA/CSE. It does mean that additional questions may need to be asked, and services provided to address the factors that render the child or family vulnerable.

There are relatively few 'indicators' of THB/CSA/CSE that definitively identify the child as a victim (e.g., sperm identified in the vagina of a prepubescent girl). Most potential indicators ('red flags') of abuse and exploitation are relatively nonspecific and may be seen in children who have not experienced THB/CSA/CSE. These may be attitudes, statements and behaviours that reflect trauma of other types, such as exposure to community violence, separation from a loved one, etc. Or they may have nothing to do with trauma, but instead reflect individual variation along a developmental spectrum. Finally, just as with risk factors, a child who has experienced THB/CSA/CSE may or may not demonstrate red flags/indicators that assist in identification of victimisation.

Risk Factors[106-110]

INDIVIDUAL (factors related to the child)

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

RELATIONSHIP (factors present within the family or peer groups)

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

COMMUNITY (factors characterising a community that render all children in that community at increased risk)

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

SOCIETAL (factors characterising a society or involving large populations that facilitate or condone THB/CSA/CSE)

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

Potential Signs of *Online Abuse*[111] (*These are especially concerning if they represent new behaviours and conditions*)

Late night use of device
Increased screen time or sudden decrease in use
Stress around the need to be online
Secretive use/hiding screen from others/hiding devices
Angry or withdrawn when online
Many new contacts or followers
Poor academic performance (especially if this represents a change)
Mental health issues
Withdrawal from friends and family
Multiple phones
New and unexplained gifts or money

Potential Emotional and Behavioural Signs of THB/CSA/CSE[86,112]

Please also see Table 5 for nonspecific reactions to trauma

CHILD	TRAFFICKER (OR PERSON ASSOCIATED WITH TRAFFICKER)
Spends more time outside home without providing any details to caregivers	Insists on speaking for child
Demonstrates inappropriate sexual behaviour	Does not know much about child
Has fear of being alone	Is resistant to leaving child alone with professional
Is afraid of specific people, situations	Is reluctant to answer questions about child
Demonstrates self-harm behaviour	Shows hostility, aggression toward child

Gives scripted or apparently inconsistent information to professional	Provides apparently inconsistent information to professional
	Has control of child's identification documents

Potential Physical Signs of THB/CSA/CSE[113-119]

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

Appendix C: Links to Important Resources

Child Rights

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

Violence Against Children Country Reports

1. Violence Against Children and Youth Surveys (VACS)
    a. https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/reports.html

Sample standards for one-stop collaborative centres

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

National and Transnational Referral Mechanism Resources

1. National referral mechanisms: Joining efforts to protect the rights of trafficked persons: A practical handbook: 2nd edition
    a. https://www.osce.org/odihr/NRM-handbook
2. Improving the communication and coordination among the NRM actors in MARRI participants: Practical guidance
    a. https://op.europa.eu/en/publication-detail/-/publication/d5542e9c-0e92-11eb-bc07-01aa75ed71a1/language-en
3. Guidelines for the development of a transnational referral mechanism for trafficked persons: South-Eastern Europe
    a. https://pdf.usaid.gov/pdf_docs/PNADS413.pdf;

Forensic Interviews of Children

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

2. Investigative interviews with children. Odeljan R, Butorac K, Bailey A. European Police Science and Research Bulletin. 2015;Summer(12):18-24.
3. The Cornerhouse forensic interview protocol: RATAC, Anderson J, Ellefson J, Lashley J, Miller A, Oliinger S, et al.
    a. https://www.cornerhousemn.org/images/CornerHouse_RATAC_Protocol.pdf. Accessed on 5/29/17.
4. The NICHD protocol: A review of an internationally-used evidence-based tool for training child forensic interviewers. La Rooy D, Brubacher SP, Aromaki-Stratos A, Cyr M, Hershkowtiz I, et al.. J Criminological Research, Policy & Practice. 2016;2:76-89.
5. Lamb ME, Orbach Y, Hershkowitz I, Esplin PW, Horowitz D. A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: a review of research using the NICHD Investigative Interview Protocol. Child Abuse Negl. 2007;31(11-12):1201-1231.

Medical Management of THB/CSA/CSE

7. Responding to children and adolescents who have been sexually abused: World Health Organisation Guidelines, 2017
    a. https://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf
8. Technical report: W.H.O. guidelines for the health sector response to child maltreatment. 2019
    a. https://www.who.int/violence_injury_prevention/publications/violence/Technical-Report-WHO-Guidelines-for-the-health-sector-response-to-child-maltreatment-2.pdf
9. Caring for child survivors of sexual abuse: Guidelines for health and psychosocial service providers in humanitarian settings; UNICEF and International Rescue Committee; 2012
    a. https://www.unicef.org/documents/caring-child-survivors-sexual-abuse
10. Sexually transmitted infection treatment guidelines; Centres for Disease Control and Prevention; 2021
    a. https://www.cdc.gov/std/treatment-guidelines/default.htm
11. Clinical report: Exploitation, labor and sex trafficking of children and adolescents: Health care needs of patients. Greenbaum, J., Kaplan, D., Young, J., AAP Council on Child Abuse and Neglect, & Health, Council on Immigrant Child and Family Health
    a. https://publications.aap.org/pediatrics/article/151/1/e2022060416/190310/Exploitation-Labor-and-Sex-Trafficking-of-Children?autologincheck=redirected
12. Improving physical and mental health care for those at risk of, or experiencing human trafficking & exploitation: The complete toolkit, 2nd edition, International Centre for Missing and Exploited Children, 2022
    a. https://www.icmec.org/healthportal-resources/topic/human-trafficking-toolkit/
13. Physical examination in child sexual abuse: Approaches and current evidence, Herrmann B., et al., 2014
    a. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4215093/

Appendix D: International and Regional Framework on THB/CSA/CSE

United Nations Convention on the Rights of the Child
Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse (Lanzarote Convention)
American Convention on Human Rights: Pact of San José de Costa Rica.
United Nations Convention against Transnational Organised Crime and the Protocols Thereto
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography
The Rio de Janeiro Declaration and Call for Action to Prevent and Stop Sexual Exploitation of Children and Adolescents
Declaration on the Protection of Children from all Forms of Online Exploitation and Abuse in ASEAN

Regional Legal Instruments

1. ASEAN Convention Against Trafficking in Persons, Especially Women and Children
2. SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution
3. Council of Europe Convention on Action against Trafficking in Human Beings
4. Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims

International Labour Organization (ILO) Conventions

1. ILO Forced Labour Convention (Convention No. 29 of 1930)
2. ILO Abolition of Forced Labour Convention (Convention No. 105 of 1957)
3. ILO's Worst Forms of Child Labour Convention (Convention No. 182 of 1999)
4. ILO Domestic Workers Convention (Convention No. 189 of 2011)

Special Procedures of the UN Human Rights Council Relevant to THB/CSA/CSE

1. Special Rapporteur on trafficking in persons, especially women and children;
2. Special Rapporteur on the sale of children, child prostitution and child pornography;
3. Special Rapporteur on contemporary forms of slavery, including its causes and its consequences.

Other International Legal Instruments

1. Universal Declaration of Human Rights of 1948
2. Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict of 2000

3. The International Covenant on Civil and Political Rights of 1966
4. International Covenant on Economic, Social and Cultural Rights of 1966
5. Convention against Torture of 1984
6. Convention on the Elimination of All Forms of Discrimination against Women of 1979
7. Convention on the Elimination of All Forms of Racial Discrimination of 1965
8. Convention on the Rights of All Migrant Workers and Members of their Families of 1990
9. Convention on the Rights of Persons with Disabilities of 2006
10. Hague Convention on Protection of Children and Cooperation in respect of Inter-Country Adoption of 1993
11. Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery of 1956

Appendix E: Ethical Issues Related to Special Populations

Children identifying as lesbian/gay/bisexual/transgender/queer/ or other (LGBTQ+):[108,120-123]

Children with non-binary gender identity or non-heterosexual orientation may experience mild to extreme stigma and discrimination by the lay public and professionals. Due to their social marginalisation, they are at increased risk for THB/CSA/CSE, as well as other forms of violence. Emotional and physical trauma, and discrimination may occur at the hands of authorities and child-serving professionals. The stigma associated with LGBTQ+ identification may inhibit a child's ability to disclose their victimisation and seek services; it may negatively impact the services provided, and result in unmet needs and further harm. It is extremely important that all MDT members be aware of and able to manage their own biases regarding LGBTQ+ issues, and provide non-discriminatory, empathic, non-judgmental care. MDT members should advocate with the public and with colleagues to provide equal access to high quality care for all children regardless of their sexual orientation or gender identity and provide special measures to protect the fundamental rights of LGBTQ+ children and youth. (NOTE: Existing laws may limit efforts to optimally serve children identifying as LGBTQ+, although respect for their basic human rights as outlined in the UN Convention on the Rights of the Child must remain the highest priority.)

Children with Disabilities/Special Needs[124-128]

Children with emotional, physical, developmental and/or intellectual disabilities/special needs are at increased risk for violence at the hands of others. They may have difficulties understanding the abusive/exploitative situation and communicating with others about their experience. Signs of abuse/exploitation may be misinterpreted as manifestations of the disability so that vulnerable children are not recognized as such and not given needed protection and services. It is important for MDT members to receive training on 1) the intersection of child disability and vulnerability to THB/CSA/CSE, and 2) appropriate ways to work with affected children and their families. Members need to ensure that children with disabilities have access to all services, with special accommodation as needed.

Children of racial/ethnic/religious/political/or cultural minority status and foreign-born individuals[123]

Children with a history of THB/CSA/CSE often experience marginalisation, discrimination, and bias, not only related to their involvement in exploitation (e.g., 'prostitution'; forced criminality), but also to their cultural, racial, ethnic, political, or religious status. These harmful attitudes and actions may be expressed by members of the dominant culture, or by those within the child's culture. Additional marginalisation may arise from biases related to gender, age, geographic location, and other factors. It is critical for MDT members to be aware of the types and manifestations of bias and discrimination common within their own culture, and that of the child. They need to work continuously to identify and manage their own explicit biases and seek to uncover and address their implicit ones. The MDT needs to implement a zero-tolerance policy for bias and discrimination of any form and implement appropriate monitoring and response mechanisms that allow individuals (children, caregivers, other professionals, the lay public) to register complaints when discrimination occurs.

MDT members need to respect and meet the unique needs of foreign-born children and those with minority

status who have experienced THB/CSA/CSE. This may involve seeking advice from cultural experts (ex., community elders, staff at migrant/refugee-serving organisations or religious leaders), receiving formal training on common beliefs and practices within relevant minority groups, facilitating focus groups of community members within a minority group to better understand views and attitudes, and ensuring ethnic and cultural diversity within the MDT. Translation of written materials and availability of trained interpreters are important. Cultural adaptation of assessment tools (e.g., screening tools, mental health assessment tools) and resources is needed. Training on common drivers of migration, the types of trauma often experienced before and during migration and common post-migration challenges will assist MDT members in understanding the perspective of foreign-born children and families. Innovation and creativity may be required to identify strategies to meet the needs of these children in the context of barriers imposed by policy and legislation (e.g., lack of access to free healthcare). Community advocacy to change legislation may also be needed.

Boys as Victims of THB/CSA/CSE[110,123,129-134]

Strict gender roles and expectations in many cultures contribute to misperceptions that boys are not vulnerable to sexual abuse, violence and exploitation. The 'machismo' culture expects boys to be leaders, protectors, and to be fully capable of defending themselves. A male who is victimised may be perceived by others (and himself) as 'weak', feminine and/or incapable of 'being a man.' These cultural views make it extremely difficult for victimised boys to disclose their THB/CSA/CSE experiences, and to seek help. And if they do disclose, the adults charged with protecting children may react with disbelief, criticism, and rejection. Boys may be treated as criminals in need of punishment instead of victims in need of assistance. It is extremely important that MDT members receive training on the vulnerabilities of males to THB/CSA/CSE; how gender roles and cultural attitudes negatively influence disclosure of abuse and exploitation, and how social stigma and discrimination regarding male victimisation can harm children and lead to poor outcomes.

Appendix F: Evidence Base for MDT Collaboration in Child Protection

Multidisciplinary collaboration in the investigation of crimes against children has been recommended in multiple international directives, conventions and reports.[2,36,37,51,135-139] **The evidence base** for the effectiveness of an MDT model in child protection cases is relatively limited but growing.[10,11,35,140] A search of the published literature on varied types of MDT approaches to child physical and sexual abuse found some evidence that supports the collaborative model, although results were mixed and tended to focus more on outputs related to criminal justice rather than the health and wellbeing of the child and family.[10,141] When compared to cases managed according to standard practices, typically with no or limited organised MDT collaboration, cases involving MDTs tended to have better criminal justice outcomes associated with activities occurring relatively early in the justice process (for example, police involvement in cases).[142] However, results were mixed in the effectiveness of MDT collaboration in percentage of criminal charges filed/prosecutions for abuse (positive result vs no difference), and with respect to percentage of convictions.[143] Generally, studies have shown that MDT collaboration is associated with increased referrals for mental health services,[144] as well as increased and/or more efficient use of mental health services.[145,146] In a US study of group psychotherapy delivered by a child advocacy centre, post-treatment results indicated clinically significant improvements in problematic behaviour and emotional distress in sexually abused children.[147] Some (but not all)[148,149] studies have found positive impacts for MDTs when examining child protection outcomes (e.g., rates of substantiation, time to substantiation, rates of referrals for services, and time to police involvement) and MDT process outcomes (e.g. increase in police involvement of cases and in joint investigations; decrease in number of interviews of the child).[10,142,143,149,150] In an Australian study comparing a co-located MDT with a 'Practice as Usual' model, investigators found no significant differences in rates of arrests or in decisions made by child protective services.[22] However, they did find significantly faster response times on a number of MDT processes, and improved collaboration between members of the co-located team. In addition, there was a perception by MDT members that the response was more victim-centred than that characterise the Practice as Usual model.

MDT training on a child-centred, trauma-informed approach to child interactions was viewed as very helpful in studies in South Africa and Zambia.[11] A study in the US found that MDT success was related to breadth of professional representation on the team, as well as the existence of organisations providing services to affected children and families.[35] When comparing MDT vs standard practice, one study found increased caregiver (but not child) satisfaction with the MDT response;[151] and multiple studies found greater rates of children receiving medical services.[144,150,152] A study of MDT collaboration in Malawi and Zambia demonstrated increased police referrals for health care of individuals experiencing sexual/gender-based violence (SGBV) after launching the collaborative approach, including multi-sectoral training.[11] Intensive, multisectoral training of MDT professionals in a Kenya study resulted in increased collaboration, improved forensic care, an increase in knowledge regarding SGBV, and increased convictions of perpetrators.[12] US law enforcement and child protective service workers participating in a qualitative study of child advocacy centre use indicated that training of MDT members was helpful in facilitating case collaboration and building morale among team members.[38] Participants further cited MDT meetings as playing multiple essential roles in the case process, including facilitating individual case management, and providing a forum for peer review of their work to improve knowledge and skills.

Together, these studies provide some evidence for the effectiveness of MDT collaboration of varied types,

although it is important to note that results have been mixed and not always positive.[10,140] For example, one study found formal MDT collaboration was associated with increased rates of referrals to service agencies but no difference in family engagement or case outcomes.[149] Another showed that an increase in access to legal services for survivors of SGBV did not necessarily lead to increased use of those services.[11] Many studies attempting to measure the impact of U.S. child advocacy centres focus on relatively highly integrated, 'full service' centres, so that results of these studies may or may not be generalisable to MDTs that do not offer the same model of services.[27]

The evidence base is dominated by US-based studies of child advocacy centres, and with a focus on criminal justice outputs.[140,141] Rigorous research is needed to assess the effectiveness of other MDT models and of MDT collaboration in low- and middle-resource countries;[11] to identify which MDT characteristics are most effective;[27] and to determine which models may be most helpful in given contexts. Outcomes related to child and family functioning, safety, health and mental health, as well as child/family resilience are needed.[140] And it is critically important to evaluate whether the needs and *services specifically identified by the child/family as important* have actually been met. Despite the limitations in the current evidence-base, international best practices continue to include multidisciplinary collaboration, and this framework is based on existing evidence regarding the important components of a collaborative approach.

Appendix G: Template for a Directory of Community Resources

PROFESSIONAL INTERPRETERS			
	Language	**Name of Interpreter/ Service**	**Contact Information**
List most common languages encountered			

THB/CSA/CSE VICTIM SERVICE ORGANIZATIONS			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Hours of operation**
Local service organisations			
National service organisations			

HOTLINES			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Hours of operation**
Anti-Trafficking Hotline			
Suicide Hotline			
Child Hotline			
Family Violence			
Missing Persons			

SHELTERS/HOUSING			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Length of Stay Permitted**
Children's shelter			
Shelter for boys			
Shelter for Transgender youth			
Migrant and Refugee shelter			
Shelter for victims of domestic violence			

HEALTH AND MENTAL HEALTH SERVICES			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Hours of operation**
Local hospital			
Children's hospital			
Trauma centre			
Migrant/Refugee clinic			
Paediatrics clinic			
Reproductive health clinic and outreach services			
Termination of pregnancy services (where legalised)			
Free health clinic			
Substance abuse treatment centre (drugs, alcohol)			
Mobile clinic, outreach services			
Obstetrics and Gynaecology			
Psychiatric hospital			
Clinic with trauma-focused mental health services			
General mental health clinic			
Paediatric mental health clinic			
Therapists, counsellors, psychologists			
Traditional healers			

RELATED SERVICE ORGANIZATIONS			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Hours of operation**
Migrant/Refugee organisations			
Family violence organisations			
LGBTQ+ organisations			
Vulnerable children organisations			
Rights organisations (e.g., child, women, labour, human rights)			
Food pantries			

LEGAL AND IMMIGRATION SERVICES			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Hours of operation**
Legal aid organisations			
Immigration lawyers			
Migrant/Refugee organisations offering referrals for legal services			

EMBASSY AND CONSULAR OFFICES			
Type of Organization/ Service	**Name of Organization/ Service**	**Contact Information**	**Hours of operation**
Embassy/Consular offices for most common populations of THB/CSA/ CSE victims			

INTERNATIONAL ORGANIZATIONS		
Type of Organization/ Service	**Website**	**Contact Information**
UNICEF		
International Labour Organization		
United Nations Office on Drugs and Crime		
United Nations High Commissioner for Human Rights		
UN Refugee Agency (UNHCR)		
World Health Organization		
Save the Children		
National Center for Missing and Exploited Children		
Internet Watch Foundation		
Add Additional International Agencies:		

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