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Systematic Review

Human Trafficking of Boys and Young Men: A Systematic Literature Review of Impacts on Mental Health and Implications for Services in Post-Trafficking Settings

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Abstract: The share of boys and men among detected victims of human trafficking is increasing globally, yet there is limited evidence on the specific experiences of these populations. The knowledge gap on mental health outcomes and support needs is particularly salient, which is problematic given the importance of psychological and emotional stabilisation in promoting recovery and avoiding re-victimisation. This systematic review reports on mental health outcomes identified in boys and young men who have experienced human trafficking. By describing the implications for services, the review seeks to identify challenges and opportunities in accessing and delivering mental health care and support to this population in post-trafficking settings. The review includes 31 papers published in English after 2000 and identified through database and grey literature searches. Despite significant limitations, such as a lack of gender-disaggregated results and imbalanced sample composition, which limit the possibility of extracting male-specific findings, the review highlights several mental health symptoms commonly described in the literature (e.g., depression, anxiety, PTSD, lack of self-esteem, lack of self-control). Regarding mental health care support, the review further identifies challenges specific to boys and young men (e.g., poor identification as trafficking victims) and challenges that disproportionately impact this population (e.g., confidentiality concerns; reluctance to seek help; trust issues).

Keywords: human trafficking; child trafficking; male; boys; youth; mental health; psychosocial health; post-trafficking; health care; systematic review

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1. Introduction

Human trafficking affects an estimated 24.9 million people around the world (International Labour Organization (ILO) et al. 2022). In the period 2004–2020, the proportion of boys and men among detected victims globally rose from 3% to 17% and 13% to 23%, respectively (United Nations Office on Drugs and Crime (UNODC) 2022). Recent data show that 66% of detected boys were trafficked for forced labour, 23% for sexual exploitation and 11% for other forms of exploitation (United Nations Office on Drugs and Crime (UNODC) 2020). Approximately 10% of victims of sexual exploitation detected globally are male and are most frequently reported in the East Asia Pacific region, where males account for one-third of victims who experience sexual exploitation (United Nations Office on Drugs and Crime (UNODC) 2022).

While these data suggest that fewer boys are trafficked for sexual exploitation than girls, research shows that Global South sexual exploitation of children is often labour-related, and boys may be more vulnerable to labour trafficking as a pathway into commercial sexual exploitation (ECPAT International 2021). Barriers to estimating the scope of sexual exploitation of boys include under-reporting, definitional ambiguities and inconsistencies, misconceptions about the abuse of boys and social stigma (United Nations Children's Fund (UNICEF) 2020; Adjei and Saewyc 2017; Edinburgh et al. 2015; Hounmenou 2017; Mitchell et al. 2017).

Studies documenting the health effects of trafficking point both to the range of health outcomes spanning physical health (e.g., cuts, burns, injuries, malnutrition), mental health (e.g., depression, anxiety, PTSD, suicidal ideation), sexual and reproductive health (e.g., STIs, unwanted pregnancy) and substance misuse (Zimmerman and Borland 2009) but also to the intertwined nature of physical and mental health symptoms (Ottisova et al. 2016; Hinton et al. 2013; Pocock et al. 2018). Younger victims, children and adolescents in particular, are likely at higher risk of longer-term physical and psychological harm from trafficking-related exposures than adults (Fazel and Stein 2002; Ottisova et al. 2018b). Trafficking-related hazards may impact children across several dimensions of psychosocial wellbeing, including cognitive abilities and cultural competencies; personal security, social integration and social competence; personal identity and valuation; and personal agency and emotional and somatic expressions of wellbeing (Woodhead 2004; Ottisova et al. 2018b; Rafferty 2008; Nodzenski et al. 2020). In addition to age, gender is also a determinant of an individual's experience of trafficking and related health outcomes (Iglesias-Rios et al. 2018). While gender shapes an individual's trafficking experience, there remains limited evidence on the specific risk factors, experiences, health outcomes and needs of trafficked men and boys. However, the existing evidence highlights the difficult conditions these individuals must navigate. Studies report strong patterns of violence experienced by boys and men (Davis et al. 2016; Kiss et al. 2015b) as well as difficult working and living conditions, resulting from more physically demanding tasks in particularly hazardous sectors (e.g., fishing industry, mining, agriculture) (Preece 2005; United Nations Office on Drugs and Crime (UNODC) 2017; Pocock et al. 2016). While evidence shows differences in psychological symptoms among victims of sexual and labour exploitation (Hopper and Gonzalez 2018), gender-specific evidence on the mental health impact of human trafficking in different sectors is limited (Iglesias-Rios et al. 2018; Kiss et al. 2015a).

Despite a consensus in existing literature on the need to address the complex psychological and social needs of all trafficking victims, access to mental health services remains scarce and inadequate to repair the damage caused by trafficking (Rafferty 2018). This service provision gap is particularly acute for boys, where the lack of evidence on mental health outcomes and specific needs is also reflected in the limited availability and/or use of assistance services by this population. The unavailability of services for men and boys may be attributed to the lack of evidence on the specific needs of these trafficking survivors, as well as a lack of awareness and inadequate training of service providers to identify and respond to men and boys affected by trafficking. Conversely, poor engagement with support services often results from socio-cultural and gender norms that constrain health-seeking and help-seeking behaviours by men and boys, who may consider mental health a low priority or may be more easily stigmatised from using mental health support (Hilton 2008; Addis and Mahalik 2003; Smiragina-Ingelstrom 2020).

Existing systematic reviews do report poor physical and mental health outcomes and needs for victims of trafficking of all genders and ages (Ottisova et al. 2016; Hemmings et al. 2016), while other reviews describe barriers to health care services for children who have experienced human trafficking (Albright et al. 2020; Garg et al. 2020) or services available to children who have been trafficked for sexual exploitation specifically (Muraya and Fry 2016). Fewer reviews focus exclusively on mental health outcomes or mental health interventions and services available to trafficking survivors (Wright et al. 2021; Mak et al. 2023). A recent systematic review (Moss et al. 2023) selected exploited boys as a population

of interest and reported on some implications for mental health but focused exclusively on sexual exploitation.

Using a conceptual framework to guide the analysis, this systematic review aims to describe mental health outcomes and related stressors in male children and youth (aged up to 24 years old) who have experienced human trafficking (Objective 1). The review further seeks to summarise types of mental health/psychosocial services and care targeting this population group (Objective 2). Finally, in describing implications for services, the review identifies challenges and opportunities in accessing/delivering mental health care and/or psychosocial support to this population (Objective 3). To our knowledge, no prior systematic reviews have focused on mental health outcomes and challenges in accessing mental health care or support specifically for men and boys impacted by labour trafficking and/or sexual exploitation.

2. Materials and Methods

2.1. Search Strategy

The review protocol is registered with the PROSPERO database of systematic reviews, registration number CRD42020198735. This review followed PRISMA guidelines (see Supplemental Data Table S1: PRISMA Checklist). A multi-stage search strategy was employed.

First, an electronic search of seven databases was conducted in July 2020 to identify studies published from 1 January 2000 [date of the adoption of the Palermo Protocol] onwards (Web of Science; MEDLINE; Embase; Scopus; Global Health; Social Policy and Practice; PsycINFO). This search was subsequently updated in June 2021 (date on which all databases were last searched). The search strategy used controlled vocabulary and free text terms, was developed in consultation with the London School of Hygiene and Tropical Medicine (LSHTM) Library Support Team and was tailored for each individual database. When a controlled vocabulary index did not exist, only free text terms were used to search the database (see Supplemental Data Table S2: Search Strategy). Key search terms for various concepts were adapted from Cochrane protocols and previous protocols related to human/child trafficking, health and health care as well as a scoping review and from existing systematic literature reviews of interest. Second, a search of the grey literature was purposively conducted across several websites of interest (Opengrey; Google Scholar; IOM; ILO Labourdoc; UNICEF; Understanding Children's Work website; Save the Children website; Young Lives website; Freedom Fund Search Library; Amnesty International; Plan International; US State Department; World Vision; DFID; ODI; USAID). Third, backward citation tracking of (a) all included studies and of (b) systematic literature reviews of interest (i.e., reviews identified in database searching that matched all inclusion criteria except for study design) was performed to identify additional studies for inclusion. Systematic literature reviews were not eligible for inclusion in the analysis. The quality of the search strategy was evaluated against criteria set by the PRESS checklist.

2.2. Selection Strategy

Studies were eligible for inclusion if they (1) were published after 2000 (2) and were published in an eligible language (English, French, Spanish, German, Portuguese). While we acknowledge potential biases resulting from language restrictions, this criterion reflects the translation capabilities of the research team. (3) They reported on primary/original data, (4) included male children and youth (aged under 24 years old)[1] and/or included service providers or informants working with males under 24 years old in the study sample. Due to the expected paucity of research specific to the population of interest, studies that included the population of interest in their sample were still eligible for inclusion regardless of whether they disaggregated outcome data by age or gender; whenever possible, data was extracted by gender and/or age group. (5) They referred to the exposure of interest as human trafficking for labour and/or sexual exploitation[2]. Recognizing that definitions of human trafficking and experiences that qualify as human trafficking may not be consistent, studies were included if participants self-identified or were identified by researchers or

by statutory or voluntary agencies as having experienced human trafficking, (6) and they referred to mental health, or the psychological, emotional, or psychosocial wellbeing of participants as an outcome of interest. Mental health outcomes were not narrowly defined, nor were pre-specified diagnostic tools used which may not be used in some contexts. The content of care delivered could range from specialized mental health care (using validated therapeutic approaches) to less formal forms of psychosocial support.[3] The review did not restrict inclusion to papers describing mental health services exclusively either. Included studies thus report on access to health care, including mental health services. This approach was deemed appropriate as the authors expected to find little evidence on access to mental health care specifically for male trafficking survivors that is relevant as many of the factors that constrain access to health care in general and mental health services in particular overlap. These barriers, including a lack of trust in providers, fear of judgement, concerns about confidentiality or lack of knowledge on available resources were also identified in existing systematic literature reviews looking at child survivors (Garg et al. 2020; Albright et al. 2020). Broadening the inclusion scope further allowed us to accommodate the various conceptualisations of mental health and mental health care, and to avoid cultural biases favouring Northern framings that can differ from wider psychosocial perspectives favoured in some Southern contexts. (7) They referred to support in post-trafficking settings[4] for the population of interest. Services may be delivered by a variety of providers (governmental, NGOs, CBOs...) in a variety of settings (health care, community...). Services used by youth in post-trafficking settings or out of an exploitative situation may include, but are not restricted to, post-trafficking services. Studies which had mental health outcomes, needs or risk factors as primary outcomes were eligible if implications for services or service providers were discussed.

No restrictions were placed for studies that did not include a comparator/control group or based on the studies' geographic scope.

Studies were excluded if they (1) were published before 2000 (2) or were not of an eligible study design. Systematic and other reviews,[5] editorials, review articles, opinion pieces, books and textbooks were not eligible unless they presented primary research results, (3) nor were they eligible if they included both males and females and/or adults and children without specifying the number or proportion of males under 24 in the study sample, (4) or did not include victims of trafficking for labour and/or sexual exploitation, or did not present data disaggregated by type of trafficking if they included other forms of trafficking (for example, forced marriage, organ trafficking...), (5) or did not report on mental health or emotional wellbeing (e.g., description of mental health symptoms, needs or stressors; prevalence of mental health outcomes) and (6) did not examine mental health care or support services used in post-trafficking settings or do not, at a minimum, report on mental health symptoms and needs' implications for service delivery (the intervention or support provided may not necessarily be focused on mental health but should at a minimum refer to observed improvements in emotional wellbeing and mental health symptoms).

Screening tools for both the title/abstract and full-text screening phases were developed, piloted on the first 50 results, adapted and used by reviewers (MN and AWdS) to screen all results.

Citations retrieved from the search outputs of the electronic databases and grey literature were imported into Rayyan (Ouzzani et al. 2016), a collaborative systematic review screening software, for screening, and duplicates were removed. Results from the grey literature search which could not be imported into Rayyan were imported to an Excel file for screening. All titles and abstracts were independently reviewed by the first (MN) and second (AWdS) reviewers against the inclusion/exclusion criteria. A full-text review was conducted for studies that could not be excluded from title and abstract revision, as well as those deemed sufficient for inclusion. The first (MN) and second (AWdS) reviewers reviewed 100% of the full texts. Reasons for exclusion were recorded at all stages of the screening process.

Backward citation tracking of included studies and systematic literature reviews identified at the title/abstract screening phase were assessed by the first reviewer (MN).

2.3. Data Extraction and Analysis

An Excel data extraction form was developed and piloted by MN. Data from all included papers were extracted by MN; AWdS independently extracted data from a random sample of 25% of included studies as a check; disagreements were resolved by discussion and consultation with a third reviewer (NP; AMB).

Data were extracted on the following: (1) Study characteristics (research objectives; study design; sampling method; sample size; study setting; survivor characteristics; type of trafficking). (2) Mental health outcomes; measures of mental health outcomes; prevalence of mental health outcomes; mental health-related stressors. (3) Type of service; mental health/psychosocial intervention. (4) Service availability; service approachability; service accessibility; continuity; safety; service effectiveness; service appropriateness; service acceptability; recommendations for improved service provision.

A conceptual framework was developed to guide the analysis of the review (see Figure 1). The conceptual framework first describes the contribution of pre-trafficking, in-trafficking and post-trafficking stressors to mental health symptoms. The conceptual framework draws on works by Levesque et al. (2013) on access to care, by Dover and Belon (2019) on health equity and by Powell et al. (2018) on barriers to human trafficking and general service delivery. Concepts of availability, accessibility, approachability, acceptability, appropriateness, continuity, safety and effectiveness are used to explore challenges and opportunities in accessing care for the population under study. These elements of access are underpinned and shaped by individual (survivors and providers) features (e.g., providers' language, gender, limited resources, sensitivity to culture, etc., and survivors' feelings of shame/stigma, culture, legal status, etc.) and system features (e.g., disagreements between systems concerning eligibility to services, lack of coordination of services, etc.), illustrating how effective care delivery must overcome barriers resulting from an asymmetry between survivors' needs and providers' capacity in a multisystem framework (Powell et al. 2018).

The framework conceptualises access to care as a two-stage process whereby meaningful health care for survivors necessitates services to be available and accessible but also to appropriately respond to survivors' individual needs and preferences (see definitions of availability, accessibility, appropriateness in Supplemental Data Table S3: Definitions Components of Care).

The review includes quantitative, qualitative and mixed-methods studies. As establishing the prevalence of mental health outcomes was not an objective of the review and owing to several limitations of the included studies (e.g., no pooled estimates were calculated for the outcomes due to heterogeneity in samples, predominance of non-representative and convenience samples, varying definitions and methods of assessing the outcomes), no meta-analysis based on results from the quantitative studies was performed. A narrative synthesis of the quantitative data was conducted. The analysis was based on framework synthesis. A list of codes was derived from the conceptual model, providing the a priori framework of themes against which to code the data extracted from the included studies (data could be verbatim quotations from the participants or findings reported by authors and supported by study data) (Brunton et al. 2020; Dixon-Woods 2011; Carroll et al. 2011).

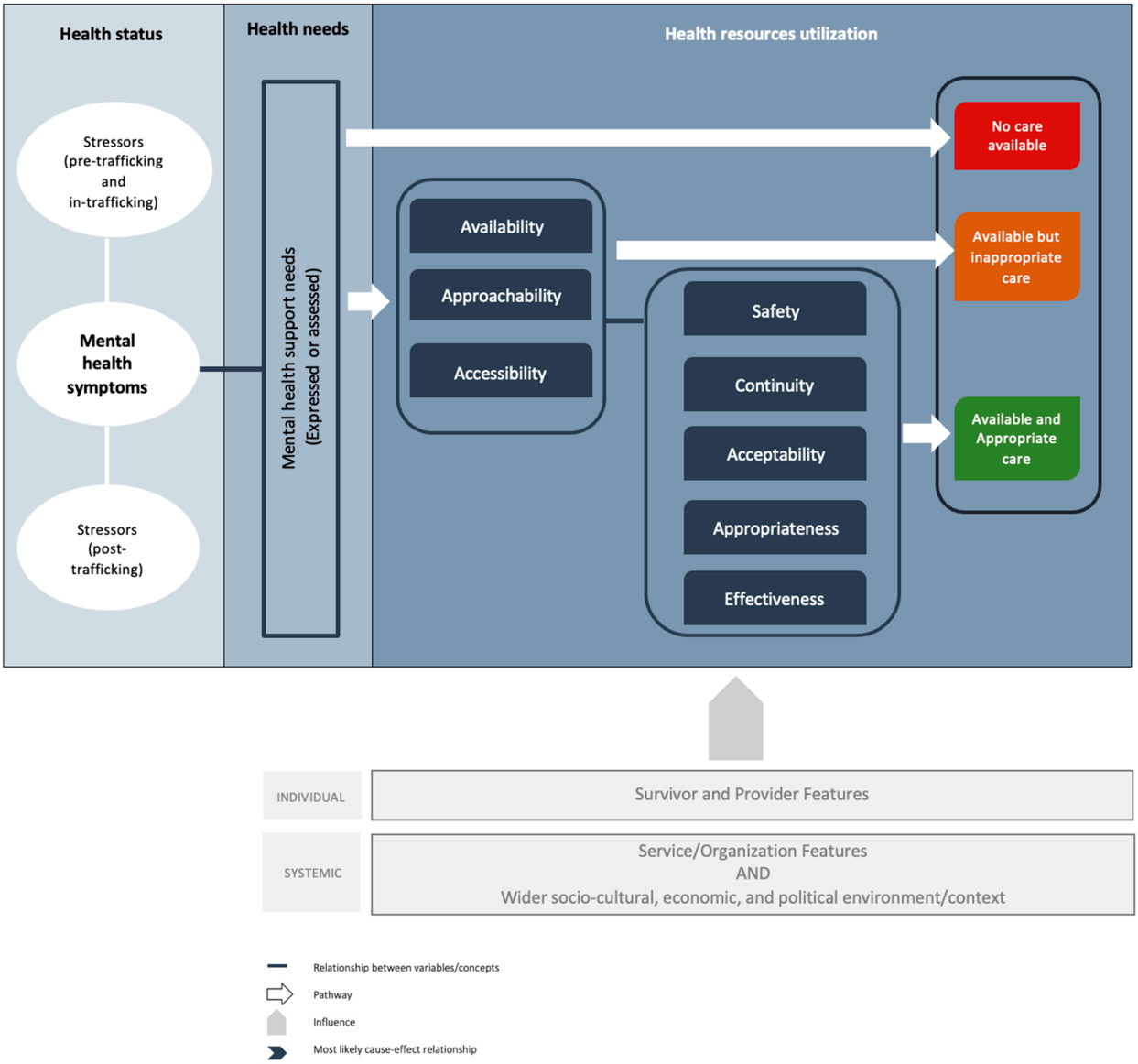

Figure 1. Conceptual framework.

2.4. Quality Appraisal

The methodological quality of included studies was appraised independently by two reviewers; MN appraised all studies, while AWdS appraised a randomly selected 25% of studies (n = 8, the same studies for which data were extracted by AWdS).

The reviewers used the Mixed-Methods Appraisal Tool (MMAT) (Hong et al. 2018) to appraise the included studies. This critical appraisal tool was designed to assess the methodological quality of five types of research designs (qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies and mixed-methods studies), and is particularly suited to the appraisal stage of systematic mixed studies reviews.

For each study design, quality was assessed using five questions. Overall quality scores were calculated based on the numbers of positive answers to the five questions. As a result, scores are presented from a scale of 1 (low quality) to 5 (high quality).

Given the scarcity of evidence on the selected topic, studies were not excluded based on study quality. Poor methodological rigor does not necessarily indicate a lack of insightful findings (Carroll and Booth 2015). This particularly applied to studies retrieved from the grey literature search to reduce bias and allow some empirical studies conducted in middle-

and low-income countries not published in peer-reviewed journals to be included. Rather, limitations related to the quality of studies will be referred to in the Limitations Section.

3. Results

3.1. Study Selection

Our searches returned 2379 unique records, of which 2267 were excluded following title and abstract screening. Full-text copies of the remaining 112 papers that met or potentially met the inclusion criteria were retrieved. After full-text screening, 23 papers were retained for inclusion in the review. Of 23 papers, 18 were identified from database searches and 5 papers were identified from the search of grey literature (Figure 2). An additional eight papers were identified from backward citation tracking (see Table S4). The 31 included papers were published in English.

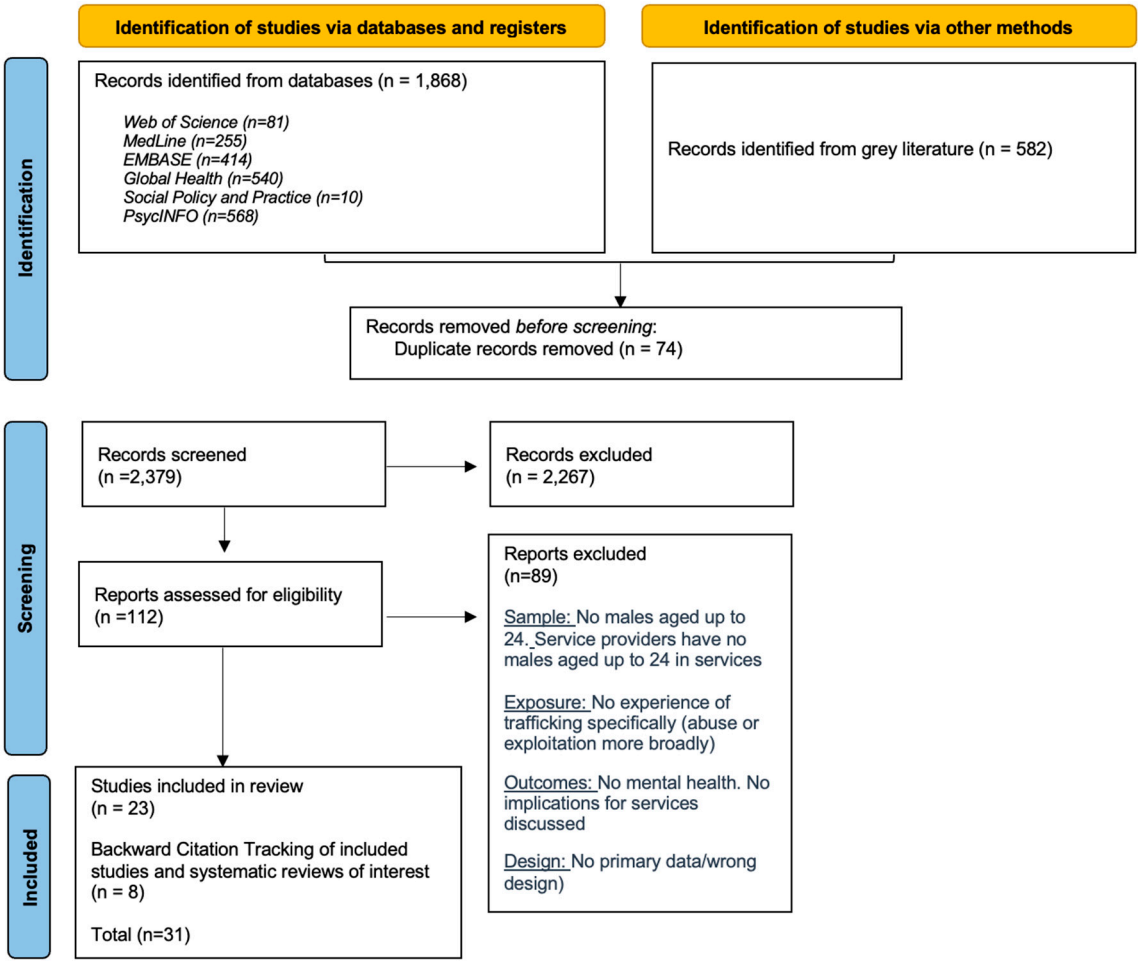

Figure 2. PRISMA flowchart.

Characteristics of Included Studies

The characteristics of included studies (n = 31) are presented in Supplemental Data Table S4: Study Characteristics. Notably, the report by Oram et al. (2016) is a collection of eight individual studies (under the same research project). While the report was screened and counted as one unique result, data were extracted and quality appraised for the three individual studies that both met the inclusion criteria and were not already included in the review as other published articles. Results and quality appraisal thus refer to these individual studies as (Oram et al. 2016, [1][6]; Oram et al. 2016, [2][7]; and Oram et al. 2016, [3][8]) (These numbers refers to identify 3 sub-studies in the larger report in (Oram et al.

2016). The three sub-studies are referred to individually in the rest of the review). As a result, in the Results Section, the total number of studies is 33.

Studies were published between 2008 and 2020 and data were collected in Cambodia (n = 9); Thailand (n = 7), Vietnam (n = 6), the Lao PDR (n = 1), Myanmar (n = 1), China (n = 1), the United Kingdom (n = 9), the US (n = 7), Ukraine (n = 1), Belarus (n = 1) and Palestine (n = 1). Most included studies had a quantitative study design (either quantitative non-randomized (n = 11) or quantitative descriptive (n = 5)). Ten studies had a qualitative design and seven used mixed methods.

All included qualitative studies were rated as very good quality (5). The four quantitative non-randomized studies which achieved a score of 4 all failed to provide complete outcome data. The three quantitative descriptive studies which achieved a score of 4 did not qualify for low risk of non-response bias. The quality of mixed-methods studies was more heterogenous, with three studies scoring 5 and two studies scoring 4 (one study did not provide an adequate rationale for using mixed methods to answer the research question, and another study did not interpret the outputs of the integration adequately). Finally, one mixed-methods study was considered of poor quality (1) because of a lack of rationale for using the mixed-methods design to answer the research question, as well as poor integration of the different components of the study and poor interpretation of the outputs of the integration, and because each component of the study did not adhere to the quality criteria of each tradition of the methods involved (see Figure 3).

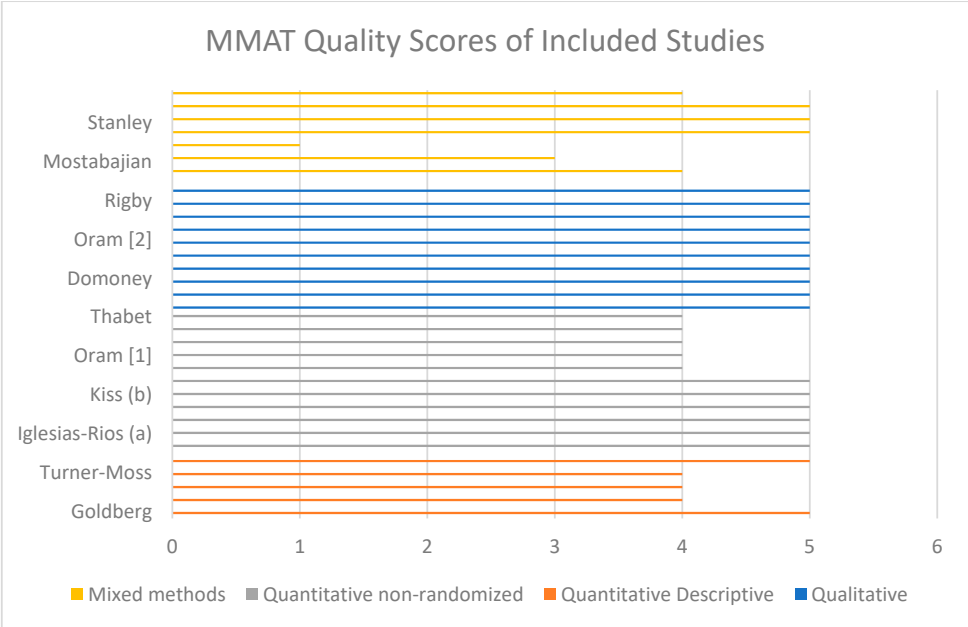

Figure 3. MMAT quality scores of included studies.

As per the inclusion criteria, all studies sampled victims of human trafficking or service providers assisting victims of human trafficking (although providers may have also been assisting other vulnerable individuals, not trafficking survivors exclusively). The definition of human trafficking varied across studies, with some referring to the UN Palermo Protocol, and others to the US Trafficking Victims Protection Act. This also influenced the type of experience considered trafficking by authors (for instance, some studies described commercial sexual exploitation of children (CSEC) as human trafficking or domestic minor sex trafficking). Similarly, the criteria by which victims were identified as trafficking victims varied depending on the study country and/or on the organization serving victims (see also Limitations Section). Twenty-four studies included victims of trafficking for both labour and sexual exploitation, six studies included victims of trafficking for sexual exploitation exclusively and three studies had a focus on labour exploitation (e.g.,

fishing industry). One study (Thabet et al. 2011) sampled children involved in child labour but was included based on the author's definition of child labour as "children working in more than light work, exposed to hazards, forcibly recruited, prostituted, trafficked and driven into illegal activities".

Studies sampled trafficking survivors (n = 21), service providers assisting survivors (n = 8) or both survivors and providers (n = 4) as participants. Concerning the 25 studies that sampled trafficking survivors, the sample composition varied in terms of gender and age. Only two studies sampled male minors exclusively (Davis et al. (2016) (n = 22); Thabet et al. (2011) (n = 780)). Most studies (n = 14) included both male and female participants, aged both under and over 18 years. Some studies sampled minors exclusively (male and female) (n = 6) or males exclusively (adults and children) (n = 3). Among the studies that include both children and adults and/or male and female participants in their samples, few disaggregated results by age or gender (see also Section 5. Limitations).

The number of young males in mixed-gender samples ranged from 1 (Goldberg et al. 2017) to 238 (Iglesias-Rios et al. 2019a, 2019b; Kiss et al. 2015a, 2015b). In studies that sampled boys and men exclusively, the number of participants aged below 24 years ranged from 3 (Munro and Pritchard 2013) to 780 (Thabet et al. 2011). For more details about sample composition see note 9.[9]

Concerning the 12 studies which had service providers as participants, the large majority sampled service providers working with survivors of trafficking in general, including young male survivors. None of the studies sampled providers working with males or male minors exclusively. Two studies (Gibbs et al. 2015; Macias-Konstantopoulos et al. 2015) sampled providers who served minors exclusively. One study (Powell et al. 2018) included three providers (T = 15) serving minors exclusively.

3.2. Thematic Findings

Included studies reported on various themes (Table 1) aligned with the review's objectives and the conceptual framework.

Table 1. Themes identified in included studies.

Author	Study Objective 1		Study Objective 2			Study Objective 3							
	Mental health Outcomes	Stressors	Service Type	Type of care—Mental Health	Type of Care—Psychosocial	Availability	Approachability	Accessibility	Safety	Continuity	Effectiveness	Appropriateness	Acceptability
Aberdein and Zimmerman (2015)			x	x	x	x	x	x	x	x		x	X
Cary et al. (2016)	x		x										
Davis et al. (2016)	x	x	x						x	x		x	X
Domoney et al. (2015)			x			x		x	x	x		x	X
Gibbs et al. (2015)	x		x	x	x	x		x	x	x			X
Goldberg et al. (2017)	x	x	x										
Iglesias-Rios et al. (2019a)	x	x	x										

Table 1. *Cont.*

Author	Study Objective 1		Study Objective 2			Study Objective 3							
	Mental health Outcomes	Stressors	Service Type	Type of care—Mental Health	Type of Care—Psychosocial	Availability	Approachability	Accessibility	Safety	Continuity	Effectiveness	Appropriateness	Acceptability
Iglesias-Rios et al. (2019b)	x	x	x										
Kiss et al. (2015b)	x	x	x										
Kiss et al. (2015a)	x	x	x	x	x								
Kung (2014)				x				x	x	x		x	X
Landers et al. (2017)	x		x		x							x	X
Macias-Konstantopoulos et al. (2015)			x			x		x		x		x	
Mostajabian et al. (2019)	x		x				x	x		x		x	X
Munro and Pritchard (2013)			x	x	x	x		x		x		x	X
Nodzenski et al. (2020)	x	x	x	x	x	x						x	
Oram et al. (2015)	x	x	x							x		x	
Oram et al. (2016, [1])	x	x	x							x			
Oram et al. (2016, [2])		x	x					x		x			X
Oram et al. (2016, [3])			x	x	x	x		x		x		x	X
Ottisova et al. (2018a)	x	x	x					x		x			
Ottisova et al. (2018b)	x	x	x					x				x	
Palines et al. (2019)	x		x					x				x	
Pocock et al. (2018)	x	x	x	x	x	x	x	x	x			x	X
Powell et al. (2018)			x			x		x		x		x	X
Rigby (2011)	x		x		x			x	x	x		x	X
Stanley et al. (2016)	x	x	x			x		x	x	x		x	X
Surtees (2008)		x	x				x	x	x				X
Thabet et al. (2011)		x											
Turner-Moss et al. (2014)	x		x										
Twigg (2017)			x	x	x					x		x	
Westwood et al. (2016)	x		x	x	x			x	x	x			X
Zimmerman et al. (2014)	x	x	x									x	

3.2.1. Mental Health Outcomes and Related Stressors

The included studies described a range of mental health symptoms and disorders in trafficking survivors (see details in Table 2), including post-traumatic stress disorders (n = 16), mood disorders (depression (n = 16)), anxiety disorders (n = 14), stress response syndromes or adjustment disorders (severe stress or distress (n = 7)) and psychotic disorders (n = 2). Addiction disorders were often reported to result from a trafficking experience (substance misuse (n = 5)).

Table 2. Prevalence of common mental health outcomes among male survivors of trafficking.

Author	Sample Size and Composition [Males]	Measure of Mental Health Outcome	Prevalence of Mental Health Outcome Among Males	Prevalence of Mental Health Outcome Among Females	Prevalence of Mental Health Outcome (Overall)
Mood disorders (including depression) [23.1–60.7%]					
Davis et al. (2016)	22 males (10 to 19 yo)	N.A *.	36% (n = 22)	N.A. (n = 0)	36% (n = 22)
Iglesias-Rios et al. (2019a)	446 males (aged 10+ yo)	Hopkins Symptoms Checklist	59% (n = 446)	61% (n = 569)	N.A. (n = 1015)
Kiss et al. (2015b)	383 adult males (including 168 aged 18–24 yo)	Hopkins Symptoms Checklist	60.7% (n = 383)	66.6% (n = 288)	N.A. (n = 671)
	344 children (males and females)	Hopkins Symptoms Checklist	N.A.	N.A.	57.3% (n = 344)
Kiss et al. (2015a)	70 male children (10–17 yo)	Hopkins Symptoms Checklist	40% (n = 70)	59.9% (n = 317)	56.3% (n = 387)
Landers et al. (2017)	87 children—including 5 male children (10–18 yo)	Child and Adolescent Needs and Strengths—Commercially Sexually Exploited (CANS-CSE) assessment tool	N.A.	N.A.	62.3% (n = 87)
Mostajabian et al. (2019)	120 youth (18–21 yo)—including 61 male youths	N.A.	N.A.	N.A.	49.3% (n = 120)
Nodzenski et al. (2020)	107 male youths (10–19 yo)	Hopkins Symptoms Checklist	37.4% (n = 107)	51.5% (n = 410)	48.6% (n = 517)
Oram et al. (2015)	37 children—including 12 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A.	N.A.	27% (n = 37)
	96 adults—including 18 male adults	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A.	N.A.	34% (n = 96)
Oram et al. (2016, [1])	150 adults—including 52 adult males	Patient Health Questionnaire9 (PHQ-9)	23.1% (n = 52)	51% (n = 98)	41.3% (n = 150)
	29 young people (16–21 yo)—including 5 male youths	Patient Health Questionnaire9 (PHQ-9)	N.A. (n = 5)	N.A. (n = 24)	N.A. (n = 29)
Ottisova et al. (2018a, 2018b)	51 children (5–17 yo)—including 11 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A. (n = 11)	N.A. (n = 40)	22% (n = 51)
Palines et al. (2019)	143 youth (12–17)—including 10 male and 4 transgender youths	N.A.	N.A. (n = 10)	N.A. (n = 129)	45.5% (n = 143)
Pocock et al. (2018)	275 males—including 126 male youths (10–24 yo)	Hopkins Symptoms Checklist	54.4% (n = 275)	N.A. (n = 0)	54.4% (n = 275)
Zimmerman et al. (2014)	465 males (adult + children)—including 174 male youths (18–24 yo) 637 females (adults + children) T= 1102	Hopkins Symptoms Checklist	57.1% (n = 465)	61.8% (n = 637)	59.7% (n = 1102)
	387 children (10–17 yo)—including 70 male children	Hopkins Symptoms Checklist	N.A.	N.A.	48.1% (10–14 yo) 58.4% (15–17 yo) (n = 387)
Iglesias-Rios et al. (2019a)	446 males (10+)	Hopkins Symptoms Checklist	48% (n = 446)	37% (n = 569)	N.A. (n = 1015)

Table 2. *Cont.*

Author	Sample Size and Composition [Males]	Measure of Mental Health Outcome	Prevalence of Mental Health Outcome Among Males	Prevalence of Mental Health Outcome Among Females	Prevalence of Mental Health Outcome (Overall)
Anxiety [19.2–48.4%]					
Kiss et al. (2015b)	383 adult males (including 168 aged 18–24 yo)	Hopkins Symptoms Checklist	48.4% (n = 383)	48.1% (n = 288)	N.A. (n = 671)
	344 children (males and females)	Hopkins Symptoms Checklist	N.A.	N.A.	32.3% (n = 344)
Kiss et al. (2015a)	70 male children (10–17 yo)	Hopkins Symptoms Checklist	32.9% (n = 70)	32.5% (n = 317)	32.6% (n = 387)
Landers et al. (2017)	87 children—including 5 male children (10–18 yo)	Child and Adolescent Needs and Strengths—Commercially Sexually Exploited (CANS-CSE) assessment tool	N.A.	N.A.	51.2% (n = 87)
Nodzenski et al. (2020)	107 male youths (10–19 yo)	Hopkins Symptoms Checklist	36.4% (n = 107)	34.9% (n = 410)	35.2% (n = 517)
Oram et al. (2016, [1])	150 adults—including 52 adult males	PTSD Checklist—Civilian (PCL-C)	19.2% (n = 52)	49% (n = 98)	38.7% (n = 150)
	29 young people (16–21 yo)—including 5 male youths	PTSD Checklist—Civilian (PCL-C)	N.A. (n = 5)	N.A. (n = 24)	N.A. (n = 29)
Palines et al. (2019)	143 youth (12–17)—including 10 male and 4 transgender youths	N.A.	N.A. (n = 10)	N.A. (n = 129)	19.6% (n = 143)
Pocock et al. (2018)	275 males—including 126 male youths (10–24 yo)	Hopkins Symptoms Checklist	44.9% (n = 275)	N.A. (n = 0)	44.9% (n = 275)
Zimmerman et al. (2014)	465 males (adults + children)—including 174 male youths (18–24 yo) 637 females (adults + children) T = 1102	Hopkins Symptoms Checklist	45.7% (n = 465)	39.3% (n = 637)	41.9% (n = 1102)
	387 children (10–1 yo)—including 70 male children	Hopkins Symptoms Checklist	N.A.	N.A.	30.4% (10–14) 33.1% (15–17) (n = 387)
PTSD [18.8–46.3%]					
Iglesias-Rios et al. (2019a)	446 males (10 yo onwards)	Harvard Trauma Questionnaire	46% (n = 446)	31% (n = 569)	N.A. (n = 1015)
Kiss et al. (2015b)	383 adult males (including 168 aged 18–24 yo)	Harvard Trauma Questionnaire	46.3% (n = 383)	43.9% (n = 288)	N.A. (n = 671)
	344 children (males and females)	Harvard Trauma Questionnaire	N.A.	N.A.	26.5% (n = 344)
Kiss et al. (2015a)	70 male children	Harvard Trauma Questionnaire	18.8% (n = 70)	26.9% (n = 317)	25.5% (n = 387)
Nodzenski et al. (2020)	107 male youths (10–19)	Harvard Trauma Questionnaire	26.2% (n = 107)	27.1% (n = 410)	26.9% (n = 517)
Oram et al. (2015)	37 children—including 12 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A.	N.A.	27% (n = 37)
	96 adults—including 18 male adults	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A.	N.A.	28% (n = 96)
Oram et al. (2016, [1])	150 adults—including 52 adult males	PTSD Checklist—Civilian (PCL-C)	25% (n = 52)	59.2% (n = 98)	47.3% (n = 150)
	29 young people (16–21 yo)—including 5 male youths	PTSD Checklist—Civilian (PCL-C)	20% (n = 5)	62.5% (n = 24)	55.2% (n = 29)
Ottisova et al. (2018a, 2018b)	51 children (5–17 yo)—including 11 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A. (n = 11)	N.A. (n = 40)	22% (n = 51)
Palines et al. (2019)	143 youth (12–17)—including 10 male and 4 transgender youths	N.A.	N.A. (n = 10)	N.A. (n = 129)	19.6% (n = 143)
Pocock et al. (2018)	275 males—including 126 male youths (10–24 yo)	Harvard Trauma Questionnaire	39.4% (n = 275)	N.A. (n = 0)	39.4% (n = 275)
Stanley et al. (2016)	29 youth (10–21 yo) including 5 male youths	PTSD Checklist—Civilian	20% (n = 5)	62.5% (n = 24)	55.2% (n = 29)

Table 2. *Cont.*

Author	Sample Size and Composition [Males]	Measure of Mental Health Outcome	Prevalence of Mental Health Outcome Among Males	Prevalence of Mental Health Outcome Among Females	Prevalence of Mental Health Outcome (Overall)
Anxiety [19.2–48.4%]					
Turner-Moss et al. (2014)	35 adults (18+ yo)	Harvard Trauma Questionnaire	N.A. (n = 27)	N.A. (n = 8)	57% (n = 35)
] Zimmerman et al. (2014)	465 males (adults + children) - Including 174 male youths (18–24 yo) 637 females (adults + children) T = 1102	Harvard Trauma Questionnaire	40.7% (n = 465)	32.0% (n = 637)	35.5% (n = 1102)
	387 children (10–17)—including 70 male children	Harvard Trauma Questionnaire	N.A.	N.A.	21.5% (10–14) 24.7% (15–17) (n = 387)
Self-harm [5.1–9%]					
Goldberg et al. (2017)	41 children (11–17 yo)—including one male and one transgender child	N.A.	N.A. (n = 1)	N.A. (n = 39)	10% (n = 41)
Kiss et al. (2015a)	70 male children (10–17)	positive for participants reporting having tried to physically harm themselves in any way	9% (n = 70)	12.6% (n = 317)	11.9% (n = 387)
Ottisova et al. (2018a, 2018b)	51 children (5–17 yo)–including 11 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A. (n = 11)	N.A. (n = 40)	33% (n = 51)
Pocock et al. (2018)	275 males—including 126 male youths (10–24 yo)	N.A.	5.1% (n = 275)	N.A. (n = 0)	5.1% (n = 275)
Suicidal ideation [7.3–20%]					
Davis et al. (2016)	22 males (aged 10 to 19)	N.A.	36%	N.A.	36%
Goldberg et al. (2017)	41 children (11–17 yo)—including one male and one transgender child	N.A.	N.A. (n = 1)	N.A. (n = 39)	20% (n = 41)
Oram et al. (2016, [1])	150 adults—including 52 adult males	Revised Clinical Interview Schedule (CIS-R)	13.5% (n = 52)	51% (n = 98)	38% (n = 150)
	29 young people (16–21 yo)—including 5 male youths	Revised Clinical Interview Schedule (CIS-R)	20% (n = 5)	45.8% (n = 24)	41.4% (n = 29)
Pocock et al. (2018)	275 males—including 126 male youths (10–24 yo)	N.A.	7.3% (n = 275)	N.A. (n = 0)	7.3% (n = 275)
Stanley et al. (2016)	29 youths (10–21 yo) including 5 male youths	Revised Clinical Interview Schedule	20% (n = 5)	45.8% (n = 24)	41.4% (n = 29)
Westwood et al. (2016)	T = 136 91 female and 45 male participants (16+ yo)—including 10 male youths (16–25 yo)	N.A.	11% (n = 45)	49% (n = 91)	N.A. (n = 136)
Suicide attempt [2.9–4.4%]					
Kiss et al. (2015a)	70 male children (10–17)	positive for participants who reported trying to take their own lives in the month before the interview	2.9% (n = 70)	6% (n = 317)	5.4% (n = 387)
Mostajabian et al. (2019)	120 youths (18–21)—including 61 male youths	N.A.	N.A.	N.A.	42% (n = 120)
Ottisova et al. (2018a, 2018b)	51 children (5–17 yo)–including 11 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A. (n = 11)	N.A. (n = 40)	27% (n = 51)
Pocock et al. (2018)	275 males—including 126 male youths (10–24 yo)	N.A.	4.4% (n = 275)	N.A. (n = 0)	4.4% (n = 275)
Psychotic disorders [up to 39%]					
Cary et al. (2016)	T = 119 28 males and 91 females—including 18 male youths (8–25 yo)	International Classification of Diseases-10 (ICD-10) diagnosis tool	39% (n = 28)	10% (n = 91)	17% (n = 119)
Palines et al. (2019)	143 youths (12–17)—including 10 male and 4 transgender youths	N.A.	N.A. (n = 10)	N.A. (n = 129)	14% (n = 143)

Table 2. *Cont.*

Author	Sample Size and Composition [Males]	Measure of Mental Health Outcome	Prevalence of Mental Health Outcome Among Males	Prevalence of Mental Health Outcome Among Females	Prevalence of Mental Health Outcome (Overall)
Anxiety [19.2–48.4%]					
Psychological distress [42–61%]					
Oram et al. (2016, [1])	150 adults—including 52 adult males	N.A.	N.A. (n = 52)	N.A. (n = 98)	N.A. (n = 150)
	29 young people (16–21 yo)—including 5 male youths	Strengths and Difficulties Questionnaire	60% (n = 5)	66.6% (n = 24)	65.5% (n = 29)
Cary et al. (2016)	T = 119 28 males and 91 females—including 18 male youths (8–25 yo)	International Classification of Diseases-10 (ICD-10) diagnosis tool	61% (n = 28)	90% (n = 91)	83% (n = 119)
Stanley et al. (2016)	29 youths (10–21 yo)—including 5 male youths	Strengths and Difficulties Questionnaire	60% (n = 5)	66.7% (n = 24)	65.5% (n = 29)
Westwood et al. (2016)	T= 136 91 female and 45 male participants (16+ yo)—including 10 male youths (16–25 yo)	N.A.	42% (n = 45)	81% (n = 91)	N.A. (n = 136)
Substance misuse [21–33.3%]					
Davis et al. (2016)	22 males (aged 10 to 19)	N.A.	21% (n = 22)	N.A.	21% (n = 22)
Landers et al. (2017)	87 children—including 5 male children (10–18)	Child and Adolescent Needs and Strengths—Commercially Sexually Exploited (CANS-CSE) assessment tool	N.A.	N.A.	46.9% (n = 87)
Mostajabian et al. (2019)	120 youths (18–21)—including 61 male youths	N.A.	N.A.	N.A.	40% (n = 120)
Oram et al. (2016, [1])	150 adults—including 52 adult males	Alcohol Use Disorders Identification Test Consumption (AUDIT-C)	33.3% (n = 52)	4.1% (n = 98)	14% (n = 150)
	29 young people (16–21 yo)—including 5 male youths	Alcohol Use Disorders Identification Test Consumption (AUDIT-C)	N.A. (n = 5)	N.A. (n = 24)	N.A. (n = 29)
Ottisova et al. (2018a, 2018b)	51 children (5–17 yo)—including 11 male children	International Classification of Diseases-10 (ICD-10) diagnosis tool	N.A. (n = 11)	N.A. (n = 40)	18% (n = 51)
Anger/hostility [up to 13%]					
Kiss et al. (2015a)	70 male children (10–17)	Brief Symptom Inventory	13% (n = 70)	24% (n = 317)	22% (n = 387)
Landers et al. (2017)	87 children—including 5 male children (10–18)	Child and Adolescent Needs and Strengths—Commercially Sexually Exploited (CANS-CSE) assessment tool	N.A.	N.A.	54.2% (n = 87)

* Not Available.

Behavioural disorders (loss of self-control (n = 1), loss of self-efficacy (n = 1), low self-esteem (n = 2), ADHD (n = 1), hyperactivity (n = 1), distractibility (n = 1), oppositional defiant disorder (n = 2) and anger (n = 1)) were also described. Being affected by one or several of these disorders resulted for some survivors in self-harm (n = 6), suicidal ideation (n = 9) or suicide attempts (n = 6). Measures of mental health symptoms varied between studies. Symptoms were reported based on participants' health records or using other mental health assessment tools (e.g., Harvard Trauma Questionnaire; Hopkins Symptoms Checklist; Strengths and Difficulties Questionnaire, etc.). These questionnaires were administered by either the practitioners working with survivors or by researchers themselves. Seven studies did not specify how the mental health symptoms described were assessed.

While the included studies described similar symptoms for both male and female survivors, some gender differences were reported in the prevalence of mental health outcomes (see Table 2). In several studies, small sample sizes affected the reliability of prevalence estimates for males.

Table 2 reports on the prevalence of common mental health outcomes among survivors of human trafficking. For those studies that disaggregated data by gender, outcomes are reported for male survivors, female survivors and for the overall sample. For included studies that report on mental health outcomes among male survivors specifically (in the

column with grey highlight), the prevalence of any mental health outcome ranges from 2.9% (suicide attempt (Kiss et al. 2015a)) to 61% (psychological distress (Cary et al. 2016)).

Large proportions of male survivors sampled presented with symptoms characteristic of depression (prevalence ranging from 23.1% to 60.7%) or psychological distress (prevalence ranging from 42% to 61%). Close to half of male participants sampled in various studies presented with anxiety (Iglesias-Rios et al. 2019a; Kiss et al. 2015b; Pocock et al. 2018; Zimmerman et al. 2014). In three of the four studies that reported on psychological distress (Oram et al. 2016, [1]; Cary et al. 2016; Stanley et al. 2016; Westwood et al. 2016), 60% or more of sampled male survivors experienced this mental health outcome. While evidence on this particular outcome is limited, Oram et al. (2016, [1]) indicated that males were eight times more likely than females to be affected by substance misuse. Despite wider variations in prevalence in some studies, male survivors and female survivors sampled had similar rates of depression and anxiety. While female survivors were often more likely to report symptoms indicative of PTSD (Kiss et al. 2015a; Nodzenski et al. 2020; Oram et al. 2016, [1]; Stanley et al. 2016), some studies reported higher rates of PTSD among male survivors compared to female survivors (Iglesias-Rios et al. 2019a; Kiss et al. 2015b; Zimmerman et al. 2014). Across all included studies, women and girls were consistently far more likely to report suicidal ideation compared to male survivors.

Stressors that influenced mental health outcomes were described in 17 studies (see Table 1). Experiences of physical and emotional violence, both during trafficking and after being removed from a situation of exploitation, featured as an important stressor for survivors in 16 of the included studies (Cary et al. 2016; Davis et al. 2016; Iglesias-Rios et al. 2018; Kiss et al. 2015a, 2015b; Munro and Pritchard 2013; Nodzenski et al. 2020; Oram et al. 2015, 2016, [1]&[2]; Ottisova et al. 2018a, 2018b; Pocock et al. 2018; Stanley et al. 2016; Surtees 2008; Zimmerman et al. 2014). Economic and financial concerns such as debt and poverty, feeling a responsibility to provide and concerns about ability to provide were described as stressors in nine papers (Davis et al. 2016; Iglesias-Rios et al. 2019b; Kiss et al. 2015b; Munro and Pritchard 2013; Nodzenski et al. 2020; Pocock et al. 2018; Surtees 2008; Thabet et al. 2011; Zimmerman et al. 2014). Unstable and/or precarious housing were other important contributors to poor mental health outcomes (Davis et al. 2016; Iglesias-Rios et al. 2019b; Kiss et al. 2015b; Munro and Pritchard 2013; Nodzenski et al. 2020; Oram et al. 2016, [1]&[2]; Stanley et al. 2016; Zimmerman et al. 2014). Male survivors commonly experienced shame, stigma and discrimination because of their experiences and worried about people finding out about their situation (Davis et al. 2016; Kiss et al. 2015b; Nodzenski et al. 2020; Pocock et al. 2018; Zimmerman et al. 2014). Poor and/or difficult relationships with others (e.g., harassment, family rejection, lack of trusting relationships, lack of support, social isolation) (Davis et al. 2016; Stanley et al. 2016; Surtees 2008; Thabet et al. 2011) and precarious legal or administrative status (e.g., being a migrant or having no documents) (Iglesias-Rios et al. 2019b; Oram et al. 2016, [1]&[3]; Zimmerman et al. 2014) were identified as stressors in four studies, respectively.

Gender differences were also observed in terms of associations between stressors and mental health outcomes.

Based on a sample of 446 males, Iglesias-Rios et al. (2019a) reported that being exposed to either "personal coercion" or to "severe physical violence and coercion" during trafficking was associated with symptoms of anxiety (affected between 45–48% of survivors), PTSD (between 39–46%) and depression (between 56–59%). Notably, the magnitude and significance of these associations were stronger in women than in men, partly owing to the classification of violence, which differed for the two samples ("sexual violence" was removed for men due to the small sample size). Drawing from the same sample, Iglesias-Rios et al. (2019b) consider the associations between adverse living/working conditions on symptoms of anxiety, depression and PTSD. After adjustment and compared to females with zero or one adverse living condition during trafficking, the prevalence of anxiety among females with two, three, four or more adverse living conditions was more than 50% and 70% higher, respectively. In contrast, males had a twofold greater prevalence of anxiety

with two or three, or four or more, adverse living conditions, compared to males with no or one adverse living condition during trafficking. Men and boys placed in detention in the destination country had a 50% elevated prevalence of anxiety, while legal and economic insecurity conditions during trafficking were not associated with anxiety among females. Similarly, none of the legal and economic insecurity conditions (including detention) were associated with depression in females, while males held in detention had a 30% elevated prevalence of depression compared to males not held in detention. Overall, the associations between working hours and PTSD were stronger in males than females. For instance, males working more than 10 h or no fixed time had more than a threefold elevated prevalence of PTSD compared to males working less than 8 h. Compared to females not working excessive time, females working 8 to 10 h or no fixed time had more than a 40% and 70% greater prevalence of PTSD, respectively.

In Nodzenski et al. (2020), concerns and worries experienced in post-trafficking settings were associated with poor mental health outcomes in both boys and girls, although gender differences were observed. While results should be interpreted with caution due to the small male samples and resulting large confidence intervals, worrying about treatment by others upon return was a strong predictor of depression, anxiety and PTSD in boys and an important predictor for depression in girls. The effect of this exposure on symptoms of depression was also stronger for boys than for girls. Similarly, while concerns about mental health remain strongly associated with all three outcomes in both boys and girls, a stronger effect was observed in boys than in girls. Concerns about religion and hope for money in the future were both predictors of anxiety among boys.

3.2.2. Mental Health Care Available to Boys and Young Men

Included studies did not extensively describe the type or nature of mental health/psychosocial care available to young male survivors of trafficking. Studies referred generically to "mental health care" or "mental health services", with a few describing such care as clinical psychology (Aberdein and Zimmerman 2015), psychiatric services (Westwood et al. 2016) or counselling (e.g., individual counselling, group counselling, family counselling) (Aberdein and Zimmerman 2015; Gibbs et al. 2015; Munro and Pritchard 2013; Nodzenski et al. 2020; Oram et al. 2016, [3]; Pocock et al. 2018; Twigg 2017; Westwood et al. 2016). Two studies referred to trauma-informed (Twigg 2017) or trauma-focused care (Kung 2014). One study (Kung 2014) described in detail the types of mental health interventions used with survivors. Psychosocial or other forms of support received mainly included physical and dental health care, sexual and reproductive health care, accommodation/housing, legal support, educational services, vocational training, family tracing and reunification and pre-return support.

3.2.3. Access to Care Services

All included studies described, to some extent, challenges related to service access for the population of interest. Studies which did not exclusively focus on access to services, did, at a minimum, describe their findings' implications for service delivery or service access. This review did not restrict inclusion to papers describing mental health services exclusively. Included studies thus report on access to health care, including mental health services [also see Section 2. Methods].

A positive observation from the included studies was the inclusion of survivors' voices and their perceptions of challenges in accessing appropriate mental health care. Of the 17 qualitative or mixed-methods studies included in the review, 9 sampled trafficking survivors and 12 studies sampled service providers whose views are critical to understanding challenges in delivering mental health care to the population of interest. Notably, meaningful engagement or representation (i.e., ensuring that people who are or have been impacted by an issue are involved in developing, implementing and evaluating the effectiveness of strategies to address the issue (Ash and Otiende 2023)) in the nine studies which sampled trafficking survivors was not assessed in the review.

Findings from studies that sample child survivors exclusively (n = 9), male survivors exclusively (n = 5) and male child survivors exclusively (n = 2), while consistent with findings from studies which had mixed samples in terms of age and/or gender, allowed us to add specificity and better understand both the barriers experienced by providers when working with males and the barriers experienced by male survivors in accessing or receiving support.

In the following sections, we report on these barriers and challenges using the different components of access to care presented in the conceptual framework (Figure 1). Notably, some data extracted could have been examined in relation to multiple components of access to care given the intersections and overlaps between the different categories. Reviewers discussed such cases to describe data points under the most appropriate component of care, based on definitions. Challenges related to availability were reported in 10 studies, to approachability in 4 studies, to accessibility in 18 studies, to continuity in 18 studies, to safety in 10 studies, to appropriateness in 19 studies and to acceptability in 16 studies. None of the studies reported on the effectiveness of care.

- Availability

None of the included studies reported on the lack of service availability and related explanations for male survivors specifically.

- Approachability

Challenges related to approachability were not extensively described in the included studies. Male survivors may be more **reluctant to see themselves as victims** and, as such, advertising of services might be more efficient if targeting men as "migrants" or "workers" (Surtees 2008). Human trafficking survivors frequently **rely on their interpersonal network to identify services**. One study participant described word of mouth to be a particularly well-suited strategy to reach out to male survivors (Aberdein and Zimmerman 2015). Male survivors may further tend to delay seeking health care, making outreach activities and mobile health units particularly relevant for this population (Pocock et al. 2018).

- Accessibility

Accessibility was described to be constrained by a range of factors, spanning various levels from individual to systemic.

At the individual level, regardless of their gender, survivors' access may be hampered by **their legal status or absence of documentation** (Domoney et al. 2015; Macias-Konstantopoulos et al. 2015; Oram et al. 2016, [2]&[3]; Pocock et al. 2018; Stanley et al. 2016; Westwood et al. 2016), **by cultural/language barriers and fears of discrimination** (Kung 2014; Munro and Pritchard 2013; Oram et al. 2016, [3]; Pocock et al. 2018; Stanley et al. 2016; Westwood et al. 2016) or of being judged (Macias-Konstantopoulos et al. 2015) and by their **experience of social stigma** (and sometimes criminalization (Gibbs et al. 2015), which may disproportionately affect male victims, which in turn creates a reluctance to seek mental health support (Aberdein and Zimmerman 2015; Palines et al. 2019).

At the systemic level, **features of services** may also act as barriers, particularly when inclusion criteria restrict access (for instance, when services are only accessible via shelters (Aberdein and Zimmerman 2015)), when services are available in specific locations only (Macias-Konstantopoulos et al. 2015), when referrals are required (with minors more likely to necessitate referrals (Macias-Konstantopoulos et al. 2015)) or when providers lack awareness and specialized training in recognizing human trafficking (Macias-Konstantopoulos et al. 2015; Mostajabian et al. 2019), especially as many victims do not identify themselves as such (Kung 2014). Importantly, boys and men, even when they are minors, are less likely to be identified as victims by authorities or providers (Surtees 2008). Finally, systems often are too complex for victims to navigate, especially for minors (Macias-Konstantopoulos et al. 2015; Oram et al. 2016, [2]&[3]; Stanley et al. 2016; Westwood et al. 2016). **Institutional barriers** which prevent victims from obtaining the full spectrum of services they require (Macias-Konstantopoulos et al. 2015) hamper accessibility (e.g., lack of social sup-

port schemes available, reluctance to enrol in schemes due to confidentiality (Aberdein and Zimmerman 2015), eligibility for schemes contingent on a mental health diagnostic (Domoney et al. 2015)). In the case of minors, the necessity to obtain parental consent or permission for young victims to receive mental health treatment can be considered an additional institutional barrier (Gibbs et al. 2015).

- Continuity

Continuity was described through various themes in many studies, possibly indicating its importance in the delivery of mental health care for trafficking survivors.

Challenges to continuity were expressed in the context of the necessity to consider access to mental health care and **mental health treatment as a long-term process**. Accessing and accepting mental health care often demands time, particularly in the case of male survivors (Davis et al. 2016; Munro and Pritchard 2013). Male survivors require enough time to develop trusting relationships and restore self-esteem (Munro and Pritchard 2013). Their mental health support needs may also not be apparent to providers at first (Oram et al. 2016, [2]; Stanley et al. 2016). As a result, time-restricted support schemes may negatively impact male survivors, either because they need longer time to recognize their needs and meaningfully engage in care plans, or because counselling will be interrupted too early in the process (Munro and Pritchard 2013; Oram et al. 2016, [3]).

> *"Quite often we would get a case and refer for assessment for counselling, the victim at this point may be in the system for three to four weeks already. Counsellor may say need seven weeks but the victim may need to leave at week five. That concerns me as you are really opening up a can of worms, that doesn't sit well with me and I don't feel good about it"*
>
> (Service provider (Munro and Pritchard 2013))

- Safety

Safety was cited as the participants' most common goal when providing therapy to survivors (Kung 2014). Included studies described safety in terms of physical (Aberdein and Zimmerman 2015; Davis et al. 2016) and emotional safety (Domoney et al. 2015; Gibbs et al. 2015; Stanley et al. 2016).

From the perspective of survivors, safety mainly concerns **confidentiality,** which may prevent them from seeking support or enrolling in public support schemes where available (Aberdein and Zimmerman 2015). Ensuring confidentiality is, therefore, critical when encouraging survivors to accept mental health care and is a pre-requisite to developing positive relationships with children who fear sharing information (Rigby 2011; Stanley et al. 2016). Confidentiality concerns should also prompt providers to consider how the physical location of services (Surtees 2008) and how the use of interpreters, by jeopardizing confidentiality (Westwood et al. 2016; Pocock et al. 2018), may deter survivors from engaging in mental health support. This is particularly relevant in the case of male survivors, who were found to be more likely to need the use of interpreters (Pocock et al. 2018).

- Effectiveness

The review did not intend to evaluate the effectiveness of services or mental health interventions, as this requires specific study designs (e.g., trials) which are rarely used in this area of research.

- Appropriateness

Appropriateness was measured by providers' ability to deliver a suitable and evidence-based health service that is balanced with individual needs and preferences. Trafficking experiences and associated mental health symptoms, **stressors and needs are often gender-specific** (Nodzenski et al. 2020). For instance, concerns about money may have a greater influence on boys' emotional wellbeing than on that of girls. Providers note that male survivors may especially be concerned with what will happen to them and how to sustain themselves and their families financially (Munro and Pritchard 2013).

"Money is definitely the main thing they want to talk about"

(Provider (Munro and Pritchard 2013))

Concerns about stigmatisation upon return were also an important concern for male survivors (Zimmerman et al. 2014). Some studies highlighted that providers often lack understanding of the specific needs of male victims (Aberdein and Zimmerman 2015) and how they experience, externalise and cope with trauma (Davis et al. 2016; Munro and Pritchard 2013). Consequently, many services neglect male survivors' emotional needs and focus on poverty alleviation and other "practical" needs (Davis et al. 2016).

"Often boys will be blamed, isolated, marginalised and punished for expressing the problems they have. A boy might act out, be aggressive and anti-social. This is a particular barrier to providing services and there is a real need to understand the perspective of men and what help they need"

(Aberdein and Zimmerman 2015)

"They keep things in as men do and when they have a drink it comes out, and it can come out in the form of violent aggression towards others and staff. But it is about understanding the trigger points."

(Provider (Munro and Pritchard 2013))

Mental health care providers should also be mindful of **how trafficking experiences, especially sexual exploitation, are understood in different cultural contexts,** including views on sexuality and attached stigmas and on dynamics related to trafficking (Kung 2014; Rigby 2011). In many cultural contexts, sexual abuse and exploitation of boys and men is especially stigmatising as boys and men are often believed to voluntarily engage in sexual activities and cannot. therefore, be victims of sexual abuse. Such beliefs and attitudes may prevent disclosure and help-seeking (Nodzenski and Davis 2023).

Finally, being culturally sensitive requires providers to **consider possible stigmas related to mental health** and the meanings survivors may attach to mental health care (Kung 2014; Powell et al. 2018; Domoney et al. 2015).

Language barriers are another culture-related challenge to delivering appropriate mental health care, with providers facing either a lack of trained interpreters within counselling services or the problems associated with discussing sensitive issues via an interpreter (Oram et al. 2016, [3]; Pocock et al. 2018; Powell et al. 2018; Rigby 2011).

Sufficient time should also be allocated to care programming so that survivors are able to **build relationships and trust** with care providers (Kung 2014; Munro and Pritchard 2013; Rigby 2011; Stanley et al. 2016).

"Sometimes it takes weeks for them to start trusting here"

(Provider (Munro and Pritchard 2013))

The ability to deliver appropriate care is highly dependent on services' resources and providers' training. Two included studies described the **lack of training of service providers to work with male survivors** (Munro and Pritchard 2013; Davis et al. 2016), which affects both the availability and appropriateness of services. Understanding how trauma is experienced by boys and men in the wider context of their lives was described as essential to knowing what form of counselling may be beneficial (Davis et al. 2016). For instance, professionally trained counsellors found that "informal counselling" was most appropriate for their male clients in one study (Munro and Pritchard 2013). The modalities of service provision should be flexible for male clients. For instance, phone counselling may be more suitable in some situations (Aberdein and Zimmerman 2015). Providers may further encounter difficulties navigating male survivors' externalising behaviours, such as anger, or coping mechanisms such as substance misuse (Munro and Pritchard 2013). Training in anger management and in how to work with survivors who are substance users would be particularly helpful for young male survivors (Munro and Pritchard 2013). Inadequate knowledge around mental health symptoms and mental health care for men in part explains

the absence of mental health programming for male survivors, which, when present, tends to ignore complex traumas or emotional needs of males, and to focus exclusively on other aspects of survivors' lives, such as poverty alleviation (Davis et al. 2016).

More generally, a **lack of awareness and attitudes of providers** around human trafficking, as well as poor training in victim identification, does not allow providers to recognize and address survivors' needs adequately (Macias-Konstantopoulos et al. 2015; Oram et al. 2016, [3]). This is problematic as children, particularly male children, may be reluctant to disclose trafficking because of shame, because of misperceptions concerning their situations or because they do not perceive themselves as victims (Rigby 2011; Macias-Konstantopoulos et al. 2015; Landers et al. 2017).

> *"Some of them will tell you…they will come in traumatised and upset and tell you quite early on. And others just won't"*
>
> (Provider (Rigby 2011))

- Acceptability

Young male survivors' ability to accept services is highly conditioned by their feelings of **shame and stigma,** which affect their mental health (Pocock et al. 2018). Stigmatisation may be perceived by survivors because of their situation (e.g., living on the street or engaging in survival sex) or experienced at the hands of service providers who may not believe or judge survivors (Mostajabian et al. 2019; Westwood et al. 2016).

When survivors engage with services, the **nature and quality of their relationships with service providers** is key. Again, building trust and ensuring confidentiality in all interactions appear as cornerstones of care delivery and condition whether services will be accepted by survivors (Kung 2014; Oram et al. 2016, [2]; Stanley et al. 2016). Experiences of trafficking affect survivors' ability to form positive relationships, particularly for male survivors who have been described by providers as "broken" and "reclusive" (Munro and Pritchard 2013). As previously highlighted, enough time should be provided for survivors to disclose their experiences and to receive mental health support when deemed appropriate (Kung 2014; Oram et al. 2016, [2]).

Feelings of disconnect from their caretakers have been expressed by survivors using services (Davis et al. 2016). In some cases, this may, in part, result from the gender of the provider (Domoney et al. 2015) as some male victims might be more comfortable disclosing personal information to a provider of the same gender. Interestingly, a systematic review on help-seeking by male victims of domestic violence and abuse identified a preference for receiving help from female professionals as a consistent theme across studies, yet could not report on any discussion around male professional support (Huntley et al. 2019). More research on the preferred gender of support professionals for male victims of different forms of violence is needed. While critical to establishing trust, survivors rarely have a choice as to the gender of the care worker assisting them.

Providing survivors with transparency and clear information about the care system and process is key to fostering trust in providers (Rigby 2011; Westwood et al. 2016). This may be challenging as providers often need to rely on interpreters to provide information to survivors (Westwood et al. 2016).

> *"It still hasn't been explained by the doctor what happened to me"*
>
> (Male survivor (Westwood et al. 2016))

Discomfort with psychiatric evaluations and mistrust in mental health providers act as barriers to seeking help (Mostajabian et al. 2019). Concerned about being labelled as psychiatrically ill, and this affecting their records and job prospects, male survivors often display antipathy towards psychological services (Surtees 2008), and accepting mental health care may be particularly challenging, as they often must reconcile gender norms and expectations which prevent them from being seen as "victims" or "weak" (Pocock et al. 2018; Surtees 2008).

While **receiving mental health support may be not socially acceptable or even stigmatising** in many cultural and social contexts (Oram et al. 2016, [3]; Powell et al. 2018), it may be especially so for male survivors (Surtees 2008), who are often raised to be strong and self-reliant and face social pressure to not seek help for their problems (Pocock et al. 2018; Surtees 2008).

> *"Many men are ashamed of appealing for help, because our society does not really accept or approve of men who appeal for assistance"*
>
> (Male survivor (Surtees 2008))

> *"They would never request assistance from organizations because they will be mocked and laughed at by their relatives. A man must manage his problems by himself"*
>
> (Male survivor (Surtees 2008))

Resisting the label of "victim" has been commonly observed among trafficking survivors and may affect the acceptability of services. In the case of male victims, trafficking is often perceived by survivors as "failed migration", hindering their decision to seek care and ability to receive services which are framed under the social construction of "victimhood" (Surtees 2008).

> *"How to say this? I don't think I am a victim. It is even ridiculous for me to think that I am a victim."*
>
> (Male survivor (Surtees 2008))

4. Discussion

The review sheds light on the mental health consequences of trafficking in young male survivors and the challenges they face in accessing services. It emphasises the need for a gendered approach to better target and make services accessible and appropriate for survivors of human trafficking.

The review includes 31 studies, which consistently report symptoms such as depression, anxiety, PTSD and self-esteem and self-control issues among men and boys. However, 14 included publications were related to two main data sources/studies,[10] highlighting the lack of reliable and representative data collected globally among survivors of trafficking, child and male survivors especially. While relevant insights were drawn from the included studies, the review confirmed the dearth of evidence on the trafficking experiences of boys and men, and particularly on aspects related to mental health and mental health care for this population group (Dennis 2008; Hebert 2016).

4.1. Mental Health Outcomes and Stressors

Experiences of human trafficking have been described as gendered (Stöckl et al. 2021). Results from the review indicate that gender differences in the prevalence of mental health outcomes and the nature and impact of various stressors and the resulting mental health needs will differ, in part depending on the gender of survivors. This should inform how service providers deliver care to this population.

In addition to sample sizes affecting the precision of prevalence estimates, the results first raise the question of why women and girls appear more likely to report symptoms across several mental health outcomes. Due to rigid social and gender norms, men and boys may be more reluctant to report mental health issues and symptoms. Feelings of shame and stigma were consistently reported in the included studies, particularly regarding perceived "failed migration" (Surtees 2008), regarding using mental health care (Kung 2014; Powell et al. 2018) or simply seeking help. Male survivors may also be unable to see themselves as victims deserving of support (Rigby 2011; Macias-Konstantopoulos et al. 2015; Landers et al. 2017) or may fear the judgment of others, including providers (Mostajabian et al. 2019; Westwood et al. 2016).

While the included studies that do report on the prevalence of mental health outcomes by gender allowed us to observe variations by gender, no clear picture of the prevalence of

mental health outcomes among male survivors could be established as the prevalence of some outcomes varied widely across studies (e.g., suicidal ideation among males ranged from 7.3% (Pocock et al. 2018) to 33% (Davis et al. 2016)). While this could in part indicate that, in addition to gender, other intersecting factors (e.g., age, sector of exploitation, length of time in exploitation, pre-existing mental health issues, etc.) must be accounted for when establishing the prevalence of mental health outcomes in survivors, this also points to the lack of rigorous studies with trafficked boys and men using validated mental health diagnostic tools. In this review, nine included studies reported on the prevalence of mental health outcomes without specifying how these outcomes were established. Other studies used standardized diagnostic tools. While some of these have been validated with vulnerable populations (e.g., the Harvard Trauma Questionnaire and Hopkins Symptoms Checklist), they may not systematically capture trafficked boys' and men's symptoms. Boys and men may describe mental health issues in ways that would not be captured by standardized diagnostic tools, describing somatic symptoms such as fatigue and pain or other various vague symptoms (Suh and Gallo 1997). For instance, in a study exploring depression among men and women, Page and Bennesch (1993) found that changing the phrasing of the Beck Depression Inventory by eliminating the word "depression" and replacing it with "hassles in living" led men (but not women) to report a greater severity of depression. Other research has suggested that differences in the prevalence of depression between men and women were less pronounced when assessment instruments were not overtly or explicitly phrased as being about "depression" (Hunt et al. 2003). The inherent gender bias in many diagnostic tools might also lead to an under-reported prevalence of mental health symptoms among male victims. Future research on the mental health of trafficked men and boys should consider testing male-specific tools such as the Male Depression Risk Scale (MDRS-22), which seeks to assess broader domains, such as anger and irritability, substance misuse, risk-taking and recklessness and non-externalising manifestations, including emotion suppression and somatic symptoms—all of which largely fall outside the prototypic symptoms of major depressive disorder (Rice et al. 2020; Herreen et al. 2021) and none of which are included in widely used depression diagnostic tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Call and Shafer 2018). Inappropriate assessment tools and lack of training of service providers hinder access to mental health support by boys and men in these populations, by preventing either identification by providers or self-disclosure by survivors [see more on challenges to accessing services in Section 4.3].

In addition to the more commonly observed symptoms of anxiety, depression or PTSD, studies which sampled male survivors exclusively highlighted the impacts of trafficking on survivors' self-esteem (Davis et al. 2016) and feelings of self-efficacy and self-control (Surtees 2008). Such feelings may result from the impossibility for male survivors to reconcile their status of "victims" with gender expectations ascribed to them to be strong and self-sufficient (Pleck 1995; Barker et al. 2010; Levant and Powell 2017). While the impact of conflicting notions of masculinity and victimhood have not been extensively researched among trafficking survivors (especially those trafficked for forced labour), these conflicts have been documented among male victims of sexual abuse and sexual exploitation (Kia-Keating et al. 2005; Hilton 2008; Miles and Blanch 2011).

Sixteen studies described some of the stressors related to poor mental health outcomes. These stressors ranged from housing, administrative and legal status to employment or financial concerns and relationships with others, particularly fears of stigma from families and communities. The role of social stigma, or the negative attitudes towards a victimised boy, has been documented to play a critical role in male victims' mental health outcomes and also in their likelihood to seek help. Gender-based perceptions (such as boys being seen as less coerced or assumed to have actively engaged in their exploitation (Family for Every Child 2018)) can lead to barriers like discrimination, failure to identify concerns in clients or even outright rejection of boys from services. All these experiences enhance self-stigmatisation (Chatmon 2020; Kavenagh et al. 2023). Shame-based stigma further acts

as a barrier to disclosure for boys who fear the responses of others, including providers (Kavenagh et al. 2023).

Stressors spanned various stages of the trafficking experience and were related to both the experience of exploitation and to individuals' situations once removed from a situation of trafficking (i.e., post-trafficking). The contribution of these daily stressors to poor mental health outcomes has been documented in other vulnerable populations, such as refugees or war-affected people (Miller and Rasmussen 2010). In the case of young male survivors, these may be especially relevant as perceptions of abuse or exploitation may differ according to the cultural and gender norms under which males are socialised. Boys and men are often attributed greater agency over their situations, experiences of abuse and violence may be downplayed as part of an initiation into adulthood and young men may be more concerned about their ability to support their families or about being stigmatised after a "failed" migration (Surtees 2008). These concerns were particularly salient in studies conducted in the Mekong region, where males worried about their treatment upon returning home. In one study (Zimmerman et al. 2014), 30% more women reported wanting to go home compared to men. In this region, rigid socio-cultural norms put young men under pressure to provide for their families (Davis et al. 2016; Nodzenski et al. 2020).

4.2. Available Services and Types of Mental Health Care

While included studies described the variety of health services and organizations accessed, most did not report on the specific nature or type of mental health care offered to trafficking survivors. Mental health care offered to male survivors of trafficking was often broadly described as "counselling". What "counselling" entails could widely vary across studies and settings. This also has cultural implications, with psychosocial concepts differing across cultural contexts. This lack of clarity regarding what specifically mental health care for survivors is or should be reflects a known gap in the field of human trafficking research (Wright et al. 2021; Williamson et al. 2010; Yakushko 2009).

The only two studies sampling male minors exclusively (Davis et al. 2016; Thabet et al. 2011) did not provide information on the type of mental health/psychosocial care offered to male survivors, and the remaining included studies did not offer gender-specific discussions of services and interventions. This is an important gap as the existing literature points to the need for gender-specific mental health services and interventions, as interventions or therapeutic styles used with female survivors may be ill suited to the needs, coping mechanisms and treatment preferences of male survivors (Moynihan et al. 2018; Addis and Hoffman 2017). Both male and female survivors would benefit from targeted gender-specific psychosocial and mental health care. For example, treatment for substance misuse may be more often needed by male survivors.

Several included studies reported on other services provided to survivors, which are labelled as psychosocial care. While not specific to mental health, they are considered a prerequisite to the delivery of more specialized mental health care as the situation of survivors must be stabilised and material/social stressors addressed for meaningful engagement in psychological care. These findings are also supported by existing evidence on the need to use a multidisciplinary approach to care and offer a comprehensive package of services to survivors of trafficking (Domoney et al. 2015; Devine 2009; Heffernan and Blythe 2014; Altun et al. 2017).

While referred to in only two studies included in the review (Kung 2014; Twigg 2017), the wider literature reports on the value of trauma-informed care for vulnerable populations, including trafficking survivors, particularly child victims of sexual exploitation (Rafferty 2016; Barnert et al. 2017).

This is a significant opportunity for improvement. Improved, consistent and evidence-based psychological care for trafficking survivors would allow us to account for victims' experiences of violence and result in better engagement with services (Macy and Johns 2011; Muraya and Fry 2016). In a trauma-informed care model for survivors of sexual exploitation, Williamson et al. (2020) recommend that providers initially focus on the provision of basic

needs, building on strengths and support networks, in a non-judgmental way. While the value of trauma-informed practitioners has been documented to improve disclosure and perceptions of support by victims (Kavenagh et al. 2023; Centers for Disease Control and Prevention 2020; Center for Substance Abuse Treatment 2014; Greenbaum et al. 2018; Kenny and Barrington 2018; Rafferty et al. 2018), the existing literature identifies few services framed as trauma-informed (in a review of 81 publications, Moss et al. (2023) identified only four examples of such services). Additionally, the existing literature mostly refers to the use of trauma-informed care among survivors of trafficking for sexual exploitation (and consequently mostly among female survivors), and evidence on the use of this approach among survivors of other forms of exploitation and among male survivors is limited. There is a critical need to establish guidelines on the systematic use of trauma-informed care for providers working with survivors of all genders and in different cultural contexts. This would provide a baseline for the response to psychosocial and mental health needs of survivors and would equip providers to recognize signs and symptoms of trauma and to ensure survivors' physical and psychological safety, avoiding retraumatisation, all the while supporting their autonomy and providing opportunities for empowerment (Bulanda and Johnson 2016; De Candia and Guarino 2015; Kavenagh et al. 2024).

Finally, when exploring the various components of access to care, the authors could not retrieve information on the effectiveness of mental health care or services from the included studies. The lack of evidence on and absence of systematic evaluation of mental health treatments for this population have resulted in recommendations for practitioners being made based on interventions used in other vulnerable populations (e.g., refugees, victims of domestic violence or sexual assault, etc.) (Kung 2014; Rafferty 2008; Williamson et al. 2010). Specific research should be designed and conducted to assess the effectiveness of mental health care and interventions for trafficking survivors of various ages and genders, and in various settings. The lack of data measuring the impact of existing mental health or psychosocial interventions likely also stems from the above point that what is actually meant by "counselling" is rarely defined and certainly not consistently delivered and/or not evidence-driven. In a recent realist review of psychosocial interventions to improve the mental health of human trafficking survivors, Mak et al. (2023) identified 41 studies that evaluated such interventions, only 2 of which focused on male survivors.

4.3. Challenges and Opportunities in Accessing Mental Health Care

Findings indicate that young male survivors may face specific challenges and/or may be disproportionately affected by some challenges when accessing care (e.g., identification as a trafficking victim, reliance on interpreting services, resisting the "victim" label, etc.). Gender not only shapes trafficking-related vulnerabilities, experiences and outcomes but also conditions whether young male survivors access or receive care, the nature of services available to them and how they use health resources.

In addition to the low priority accorded to mental health care for trafficking survivors in many contexts, gendered beliefs, including that boys do not need and/or seek help, may affect the **availability** of services, with fewer resources being allocated to serve this population. **Accessibility** is also limited for boys as male victims of trafficking continue to be misidentified and, as a result, are seldom assisted (Surtees 2008). Identification challenges can be explained through the hierarchy of victimhood and the concept of masculinity (Smiragina-Ingelstrom 2020). Masculine attributes and ascribed roles cannot be reconciled with the collective imagination of an "ideal victim", whose first characteristics should be vulnerability and weakness (Christie 1986; Smiragina-Ingelstrom 2020). The position of male victims towards aid, which results from socially constructed gender norms establishing victimhood in opposition to masculinity, is not held solely by male victims themselves, but by society, including policy makers, NGO representatives, medical practitioners, etc. (Sundaram et al. 2004; Smiragina-Ingelstrom 2020), limiting both the approachability and accessibility of services. As a result of pervasive gender norms, young male survivors may be attributed greater agency and control over their situations, resulting

in less empathy and more stigmatisation, including from service providers, hindering the possibility of them receiving support. Evidence indicates that boys and men are also more likely to be criminalized or to come into contact with law enforcement or the justice system rather than health care services (Cole 2018; Cockbain et al. 2017; Kavenagh et al. 2023).

Access, both in terms of providers' capacity to deliver services (**appropriateness**) and survivors' ability to engage with care (**acceptability**), is also underpinned by socio-cultural norms pertaining to gender. The lens of gender can help understand how young survivors perceive their trafficking experiences, process trauma and express their needs, but also how providers will make sense of survivors' experiences and needs. Young male survivors may display externalising behaviours, such as anger and violence, which providers struggle to navigate. There is also a need to understand, in specific contexts, gender roles and expectations that fall onto young male survivors who may act as providers and be responsible for families. An experience of "failed migration" and the inability to provide may act as considerable stressors for these survivors and may contribute to poor mental health outcomes beyond their experience of exploitation. Rigid gender norms and narratives may also foster strong feelings of shame and fears of stigmatisation among boys and young men who have experienced trafficking, particularly in cases of sexual exploitation. As a result, disclosure of exploitation rarely occurs as a single event but should rather be understood as a dynamic (and often delayed) process (Mathews et al. 2016).

These factors should be paramount when considering how to frame mental health care and psychosocial interventions for young male survivors, but also when training service providers, considering the social construction of "victimhood" for males, as this would improve the appropriateness and acceptability of care to this population. While it may be perceived that male victims either do not want or do not need assistance, evidence suggests that this results from services not being structured to meet the needs of men (Rosenberg 2010). Similarly, beliefs that male victims are resistant to psychological support warrant further research to identify the causes of such resistance, including how counselling may be introduced to male victims or the perceived consequences for young males of seeking psychological support (Surtees 2007, 2008; Rosenberg 2010). These findings are consistent with the existing literature describing the lack of tailored psychological rehabilitation for male survivors of trafficking (Hacker et al. 2015) or the heavy focus on PTSD in evaluated interventions, which risks excluding those with other needs (Wright et al. 2021). Education and awareness-raising about trafficking risks and vulnerabilities, but also how boys may present and respond to an experience of trafficking (including externalising behaviours and coping mechanisms), is needed to reduce stigma but also increase providers' ability to identify male victims and respond to their needs more efficiently (Nodzenski and Davis 2023; Kavenagh et al. 2023) [see also Section 4.1].

Finally, this review sheds light on the intersecting nature of several challenges, which can, at times, condition multiple components of access simultaneously. For instance, building trust between providers and survivors was discussed by several authors, either as a challenge to the delivery of appropriate or acceptable care but also as a condition to ensure continuous and safe care provision. These intersecting challenges should, therefore, be considered as priority action points by researchers and practitioners to efficiently improve access for young male survivors of trafficking (see Table 3). Recommended actions are mainly drawn from the included studies, although some references draw from the wider literature. Examples of good practices are drawn from published case studies or initiatives known to the authors.

Table 3. Intersecting challenges for young male survivors in accessing mental health care—recommended actions for practice and research.

	Challenge	Areas of Access	Recommended Action
1.	Mental health is often not prioritized, and few resources are allocated to mental health care	Availability Accessibility Acceptability Continuity	1. Advertise mental health care as an essential component of care for all survivors of trafficking, including male survivors. 2. Mental health screening should be integrated into routine care for all survivors, including male survivors. 3. Sufficient financial resources should be allocated to match the demand for services (Macias-Konstantopoulos et al. 2015). 4. Intervention research is needed to identify effective forms of psychological support that can be easily implemented in low-resource settings and in multilingual, multicultural populations (Kiss et al. 2015b).
2.	Male survivors' reluctance to seek mental health care and services	Approachability Accessibility Safety Acceptability Appropriateness	1. Mental health services should be carefully labelled and advertised to ensure they are approachable and acceptable to male survivors. Labels such as "migrants" or "workers" might be more acceptable. Avoid labelling services under the social construction of "victimhood" (Surtees 2008). 2. Consider the gender of providers. Men may be better placed to reach out to trafficked males (especially former victims). 3. Services and providers should adopt proactive strategies to reach out to male survivors, who tend to delay seeking health care when ill. Outreach initiatives or mobile health units are particularly suitable to this population (Pocock et al. 2018). 4. When possible, providers should rely on survivor networks as well as cultural/social focal points to make services visible. Word of mouth is a well-suited strategy to reach out to male survivors (Aberdein and Zimmerman 2015; Westwood et al. 2016). 5. Mental health providers should be flexible in service provision and adapt to male survivors' preferred delivery modes. In some settings, community-based rather than residential care may be better suited. Walk-in clinics or telephone counselling services may also offer flexibility and confidentiality (Westwood et al. 2016; Aberdein and Zimmerman 2015). 6. Raise awareness of male trafficking among providers and the wider public. Educate service providers about the effect of abuse and on providing care in a non-judgmental manner to diminish discriminatory behaviours that prevent survivors from using services (Aberdein and Zimmerman 2015; Oram et al. 2016, [3]). 7. Health care providers should be informed of individuals' full range of rights and entitlements to services to ensure trafficked individuals are not unjustifiably denied medical care, to discourage racism and bias and to prevent refusal of services based on nationality, sex, language, race, stigma or other protected characteristics (Oram et al. 2016, [3]). 8. Whenever possible, aftercare and reintegration services should closely work with families to improve their understanding regarding the (care) needs of trafficked males (Davis et al. 2016). When safe and appropriate, survivors should be encouraged (especially male survivors) to make/re-establish contact with family members, in cases where such contact would be considered to aid support. → Good practices—examples 1. **EMMAUS**, a US-based non-profit working to prevent exploitation and empower male survivors of the sex trade to rebuild their lives, uses outreach teams and cutting-edge scraping technology to reach exploited men and boys on the streets and online (https://streets.org/ [accessed on 26 September 2024]). 2. The non-governmental organization **INTERSOS** operates a mobile unit in Rome, Italy. The unit includes cultural mediators, and a psychologist who provides life-skills education and awareness-raising about sexual violence and who interacts with many young men who live on the streets, as well as a mobile health clinic for medical check-ups and mental health counselling for refugees and migrants (Women's Refugee Commission and UNICEF 2021a). 3. **Urban Light**, a Thailand-based NGO supporting trafficked and sexually exploited young men, conducts outreach activities to identify trafficking victims and locations where exploitation is occurring. At-risk and vulnerable males in Chiang Mai's notorious sex bars, massage parlours and street-based locations will have weekly visits by a staff member who will provide emergency on-site health services and resources, health kits, emergency hotline information and access to snacks/food (ECPAT International 2023).
3.	Building trusting relationships between survivors and providers	Accessibility Continuity Safety Appropriateness Acceptability	1. Care plans should consider the length of time needed for male survivors to build relationships, disclose their experiences and accept receiving mental health support when deemed appropriate (Kung 2014; Oram et al. 2016, [2]). 2. Foster the development of positive community-based mentor relationships for males (Davis et al. 2016). 3. Consider the gender of providers when planning assessments and booking interpreters as good practice, given this is an issue for survivors of trafficking where experiences of sexual violence were common (Domoney et al. 2015).

Table 3. *Cont.*

	Challenge	Areas of Access	Recommended Action
4.	Ensuring confidentiality	Safety Accessibility	1. Ensuring confidentiality should be considered paramount to encourage survivors to accept mental health care and a pre-requisite to develop positive relationships, particularly with young people who fear sharing information (Rigby 2011; Stanley et al. 2016). 2. Confidentiality concerns should prompt providers to consider how the physical location of services (Surtees 2008) and the use of interpreters (Westwood et al. 2016) may deter survivors from engaging in mental health support. 3. GPs may consider offering walk-in clinics in partnership with other services for those who wish to access care anonymously (Westwood et al. 2016). 4. User-friendly materials should be developed and disseminated to inform survivors about how confidentiality is defined and the processes through which services guarantee confidentiality (Oram et al. 2016, [3]). → Good practices—examples 1. The THRIVE clinic is located in a secured area with special accommodations to increase victim privacy (Jain et al. 2022). 2. The H.E.A.L.T.H. Clinic of Ottawa, Ontario, Canada, a primary health care clinic designed specifically for those who have experienced, are currently experiencing or are at risk for sexual exploitation, coercion or human trafficking, offers a private and population-controlled waiting area. No identification or insurance is required for clients. This allows for anonymity and equitable service delivery (Leach 2020).
5.	Communicating	Safety Appropriateness	1. To assist them in articulating their health needs and accessing health services, social workers should arrange professional interpreting services (Westwood et al. 2016) which trafficked adults, children and young people perceive as accessible and confidential (Oram et al. 2016, [2]). 2. Whenever possible, providers should ensure victims can choose the gender of interpreters (Oram et al. 2016, [2]). 3. Providers of interpreting services should be accountable to quality assurance standards (Oram et al. 2016, [3]). → Good practices—examples 1. "Supporting Survivors of Violence", a training curriculum for linguistic and cultural mediators that includes modules on how to appropriately receive and manage disclosures of sexual violence by male survivors, was developed in response to the demand for greater professionalization of LCMs. The training guide aims to improve effective engagement with survivors of GBV and sexual violence, including male victims (Women's Refugee Commission and UNICEF 2021b).
6.	Ensuring continuous and coordinated access to services and providers over time	Continuity Safety Appropriateness Acceptability	1. Mental health care for survivors should take a longitudinal approach (Macias-Konstantopoulos et al. 2015). Sufficient time should also be allocated to care programming so that survivors are able to build relationships and trust with care providers (Kung 2014; Munro and Pritchard 2013; Rigby 2011; Stanley et al. 2016). From the perspective of providers, this would also allow better adherence to trauma-sensitive care in clinical settings, which are often fast-paced and result in negative effects on the relationships between providers and survivors. 2. With evidence that male victims are less likely to disclose abuse compared to female victims (Sivagurunathan et al. 2019), it is recommended that services allow time for male survivors to build trust and do not require explicit disclosure as a condition to provide support. 3. Providers should aim to provide ongoing mental health surveillance even after the immediate post-trafficking period. 4. Continuous access to care must be supported by health policies that remove budget-based limitations on service eligibility and service quotas that lead to premature cessation of psychotherapy. In addition, providers should be equipped with guidance on procedures to extend pre-determined reflection and recovery periods for potentially trafficked people (Oram et al. 2016, [3]). 5. The high rates of case closings due to lost contact suggest that initial and sustained engagement must be identified as a priority for future programme design and a primary outcome in future evaluations (Gibbs et al. 2015). 6. Providers should promote and adopt a case management approach (Gibbs et al. 2015; Ottisova et al. 2018a; Twigg 2017) to avoid re-victimisation due to early cessation of treatment. While case management is an essential component of continuous relationships, the content and process of case management deserves more in-depth examination (Gibbs et al. 2015). 7. Strive towards streamlining of services and care coordination that would facilitate the access, proximity and timeliness of services (Powell et al. 2018). 8. States should develop regional and national referral mechanisms to ensure that the health of trafficked persons is prioritized through safe and supported referrals between agencies, transfer of medical information and measures to ensure the continuity of necessary care. → Good practices—examples 1. Bob's House of Hope, a US-based safe house for young men who have been victims of sex trafficking, offers a safe, long-term therapeutic environment with total wraparound care and free, secure housing for up to three years (https://ranchhandsrescue.org/bobs-house-of-hope/ [accessed on 28 September 2024]). 2. EMMAUS, an organization supporting male-identified victims of trafficking, offers all clients the option to participate in case management and to work with a staff manager to pursue self-identified goals towards health and self-sufficiency. In addition, EMMAUS partners with numerous government and community organizations to offer a comprehensive array of services to clients beyond what EMMAUS can offer (https://streets.org/ [accessed on 28 September 2024]). 3. A citywide collaborative victim services model, including the Greater Houston Area Pathways for Advocacy-based, Trauma-Informed Healthcare (PATH) Collaborative at Baylor College of Medicine, CommonSpirit Health and the San Jose Clinic in Houston, Texas, funded in part by the Office for Victims of Crime, focuses on trauma-informed health care delivery for victims of human trafficking. The dual mission of the PATH Collaborative—health care intervention and advocacy—is accomplished by codifying a network in which all participant health systems are trafficking-informed by trainings headed by Doctors for Change and that includes an integrated referral pathway for identified trafficking victims (Jain et al. 2022).

Table 3. *Cont.*

	Challenge	Areas of Access	Recommended Action
7.	Identification of boys as victims of trafficking		1. Trafficked children present significant histories of violence, considerable social needs and a range of clinical presentations. Mental health professionals need to be aware of indicators of possible exploitation and be supported to develop skills to enquire safely about suspected trafficking and respond appropriately, including through referrals to social and legal support (Ottisova et al. 2018b). Providers should be trained to use sensitive questioning to gain a better understanding of survivors' situations as they may not identify as victims of a crime or may be reluctant to disclose (Westwood et al. 2016). 2. Because in most contexts, human trafficking is understood to be mainly associated with women, identification tools may not be tailored to identify male victims as the "profile of trafficked persons is based on known victims" (Rosenberg 2010). Better identification would also require a proactive approach to engage with male victims where they live or work, as they are less likely to reach out to services (Rosenberg 2010). 3. Health care providers who work with male adolescents and young adults in high-risk situations (e.g., experiencing homelessness) are critically important to identifying youths experiencing human trafficking. These providers should be equipped with specialized training in recognizing human trafficking and addressing the needs of these youths. 4. In high-risk populations, using a structured human trafficking screening tool in addition to HEEADSSS may improve detection and subsequent treatment for exploitation (Mostajabian et al. 2019). 5. Further research is needed to determine best practices in training health care providers to assist youths in the disclosure of human trafficking and to explore best practices in post-disclosure experiences to address barriers to disclosure (Mostajabian et al. 2019). 6. Organizations responsible for setting training standards for health care professionals must ensure that professionals are trained to be aware of indicators of trafficking and how to respond appropriately to suspicions or disclosures of abuse; to conduct identification and referral in safe and linguistically appropriate ways that prioritize providers' and trafficked people's safety; to be aware of the likelihood of people who have been trafficked having high levels of mental health needs and a high prevalence of abuse both prior to and during trafficking and can make referrals to appropriate agencies; to be aware of the needs of people with complex trauma and the impacts on their children; and to obtain a sexual history from trafficked people who access health services (Oram et al. 2016, [1]). 7. Existing training programmes need to be evaluated to determine whether they improve identification, referrals and care (Domoney et al. 2015). → Good practices—examples 1. The San Diego County District Attorney and Health and Human Services Director launched an outreach campaign running in January 2023 aimed at raising awareness about boys who become victims of human trafficking. The month-long campaign's goal was to broaden the public perception of who is vulnerable to being sexually trafficked. Officials hope that bringing attention to this issue will improve screening, identification and services for boys who are victims of sex trafficking (www.sdcda.org [accessed on 26 September 2024]).
8.	Providers' ability to effectively address the specific and complex needs of young male survivors	Availability Appropriateness Acceptability	1. Provide more mental health professionals with complete specialized training in the area of human trafficking (Turner-Moss et al. 2014), in complex trauma and polyvictimisation (Macias-Konstantopoulos et al. 2015) and in trauma intervention. Ensure they can provide culturally sensitive and multilingual services (Powell et al. 2018). Providers should be trained to adopt an empathetic and non-judgmental approach to care (Macias-Konstantopoulos et al. 2015). 2. Build service providers' confidence in responding to survivors' needs by either training them or making referral pathways clear to them. Training for mental health professionals should include information about systems currently available for trafficked people as it would help them respond to the needs of victims (Domoney et al. 2015). 3. All agencies in contact with trafficked children should incorporate mental health screening as part of standard service provision to facilitate timely referrals to psychiatric care. Staff should be aware of signs of mental distress and trained on how to respond (Ottisova et al. 2018b). 4. Raise awareness among service providers of human trafficking of boys, specific vulnerabilities and related consequences (Macias-Konstantopoulos et al. 2015; Oram et al. 2016, [4]). Given that NGOs in many contexts fill the mental health gap, they play an important role in raising awareness about the range of post-trauma reactions (Aberdein and Zimmerman 2015). 5. Build service providers' understandings of cultural and gender-based beliefs and/or assumptions and develop male-specific emotional support systems (Davis et al. 2016). 6. Mental health providers working with young male survivors would benefit from training in anger management and/or in substance misuse/abuse (Munro and Pritchard 2013). 7. Providers working with young male survivors of trafficking should consider the possible stigmas related to mental health and the meanings survivors may attach to mental health care (Kung 2014; Powell et al. 2018). Understanding what constitutes mental wellbeing in specific contexts, and from children's perspectives, should be central to service provision (Nodzenski et al. 2020). 8. Providers working with young male survivors need to consider the mental health-related trauma associated with working and living conditions, taking gender into account (Iglesias-Rios et al. 2019a, 2019b). 9. Providers should take account of the high levels of violence, sexual abuse and deprivation that trafficked adults, children, and young people may have experienced and the implications this may have for their ability to trust others and feel secure (Oram et al. 2016, [1]). 10. Responses to trafficked youth should reflect the diversity of young people involved and their needs, as well as community resources and relevant state law. No single programme model will exist (Gibbs et al. 2015) and one-size-fits-all mental health service programmes cannot be expected to care for all mental health patients efficiently (Macias-Konstantopoulos et al. 2015).

Table 3. *Cont.*

	Challenge	Areas of Access	Recommended Action
			11. Build the capacity of delivery models to be tethered to the unique personal, cultural and contextual features of the survivor. While the development and exchange of care models may provide a starting point for NGOs delivering and facilitating mental health services, the heterogeneity of this population leads NGOs to tailor models in accordance with the survivor population(s) being served (Powell et al. 2018). 12. Providers should strive to adopt flexible modalities in service provision when considering male clients. For instance, phone counselling may be more suitable in some situations (Aberdein and Zimmerman 2015). In some services, providers note that the support they provide to male survivors could be labelled "informal counselling" (Munro and Pritchard 2013). 13. When designing care strategies for young trafficking survivors, providers should carefully assess young people's actual circumstances and their perceptions of their future opportunities, constraints and risks. 14. Providers should encourage victims (especially male victims) to make/re-establish contact with family members, in cases where such contact would be considered to aid support. 15. Expand the field of research on mental health and trafficking beyond human trafficking for sexual exploitation or trafficking of women/girls to inform interventions and practice with male survivors. Conduct further research on the links between trauma and labour trafficking or how victims with different profiles experience trafficking and trauma (Surtees 2008). 16. Conduct further gender-specific research to generate evidence on how different experiences of trafficking and pre-migration circumstances affect mental health and on how different patterns of violence and coercion affect the mental health of female and male survivors. This would allow providers to employ targeted mental health interventions and assess which interventions would be more beneficial for specific groups of survivors (Iglesias-Rios et al. 2018). 17. Consider the use of a health equity framework to deliver mental health care in post-trafficking settings to address the imbalances between boys and girls in terms of access to resources and benefits and to understand differences in health determinants and health status as well as the factors from economic, social, political and cultural environments which have gender implications for health. 18. Provide practitioners with helpful theoretical knowledge to make sense of trafficking as a phenomenon. In relation to child trafficking, information is sparse and constantly changing, yet practitioners have to undertake comprehensive assessments and provide services to safeguard children with a limited theoretical framework to guide them. Without a broader conceptual understanding, they may struggle in their assessments to make sense of the complex inter-relationships of the social, economic and cultural factors that may increase risk and vulnerability for children or inform recovery. Research should respond to the need for empirical evidence and the development of a broader understanding of trafficking, although issues regarding varying definitions complicate progress in this respect (Rigby 2011).
8.	Providers' ability to effectively address the specific and complex needs of young male survivors	Availability Appropriateness Acceptability	19. Develop diagnostic tools adapted to various cultural contexts. Some Western concepts used to describe psychological symptoms and mental health support may not be adapted to other contexts (Aberdein and Zimmerman 2015). 20. Intervention research is needed to identify effective forms of psychological support that can be easily implemented in low-resource settings and in multilingual, multicultural populations, including by non-professionals and with men. 21. Conduct further evaluation research to determine the effectiveness of interventions, services and treatment approaches (Kung 2014; Landers et al. 2017). 22. Include male survivors' voices in the development of mental health interventions for this group. Given the complexity and changing nature of trafficking as a phenomenon, practitioners spending time with children developing relationships, listening to their stories and allowing their experiences to inform interventions may help to demystify trafficking for practitioners and would also help children overcome their fears and mistrust of authorities (Rigby 2011). Survivors should be involved in the development/evaluation/improvement of programs. → Good practices—examples 1. The **National Human Trafficking Training and Technical Assistance Center** developed a toolkit for providers to improve services for males experiencing human trafficking. This tool provides suggestions on how to build rapport with male clients; leverage universal education and motivational interviewing techniques to engage in meaningful conversations that help male clients understand their risk factors; differentiate between what trauma and exploitation is and what it is not; and encourage them to commit to accessing services (National Human Trafficking Training and Technical Assistance Center 2022). 2. A training resource for providers working with sexually exploited boys is **"Bridging the Gap"**. The objectives of the toolkit are to educate, raise awareness and increase knowledge and the development of skills, approaches and confidence to work with boys affected by sexual exploitation. By promoting positive attitudinal and behavioural change with organizational strategies and responses, practitioners are equipped with specific tools and resources that can be used in contexts related to the sexual abuse and exploitation of boys (Down to Zero 2020). 3. **The Office of the Special Representative and Co-Ordinator for Combating Trafficking in Human Beings** report, "Applying gender-sensitive approaches in combating trafficking in human beings", serves as an evidence base for the global anti-trafficking community, supporting it to develop more holistic, tailored and gender-responsive prevention, protection and prosecution strategies and to address the gender-specific vulnerabilities and needs of victims of trafficking, as well as to become more alert to crimes that are oftentimes overlooked (OSCE Office of the Special Representative and Co-Ordinator for Combating Trafficking in Human Beings 2021). 4. In 2014, in the UK, a national awareness-raising campaign highlighting male violence was launched. As a result of this, the **Male Survivors Partnership**, a charity supported by the Home Office, was established to provide male victims of sexual abuse, rape and sexual exploitation a single point of reference for national and local support services. It has since become the national umbrella agency for organizations working with victims of sexual abuse who are boys and men, and a reference point for male survivors to find national, regional or local support (www.malesurvivor.co.uk). 5. The US-based non-profit organization **Male Survivor** has over 14,000 international registered members from over 200 countries in the world. It is committed to preventing, healing and eliminating all forms of sexual victimisation of boys and men through support, treatment, research, education, advocacy and activism. It is dedicated to providing personalized support for men at every stage of the healing process through a variety of educational resources, online forums, professional therapists and in-person events (www.malesurvivor.org).

Table 3. *Cont.*

	Challenge	Areas of Access	Recommended Action
9.	Unfulfilled basic needs and unstable situations	Continuity Appropriateness	1. Service providers should adopt a holistic and multidisciplinary approach to mental health care (e.g., psychosocial care). Addressing social and welfare needs (including meeting basic needs for food, clothing and appropriate housing; supporting the regularization of immigration status or return to the country of origin and participation in criminal proceedings against their traffickers; and providing opportunities for education, employment, vocational training and social integration) is likely to be important in supporting the wellbeing and recovery of trafficked people (Oram et al. 2015). Addressing mental health concerns of children and adolescents within a wider psychosocial approach to post-trafficking care, and by linking social and cultural factors to wellbeing, may yield significant results (Nodzenski et al. 2020). Mental health responses that are integrated with socio-economic planning and strategies for return or reintegration are probably more likely to succeed (Nodzenski et al. 2020). 2. Providers should consider a case management approach to go beyond immediate needs and address the long-term needs of survivors. Providers should be aware that mental health needs evolve according to the different stages of rehabilitation and, as such, mental health care plans need to be adapted. 3. Providers should be aware of the potential ongoing interpersonal abuse faced by survivors, which may contribute to poor mental health, and it should be taken into consideration during therapeutic interventions and during risk assessment and planning (Oram et al. 2015). 4. Strategies for young trafficking survivors will need to be built from careful assessments of young people's actual circumstances and their perceptions of their future opportunities, constraints and risks. For instance, concerns about money-earning abilities or money issues in the family and their implications for mental health in children and adolescents are evidence of the responsibilities endorsed by children from a young age. Such roles and responsibilities should be central concerns of policy makers and service providers working on the reintegration of trafficking survivors and the prevention of re-trafficking (Nodzenski et al. 2020). 5. Given the importance of social contexts, enquiring about a child's pre-migration social situation as well as their experiences of exploitation may help clinicians identify important risk factors for future and ongoing harm and contribute to the development of a more robust care plan (Ottisova et al. 2018b). → Good practices—examples 1. **Bob's House of Hope**, a US-based safe house for young men who have been victims of safe trafficking, offers a safe, long-term therapeutic environment with total wraparound care and free, secure housing for up to three years (https://ranchhandsrescue.org/bobs-house-of-hope/ (accessed on 27 September 2024)).
10.	Difficulties navigating the system and other institutional/systemic barriers	Accessibility Safety Availability Continuity	1. Access to medical treatment for young survivors should be guaranteed regardless of their ability of provide proof of identity or of legal status (Westwood et al. 2016). General practitioners should remove any barriers to GP registration (Oram et al. 2016, [3]). 2. Young survivors should be provided with information on the documentation necessary for registration, waiting times for appointments, tests and procedures they will undergo, accessing interpreters and who can accompany them to appointments (Westwood et al. 2016). National Departments of Health should lead in the development and dissemination of user-friendly information materials (Oram et al. 2016, [2]). 3. Voluntary sector support services should both inform and support trafficked youth in accessing health care services, including by assisting in appointment booking, providing interpretation services, applying for exemptions from prescriptions charges and providing health care professionals with basic information about human trafficking and appropriate referral pathways into and from support services (Oram et al. 2016, [2]). 4. Voluntary sector support services should develop links and supported referral pathways with relevant health providers to ensure that health professionals are prepared to identify, refer and treat individuals who have been trafficked (Oram et al. 2016, [2]).

5. Limitations

5.1. Limitations of Included Studies

5.1.1. Sampling Limitations

The generalizability of results for young male survivors was constrained by the characteristics of the included studies. Many studies had mixed samples (adults/children and male/female), often with an imbalance where males were under-represented. Only two studies exclusively sampled male minors. Few studies disaggregated data by both gender and age, limiting insights specific to young male survivors.

Almost no studies presented disaggregated data by gender and/or age groups, particularly when discussing access to services. These sampling limitations confirmed the authors' perception that few studies are male-specific and that, both in service practice and research, young males or boys tend to be lumped together with women and children as a vulnerable group.

5.1.2. Lack of Specificity

Although the search aimed to focus on young male survivors and mental health outcomes, many studies lacked specificity. A significant number of studies were excluded because they did not include males under 24 or focused on exploitation rather than trafficking (as described in the Limitations of the Review's Methodology Section), various experiences of exploitation or abuse tend to be conflated in research) or because they did not discuss the mental health of survivors, which may point to a lack of specialized mental health services and/or a lack of research on these services.

5.1.3. Issues with Reliability and Comparability

Mental health diagnoses varied between studies, with different tools used (e.g., Harvard Trauma Questionnaire, Hopkins Symptoms Checklist). Some studies did not specify how symptoms were assessed, affecting the comparability of results.

5.1.4. Geographic Representation

Despite the global scope, the review lacked geographic representation. No studies were from Africa, despite data showing high rates of trafficking in that region. This could reflect limited research in African regions or structural factors, such as the absence of post-trafficking services.

5.1.5. Quality of Studies

To fairly assess studies with mixed designs, the authors used the MMAT as a quality appraisal tool. The tool does not provide an extensive list of criteria by which to assess included studies and, as a result, most studies achieved a high rating with the MMAT. This is not considered problematic in this review, which, given the sensitivity of the topic and scarcity of existing evidence, did not aim to exclude studies based on quality.

5.2. Limitations of the Review's Methodology

5.2.1. Definitions of Human Trafficking

An initial scoping review of the literature on the exploitation of boys and young men showed that authors tend to generally report on different (although related) phenomena using terminology like "sexual abuse", "sexual exploitation" and "sex trafficking" interchangeably. Similarly, initial test searches retrieved results which did not refer to "human trafficking" but described various experiences of exploitation such as "forced labour", "child labour" or "modern slavery". Several results also referred to experiences of groups considered vulnerable to trafficking, such as unaccompanied refugee minors or street-involved youth, without identifying them as victims of trafficking. Different forms of abuse should be examined on their own to identify specific causes, vulnerabilities and outcomes. Ultimately, the lack of a specific evidence base also impacts how service delivery is informed.

While many overlaps exist between these experiences, for consistency and comparability purposes, the authors decided to consider human trafficking specifically rather than exploitation more broadly (not all victims of exploitation have been trafficked). Although this approach aimed for specificity, it may have excluded relevant studies that did not explicitly use the term "trafficking" but described similar experiences, particularly around commercial sexual exploitation of children.

Authors also acknowledge that while the included studies all refer to human trafficking, the definitions of human trafficking used by authors or providers sampled could vary.

5.2.2. Post-Trafficking Settings

This review considered mental health outcomes and access to mental health care in post-trafficking settings specifically, as victims who are still in a situation of exploitation will experience different stressors, outcomes and barriers to care.

While the search strategy included terms related to "post-trafficking" settings and services which could have limited the number of relevant results (as studies may have been describing mental health care for survivors in post-trafficking settings without using this specific terminology), this risk has been mitigated by the inclusion of broader search terms related to trafficking and/or health care for trafficking survivors.

5.2.3. Approach to Gender

The review focused on male survivors and used a binary gender construct, acknowledging that individuals of other gender identities face additional vulnerabilities and barriers. Only one included study addressed these groups, which remain under-represented in trafficking research.

5.2.4. Language and Publication Bias

The review only included studies published in English, likely excluding studies from low- and middle-income countries that may have provided valuable contextual insights. Additionally, relevant studies might have been missed due to variations in terminology and indexing across disciplines.

6. Conclusions

Findings from this review confirm that mental health and mental health care for trafficking populations remains an under-researched area, particularly among victims trafficked in sectors other than sexual exploitation and among male survivors of all ages.

Rigid social and gender norms which dictate that boys and men should be strong and self-reliant and cannot be victims affect the possibility of men and boys to both seek help and receive support. A lack of rigorous research into the prevalence of mental health outcomes, gender-specific stressors and related support needs for boys and young men, using standardized and gender-sensitive assessment tools, constitutes an additional barrier to service provision.

In exploring challenges to accessing mental health care, this review further identifies knowledge gaps in factors affecting the availability of care and the effectiveness of mental health interventions. This dearth of information, in turn, limits the possibility of creating evidence-based mental health programming for this population.

While it is helpful to consider gender to understand needs and tailor care delivery, researchers and practitioners should also consider how gender intersects with factors such as age, ethnicity, socio-economic status, etc., which shape experiences of trafficking and constrain access to mental health care in post-trafficking settings. The evidence base of experiences and outcomes of different survivors in different settings must be strengthened to better inform practice and care delivery.

Supplementary Materials: The following supporting information can be downloaded at https://www.mdpi.com/article/10.3390/socsci13110567/s1, Table S1: PRISMA Checklist; Table S2: Search Strategy; Table S3: Definitions Components of Care; Table S4: Study Characteristics

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Notes

1 The WHO defines "adolescents" as individuals in the 10–19 years age group and "youth" as the 15–24 years age group.

2 Considering the available evidence on the trafficking of young males presented above, the scope of the review will be limited to two forms of human trafficking, for the purposes of sexual exploitation and/or human trafficking for the purposes of labour exploitation. Other forms of modern slavery which are either less prevalent (for instance, trafficking for the removal of organs) or that affect mainly women and girls (for instance, forced marriage) are excluded from the review.

3 The Psychosocial Working Group (2003) adopted the term "psychosocial wellbeing" rather than psychological wellbeing to emphasise the role of social and cultural factors in individual experiences and development. The concept of psychosocial is closely linked to the concepts of "wellbeing" or "wellness". Most definitions of psychosocial are based on the assumption that psychological and social factors are responsible for the wellbeing of people. Humanitarian agencies have come to prefer the term "psychosocial wellbeing" over narrower concepts such as "mental health", because it points explicitly to social and cultural as well as psychological influences on wellbeing. The term psychosocial implies a very close relationship between psychological and social factors (Devine 2009). Humanitarian practitioners may use the composite term "mental health and psychosocial support (MHPSS)" to describe "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder". This approach may better address the diverse needs of populations and is often depicted as a pyramid of multi-layered support (Purgato et al. 2018).

4 Post-trafficking settings refer to the various stages following a survivor's exit (via removal or escape) from a situation of exploitation. These stages include—but are not limited to—possible detention, immediate aftercare, aftercare, return, (re)integration and life beyond. Post-trafficking services may offer support to survivors following exit (removal or escape) from a situation of exploitation and at different post-trafficking stages. By this definition, post-trafficking services do not refer to care provision while individuals are still in a situation of exploitation or while they are being trafficked. Considering known methodological and ethical difficulties in conducting research both prior to exit from the situation of exploitation but also from the point of return/(re)integration and onwards, a large number of studies focus on detention and aftercare stages. Immediate aftercare can also be considered a crucial intervention point to provide mental health and psychosocial care to young survivors.

5 Systematic and other reviews were not eligible for inclusion, although they were identified during title and abstract screening and used for the purpose of backward citation tracking.

6 Cross-sectional survey of health needs, access and care experiences reported by trafficked people.

7 Qualitative interviews with trafficked adults and adolescents in contact with support services in England.

8 Qualitative research with NHS and non-NHS professionals to explore experiences of responding to human trafficking.

9 Across studies with mixed samples of survivors (either in terms of age and/or gender), Cary et al. (2016) had 18 males under 25 (T = 119), Domoney et al. (2015) had 10 male minors (T = 130), Iglesias-Rios et al. (2019a, 2019b), Kiss et al. (2015a, 2015b) had 238 males under 24 (T = 1015), Mostajabian et al. (2019) had 61 males aged 18–21, Nodzenski et al. (2020) had 107 males aged 10–19 (T = 517), Oram et al. (2015) had 12 males under 18 (T = 133), Stanley et al. (2016) had 5 males aged 16–21 (T = 29), Turner-Moss et al. (2014) had 6 males aged 18–25 (T = 35) and Westwood et al. (2016) had 10 males aged 16–25 (T = 160). Across studies with samples of males, Munro and Pritchard (2013) had 3 survivors aged 18–24, Pocock et al. (2018) had 116 males aged 10–24 (T = 275), Surtees (2008) had 18 minors (T = 685) and Zimmerman et al. (2014) had 244 males aged 10–24 (T = 1102). Across studies with samples of minors, Goldberg et al. (2017) had 1 male (T = 41), Landers et al. (2017) had 5 males (T = 87), Ottisova et al. (2018a, 2018b) had 11 males (T = 51) and Palines et al. (2019) had 10 males (T = 143). Across studies sampling male minors exclusively, samples ranged from 22 (Davis et al. 2016) to 780 participants (Thabet et al. 2011).

10 Seven studies published using the SLaM CRIS database and seven studies published using the STEAM dataset.

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