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CLINICAL CHALLENGES

- **What types of trafficking** may be experienced by children and adolescents?
- **What are the history and physical examination findings** that may indicate a pediatric patient is experiencing trafficking?
- **How should emergency clinicians respond** when there is concern that a patient may be impacted by trafficking?

# Human Trafficking of Children and Adolescents: Recognition and Response in the Emergency Department

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## Abstract

Labor and sex trafficking impact children of all ages, genders, and nationalities. Trafficked patients present to the emergency department for illnesses and injuries both related and unrelated to their trafficking experiences. Emergency clinicians are not meant to be experts in labor and sex trafficking, but they must know enough to be able to identify patients at risk for trafficking and ensure that these patients have the opportunity to be connected to relevant services and support. This issue reviews the ways in which youth are trafficked, the indicators of trafficking, and the evidence-based and best-practice recommendations for addressing suspected or confirmed trafficking in the pediatric and adolescent patient populations.

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# Case Presentations

**CASE 1**

**A 15-year-old boy presents to the ED with an injury to his right eye...**

- He is accompanied by a coworker who speaks for him because the patient speaks only Mam, a Mayan language.
- The coworker reports that the patient was cutting tile with a handheld saw when a piece of tile flew into his right eye. The patient looks uncomfortable and anxious.
- Your initial examination of the eye is suggestive of an open globe injury, so you call for an ophthalmology consult and place an eye shield over the affected eye.
- As you offer the patient pain medication, it occurs to you that it is late morning on a weekday. You wonder why this young man is not in school...

**CASE 2**

**A 13-year-old girl arrives in the ED complaining of dysuria and abdominal pain...**

- She says she has been experiencing these symptoms for the past week.
- You see in her chart that she has a history of depression and post-traumatic stress disorder, with multiple inpatient psychiatric hospitalizations.
- The chart also indicates that this patient tested positive for chlamydia and genital herpes in the past year, and a prior chart note says she has been in foster care and had run away from a group home.
- You assess her pain score for pain relief, set up for a pelvic exam, and order lab work. As you address her medical needs, you consider whether and how you should address the multiple indicators that this patient may be experiencing trafficking…

## Introduction

Human trafficking is a prevalent national and global public health issue with many detrimental health consequences.[1,2] Contrary to popular misconceptions, trafficking does not require transportation away from home or across borders. The first comprehensive federal law in the United States to address trafficking in persons was the Trafficking Victims Protection Act of 2000; under current United States federal law, "severe forms of trafficking in persons" includes both labor trafficking and sex trafficking.[2-4] According to the International Labor Office, there were approximately 40.3 million people impacted by trafficking worldwide in 2016, including those in forced labor, forced sexual exploitation, state-imposed forced labor, and forced marriage.[5] Although the lay media often report a 2001 study statistic that 200,000 to 325,000 minors in North America are at risk for commercial sexual exploitation each year,[6] no current, reliable data are available on the incidence or prevalence of any type of trafficking of minors.[2]

Clinicians working in emergency departments (EDs) are uniquely positioned to recognize trafficking, treat the associated health complications, refer patients to support resources, and report concerns of abuse, when appropriate.[7] The majority of people being trafficked in the United States report being cared for in a healthcare setting during their period of exploitation,[8,9] and a 2018 study found that 83% of children who experienced commercialized sexual exploitation had been cared for in a pediatric hospital within 1 year of their exploitation.[10] In a 2021 study of patients aged 12 to 17 years who presented to a large, urban pediatric ED with a high-risk chief complaint (eg, a psychiatric or genitourinary concern, sexual abuse, sexual assault, or law enforcement concern for trafficking), the prevalence of child sex trafficking was found to be 12.3%.[11] There are scant data on the prevalence of pediatric labor trafficking, as comprehensive studies that include labor trafficking are limited. Self-reporting of trafficking is rare due to stigma, shame, hopelessness, fear of retaliation, and/or the individual's lack of awareness of their own exploitation, sometimes due to trauma bonds.[12] A trauma bond is a strong sense of loyalty and compassion that people who experience abuse may develop for their abuser, even though the bond is generally detrimental to themselves.

Trafficking has been shown to have profound negative health consequences for survivors. In a study of 387 children aged 10 to 17 years, survivors of trafficking had higher than average rates of depression (52%), post-traumatic stress disorder (26%), anxiety (33%), and suicide attempts (12%) in the 30 days prior to survey.[13] One study found that youth who reported being paid for sex were 4.5 times more likely to test in the clinical range for having substance use disorders.[14] High rates of opioid use disorders have also been reported among survivors of domestic sex trafficking in minors.[15] Similarly, there are data to suggest that patients with a sex trafficking experience have a variety of negative health consequences including sexually transmitted infections (STIs), unintended pregnancies, and chronic pelvic pain.[16] There have

been fewer studies on the health of children who experienced labor trafficking, but along with profound mental health consequences such as post-traumatic stress symptoms, these children may experience physical injuries from assault (including sexual assault), work-related injuries, untreated medical conditions, unsafe sleeping or living conditions, malnutrition, and exhaustion.[13,17-19] While many trafficked children in the United States may interact frequently with the healthcare system, some trafficked children (such as children in immigration detention centers) may receive little or no medical care.[2,20] This issue of *Pediatric Emergency Medicine Practice* presents the key indicators of human trafficking in pediatric patients who present to the ED and reviews trauma-informed intervention strategies for children and adolescents who may have experienced trafficking.

## Definitions

*Labor trafficking* is defined in the United State Code as "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery."[21] Children may be trafficked in a variety of legal industries, such as agriculture, manufacturing, restaurant, and domestic work, as well as in illegal industries, such as drug trafficking, gang-related activity (eg, gun carrying), and forced burglaries.[22,23] There are insufficient data on labor trafficking in children to provide estimates on its prevalence.

The United States Code defines *sex trafficking* as the "recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age."[21] This legal definition of sex trafficking of minors does not require force, fraud, or coercion because minors cannot consent to any commercial sex. To reflect this nuance, the terms *child sex trafficking* (CST) and *commercial sexual exploitation of children* (CSEC) are often used. According to the United States Department of Justice, CST involves "a range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person or in exchange for anything of value (including monetary and nonmonetary benefits) given or received by any person."[24] The possible manifestations of CST include illicit sexual photographs or videos of children, sex tourism, and minors dancing in strip clubs or on live video streaming.[25] In the pediatric and adolescent populations, *survival sex* (ie, the exchange of sex for something of value such as shelter, food, or other material needs) is also considered trafficking, even if the minor perceives the exchange to be consensual.[1]

## Critical Appraisal of the Literature

A PubMed literature search for the terms *child labor trafficking*, *commercial sexual exploitation of children*, and *child sex trafficking* from 1975 to 2021 yielded 1937 results, with the number of publications increasing over time, with the highest number of publications (230) in 2019. The Cochrane Database of Systematic Reviews was searched for reviews related to labor and sex trafficking but no results were found. Four relevant trials were found in a search of the Cochrane Library, but none of these trials were focused on children. There were no randomized controlled trials for interventions for human trafficking, no validated pediatric screening tools for labor trafficking, and only 1 rigorously validated screening tool for CSEC in healthcare settings. Greenbaum et al developed a 6-item screen via a cross-sectional study of children aged 12 to 17 years who presented to metropolitan-area pediatric EDs and a child protection clinic;[12] however, of the 25 patients impacted by CSEC in this study, many had been previously identified by authorities. A 2016 systematic review identified 31 relevant studies, but most of these were focused on women and girls experiencing sexual exploitation, highlighting the need for additional studies on labor trafficking and on non–female-identifying persons who experience human trafficking.[26]

There are several relevant professional guidelines on human trafficking, including policy statements from the American College of Emergency Physicians[27] and the American Academy of Pediatrics,[2] and a Committee opinion from the American College of Obstetricians and Gynecologists.[28] HEAL Trafficking, a multidisciplinary network that addresses human trafficking via public health principles, provides many resources for practicing clinicians on its website: (https://healtrafficking.org)[29]

## Core Competencies

Core competencies for medical education on human trafficking have recently been published by the National Human Trafficking Training and Technical Assistance Center in partnership with the United States Office on Trafficking in Persons, HEAL Trafficking, the International Centre for Missing and Exploited Children, and the National Association of Pediatric Nurse Practitioners.[30] **(See Table 1, page 4.)** These competencies highlight the need for trauma-informed care,[31,32] which involves:

- Establishing the physical and emotional safety of patients, clinicians, and staff
- Building trust between clinicians and patients
- Recognizing the signs and symptoms of trauma exposure on physical and mental health
- Promoting patient-centered, evidence-based care
- Ensuring collaboration between clinicians and patients by welcoming patients into the treatment

process and discussing mutually agreed-upon goals for treatment
- Providing care that is sensitive to the patient's gender identity and to their racial, ethnic, and cultural background
- Resisting retraumatization by approaching patients who have experienced adversities with nonjudgmental support
- Recognizing that in the setting of human trafficking, disclosure is not the focus

## Etiology and Pathophysiology

Much of the national conversation about the trafficking of young people in the United States has focused on sex trafficking,[1,33] to the detriment of labor trafficking survivors, whose experience is often overlooked and underreported.[34-36] When researchers have allowed for a diversity of experiences to be shared, they have found that 20% to 50% of young people who experience human trafficking specifically experience labor trafficking.[34-37]

The risk factors for labor and sex trafficking are multifactorial and may be compounded. Empirical data suggest that a number of childhood experiences are risk factors for being trafficked, including homelessness, physical or sexual abuse, neglect, involvement in the foster care system, being arrested, witnessing violence at home, and having an individualized education plan or a Section 504 plan for special education accommodations.[34-36] However, many of the existing studies on trafficking risk factors allow only for statements of association rather than causality, and do not establish whether the trafficking experience or the risk factor condition (eg, suicidality) occurred first. These experiences may also be intermingled with larger structural factors such as poverty, racism, transphobia, homophobia, and sexism, resulting in inequitable distribution of opportunities for wellbeing. For example, a young person with a transgender experience may leave home to escape physical abuse but then struggle to survive without assistance due to the difficulty of securing a livable-wage job in a cultural climate of transphobia. Children and youth who have run away or been forced to leave their homes are also particularly at risk for being trafficked.[38] Three different studies of homeless young adults aged 18 to 23 years found that between 9% and 15% of homeless young people had experienced labor and/or sex trafficking.[34-36]

Human trafficking survivors may struggle with exacerbations of chronic illnesses as well as negative health consequences directly related to their trafficking experience. Individuals experiencing trafficking may struggle with food insecurity, leading to malnutrition; poor living conditions and limited sanitation access, leading to acquisition of communicable diseases; forced use of drugs or use of drugs to cope with the situation, leading to substance use disorder(s); and forced sex, leading to unplanned pregnancies and STIs.[26,39-41] Patients experiencing trafficking may sustain traumatic injuries that are life-threatening and/or result in chronic pain,[17,42-44] and they may have post-traumatic stress disorder or depression, among other mental health complications.

### Table 1. Core Competencies for Human Trafficking Response in Health Systems

- **Universal competency:** Use a trauma- and survivor-informed, culturally responsive approach.
- **Competency 1:** Understand the nature and epidemiology of trafficking.
- **Competency 2:** Evaluate and identify the risk for trafficking.
- **Competency 3:** Evaluate the needs of individuals who have experienced trafficking or individuals who are at risk for trafficking.
- **Competency 4:** Provide patient-centered care.
- **Competency 5:** Use legal and ethical standards.
- **Competency 6:** Integrate trafficking prevention strategies into clinical practice and systems of care.

Adapted from: National Human Trafficking Training and Technical Assistance Center. *Core Competencies for Human Trafficking Response in Health Care and Behavioral Systems*. United States Department of Health and Human Services, Administration for Children and Families, Office on Trafficking in Persons, 2021. Available at: https://nhttac.acf.hhs.gov/resource/report-core-competencies-human-trafficking-response-health-care-and-behavioral-health

## Differential Diagnosis

Patients with a history of trafficking may present to the ED with multiple health concerns, each with its own differential. Many patients with a trafficking experience have also survived intimate partner violence, sexual abuse, or physical abuse. **Table 2 on page 5** lists situations that are on the differential for human trafficking. These situations may overlap and/or coexist with trafficking.

## Prehospital Care

Human trafficking requires a multidisciplinary response. All parties involved in responding to youth who may be at risk for exploitation should be trained in how to recognize the indicators of human trafficking, how to connect patients with supportive responses, and how and when to report child protective concerns. This includes emergency medical services (EMS) professionals, who may be uniquely positioned to recognize patients experiencing trafficking. In the field, EMS staff may interact with a patient away from any individual who might later accompany the patient in the ED (eg, during an ambulance ride). As institutions develop trafficking response protocols, EMS staff should be trained to communicate key findings from the prehospital team to the appropriate ED personnel;[45] this facilitates the provision of care and helps the ED team intervene appropriately if there is a dangerous or concerning psychosocial situation.[46-48]

The information gathered by ED triage and registration staff may also include potential indications that a patient is being trafficked, such as lacking identification (in older adolescents), having frequent phone number changes, being unable to provide a home address, being from out of town, or seeming to be traveling more than might be expected.

The standard of care and best practice is to not criminalize children impacted by exploitation, but laws vary from state to state, so trafficked patients may interact with law enforcement.[49] Law enforcement agencies sometimes organize operations meant to identify and intervene on behalf of trafficked individuals,[50,51] and youth identified during these operations may be taken to an ED for medical clearance. Ideally, nonemergent care should be handled by the patient's medical home, and patients should be taken to the ED only for urgent or emergency health concerns.

## Emergency Department Evaluation

Patients impacted by trafficking can present with any number of chief concerns.[52] For labor trafficking, an occupational injury that seems inconsistent with a safe workplace may be a red flag, as is the presence of multiple injuries in various stages of healing.[53,54] Sex trafficking or sexual assault in the course of labor trafficking can lead to reproductive health complications such as frequent STIs, HIV/AIDS, unplanned pregnancies, spontaneous or elective abortions, and chronic pelvic pain.[26,39-41] Assault-related presentations such as head, dental, and oral injuries are common among people with various trafficking experiences.[55] Patients experiencing trafficking often have delayed presentation for medical care; for example, a patient with type 1 diabetes may have repeated presentations with diabetic ketoacidosis, or a patient may present with pelvic inflammatory disease after previously testing positive for an STI but being unable to complete antibiotic treatment in a timely manner. It is not uncommon for patients experiencing exploitation to seem to be in a rush or to leave against medical advice.[39] Patients impacted by trafficking can also present with mental health concerns, including suicidality, depression, anxiety, emotional dysregulation, sleep disturbances, or issues related to substance use.

### Privacy and Confidentiality

Privacy should be ensured before any sensitive topics are broached, ideally in a space that is not shared and that has doors that close; this need not be the space that the patient will remain in for the duration of their ED care. This can be difficult to achieve in many EDs and may require some creativity (eg, making use of an available trauma bay or an unoccupied radiology, procedure, or family room). During a pandemic, the need for infection control may provide justification to room a patient alone. Another option is to explain that it is hospital practice for each patient to receive a private examination.[39] The patient's history should

### Table 2. Differential Diagnosis for Human Trafficking

| Situation | Definition |
|---|---|
| Domestic violence | • Violent or aggressive behavior in the home[56]<br>• Domestic violence survivors can be spouses, children or other family members, cohabitants, or sexual/dating/intimate partners[56] |
| Emotional abuse | • Behavior that causes psychological injury in another person, resulting in notable changes in that person's cognition, conduct, or emotional response (eg, emotional or social withdrawal, aggression, depression, anxiety)[57] |
| Physical abuse | • Any nonaccidental physical act that causes bodily injury to another person, including but not limited to kicking, biting, striking, or burning[57] |
| Intimate partner violence | • Abuse or aggression that occurs in a close relationship<br>• "Intimate partner" refers to both current and former dating partners or spouses[58]<br>• There are 4 types of intimate partner violence: physical violence, sexual violence, stalking, and psychological aggression[58] |
| Labor exploitation (excluding labor trafficking) | • Labor law violations of minimum wage or overtime pay requirements[59] |
| Child neglect | • Failure by a parent or other adult who is responsible for a child's care to meet that child's basic needs (eg, food, shelter, clothing, or medical care), endangering the safety or well-being of the child[57] |
| Prostitution | • Participation by an adult in sex acts in exchange for payment[60] |
| Child sexual abuse | • Engaging a child in sex acts or sexually explicit conduct through any means (eg, coercion, enticement, or intimidation)[61]<br>• Includes molestation, rape, statutory rape, and incest involving a child[61] |
| Sexual assault | • Engaging another person in sexual contact without their consent, including through use of physical force or misuse of a position of trust[62]<br>• Includes situations in which sexual contact occurs with a person who is unable to give consent due to incapacity, impairment, or being below the legal age of consent[62] |

be obtained without any visitor(s) present; reticence on the part of the patient or the visitor to be separated may be an indicator that something is amiss.

A visitor with a socially acceptable relationship to the patient (eg, a parent, sibling, partner, or employer) can still be a trafficker, so minor patients who are of maturity—a clinical determination made on a case-by-case basis—should be interviewed without visitors. When there is a language barrier, a certified interpreter should always be used in order to allow patients to speak for themselves, in private, even if a visitor offers to interpret for a patient without objection from the patient. This is in accordance with best practice as established by the United States Department of Health and Human Services' Culturally and Linguistically Appropriate Services standards.[63]

The ground rules of confidentiality should be reviewed with the patient, including mandated reporting requirements. The conversation can be kept broad; for example, a clinician might say, "I want you to feel safe here so that we can provide you with the healthcare that you need. If it sounds like you are being hurt or are in danger, I may have to get more help to make sure we're providing you with the best possible care, but I will let you know if I must involve more people."

A disclosure that meets the threshold of a mandated report sometimes occurs before the limits of confidentiality have been discussed with the patient. If this occurs, the clinician should focus on providing relevant healthcare and making a follow-up plan (if the patient does not require admission), then the clinician should transparently share with the patient the requirement to report on the situation that was disclosed. (See the "Treatment—Mandated Reporting" section beginning on page 10.)

In some cases, an exploiter may use technology (eg, trackers or video streaming) for monitoring when not physically present with a patient.[64] Clinicians may not notice that a phone call is in progress if the phone is hidden, but if an in-progress call is noted, the situation should be approached in a respectful manner, as in this example: "I see you are on your phone; would you mind calling the person back so that we can focus on your care? I'm happy to speak with them about the plan of care after we talk if you would like."

While patients should be provided with privacy, every effort should be made to maintain a collegial relationship between the ED staff and patients' visitors. Negative interactions between visitors and ED staff can have adverse impacts on the wellbeing of the patient outside the safety of the ED, and may result in delay or deferral of healthcare in the future.[65]

## History

In addition to the relevant medical history for the presenting chief concern, clinicians should obtain a psychosocial history from adolescents and children who are at risk for trafficking, after reviewing the ground rules of confidentiality and mandated reporting requirements with the patient. The HEADS-ED is a convenient, rapid screening tool for adolescent mental health; the acronym is derived from the content covered by the tool: home, education, activities (including with peers), drugs (including cigarettes and alcohol), suicidality, emotions/behaviors/thought disturbances, and discharge resources.[66] **(See Table 3, page 7.)** HEADS-ED can be adapted for specific clinical scenarios; for example, when assessing a patient who lives in a foster care group home, consider asking "How is your living situation?" rather than "How does your family get along?" If the HEADS-ED screening identifies domains that are concerning, or if the clinician senses that the patient may be at risk, a more specific human trafficking assessment can be helpful. These assessments are best administered by a practitioner who has significant experience with trafficking, and with the involvement of a multidisciplinary team including social work and child protection teams, if available.

## Physical Examination

A relevant, focused physical examination should be conducted with the patient's consent, using a trauma-informed approach, and with a qualified and supportive chaperone present.[31,39] Clinicians should not assume the meaning of physical examination findings but should respectfully inquire about any concerning findings in a nonjudgmental manner. Survivors of assault or abuse may choose to defer some parts of a standard physical examination; emergency clinicians should follow their lead in these situations.

Trafficked children may present with malnutrition and/or poor dentition, and may be dressed in a manner that is incongruous with the weather or situation. Patients experiencing trafficking (including CSEC and illicit drug trade) may have multiple mobile phones with them,[67] and may have branding or tattoos. Inquiries about tattoos should be made using respectful language (eg, "Could you tell me more about this tattoo?").[68] Scarring, burns, or other injuries from past trauma may also be observed in patients with trafficking experience.[8,12] If the patient's stated age is older than the patient's appearance, further information should be gathered, as this may be an indicator of exploitation.[2] Patients impacted by labor trafficking may have health complications that are specific to the industry in which they work; these can include injuries related to operation of heavy machinery and high-risk equipment or exposure to electrical or chemical hazards, as well as heat stroke, hypothermia, repetitive stress injuries, accidents, or infectious disease complications.[22,34,35] Children experiencing trafficking may also present with illnesses or injuries that are not specific to their trafficking (eg, a child impacted by labor or sex trafficking seeking ED care for an asthma exacerbation in the setting of an upper respiratory infection).

If the patient has presented due to sexual assault or abuse, the clinician with the most experience conducting forensic examinations, such as a sexual assault forensic examiner, should conduct the examination, collect forensic evidence with the patient's consent, and offer prophylactic treatment for STIs and pregnancy, if indicated.

### Documentation

Clinicians should follow any state-specific laws regarding documentation and consent. Detailed documentation of the relevant physical examination findings in the electronic health record (EHR) can be important, particularly in cases of sexual assault.[69] In some clinical situations, it may also be helpful to include photographs of key findings, such as injuries from an assault.[70] Patient consent must be obtained for any photographs; if the patient does consent to be photographed, that consent should be documented in the medical record. Documentation of the patient's history should be limited to relevant health information unless the clinician is trained in forensic documentation, and the potential impact of sensitive information in the medical record should be discussed with minor patients who are of maturity.[52,71,72]

## Diagnostic Studies

Because labor and sex trafficking are not inherently pathologic conditions of the body, there are no biologic or radiographic studies that will yield a determination of a trafficking experience, but imaging and laboratory testing may be indicated as part of the medical assessment. The astute clinician will include trafficking on the differential and consider whether a referral to an ED social worker and/or a community-based trafficking response organization is appropriate, as well as whether the situation invokes mandated report requirements.

### Imaging Studies

Some indicators of physical abuse can be seen on imaging, such as multiple, old fractures or inappropriately healed fractures; as with other child maltreatment situations, if the history of these injuries seems scripted, memorized, and/or recited, or is inconsistent with the presenting medical issue, the index of concern for an abusive situation rises. If there is concern about the reported age of a patient and imaging is otherwise indicated, a request can be made for the radiologist to comment on the apparent bone age.

## Table 3. HEADS-ED Adolescent Mental Health Screening Tool

| Variable | 0<br>No action needed | 1<br>Needs action but not immediate/ moderate functional impairment | 2<br>Needs immediate action/severe functional impairment |
|---|---|---|---|
| **H**ome<br>Example: How does your family get along with each other? | Supportive | Conflicts | Chaotic/dysfunctional |
| **E**ducation and employment<br>Example: How is your school attendance? How are your grades? Are you working? | On track | Grades dropping/or absenteeism | Failing/not attending |
| **A**ctivities and peers<br>Example: What are your relationships like with your friends? | No change | Reduction in activities/increased peer conflicts | Increasingly to fully withdrawn/ significant peer conflicts |
| **D**rugs and alcohol<br>Example: How often are you using drugs or alcohol? | None or infrequent | Occasional | Frequent/daily |
| **S**uicidality<br>Example: Do you have any thoughts of wanting to kill yourself? | No thoughts | Ideation | Plan or gesture |
| **E**motions, behaviors, thought disturbance<br>Example: How have you been feeling lately? | Mildly anxious/sad/acting out | Moderately anxious/sad/acting out | Significantly distressed/unable to function/out of control/bizarre thoughts/significant change in functioning |
| **D**ischarge or current resources<br>Example: Do you have any help or are you waiting to receive help (counseling, etc)? | Ongoing/well connected | Some/not meeting needs | None/on waitlist/noncompliant |

The HEADS-ED is a screening tool and is not intended to replace clinical judgment.
Scoring: Variables can be evaluated independently in terms of need for action. To obtain a total score, add the value of each variable together. Referral for a specialized mental health assessment should be considered if the total sum score is ≥8 and the "Suicidality" variable is rated as a 2.

### Laboratory Studies

Youth impacted by trafficking have high rates of STIs, so testing should be offered routinely, especially in the context of a history of sexual assault or exploitation. Blood tests for HIV, syphilis, hepatitis B, and hepatitis C are recommended. Patients should be offered molecular-based testing (eg, nucleic acid amplification testing) for gonorrhea and chlamydia, with sample collection from the sites of sexual activity (oropharynx, urogenital system, and rectum). For patients who have a vagina and are not currently menstruating, swab testing is more sensitive than urine-based testing. For all other patients, a non–clean-catch urine sample can be collected. Testing for trichomoniasis is also recommended, via nucleic-acid amplification testing with either swab or urine collection, or via wet mount microscopy. Molecular herpes simplex virus testing should be ordered if the patient has lesions suggestive of herpes simplex virus.

### Screening Tools

As of June 2022, the 6-item screen developed by Greenbaum et al is the only screening tool for sex trafficking that has been validated for use in adolescent patients in healthcare settings.[12] Other screening tools for trafficking have been developed, including comprehensive tools that aim to also recognize labor trafficking,[73] but none of these tools have been validated for use in minors in healthcare settings.

### Trauma-Informed Care

Trauma-informed care approaches are critically important for patients who may have a trafficking experience, particularly in lieu of validated screening tools. The PEARR tool details principles of trauma-informed care that may facilitate a feeling of safety in patients so that they are more able to share their experience. The tool encourages clinicians to (1) provide privacy; (2) educate patients about abusive and exploitative situations; (3) ask about their clinical concerns for patients; and (4) respect and respond to the needs of patients.[74] **(See Figure 1, page 9.)**

When clinicians use the techniques described in the PEARR tool, patients have the space to tell their stories without feeling pressured or interrogated. While a clinician may have a singular concern, offering questions respectfully, using normalizing language in an open-ended manner and in a private space, allows the patient an opportunity to share information about situations the care team might not have considered. If the focus is on sex trafficking, labor trafficking may be missed; if the focus is on intimate partner violence, trafficking may be missed completely. By using a tool that does not have a singular diagnosis as an endpoint, clinicians afford patients a greater opportunity to connect with the care and services that are most relevant to their situations.

## Treatment

Emergency clinicians should focus first on the provision of healthcare, then on respectful and honest conversations with the patient about concern for safety, connections to local resources when welcomed, and mandated reporting when required. In general, the emergency clinical care of patients impacted by trafficking does not differ from the care of other patients, but there are important exceptions regarding sexual and reproductive health. Emergency clinicians should be familiar with their state-specific minor consent and confidentiality laws so that patients' legal rights are upheld. Patients may find it helpful to be informed of which medical scenarios can be kept strictly confidential and which must involve a legal guardian or a governmental agency.[75] The Guttmacher Institute maintains an overview of each state's minor consent laws related to reproductive health, available at https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law

It is important that clinicians not fall into a "rescue" or "save" mentality. In trafficking situations, it is the job of the emergency clinician to support patients in furthering their own health and safety, similar to the "stages of change" model that has historically been applied to the process by which people recover from substance use disorders. Rescuing a patient from a social or living situation is not sustainable, especially for emergency clinicians.[76] The root causes of trafficking at the individual and societal levels are too complex for a rescue to solve the problems of a trafficked child, and the concept of "rescuing" does not respect the agency that some adolescents may feel about their situations.[77] Efforts to rescue patients may be received as disrespectful, patronizing, or even coercive; ultimately, such an approach can do more harm than good to both the patient-clinician relationship and the patient's health.[78]

### Sexually Transmitted Infections

Best practice for the care of patients impacted by sex trafficking or who have been sexually assaulted in a labor trafficking situation includes offering empiric antibiotic therapy for STIs. Chlamydia, gonorrhea, and trichomoniasis should be treated with appropriate antibiotic therapy. Other STIs (eg, syphilis) may also require treatment, depending on patient presentation and local context.[79,80] Because some STI therapies can cause nausea, food and antinausea medications may be warranted.

HIV postexposure prophylaxis should be offered to patients who were made to engage in penetrative sex within the previous 72 hours, per institutional guidance and if the patient can complete therapy safely. HIV pre-exposure prophylaxis (PrEP) can be difficult to provide from the ED, as patients will need regular access to healthcare.[81,82] Recent studies have examined the role of the ED in raising PrEP awareness

among patients at high risk for HIV infection, as well as in actively referring patients for PrEP to a medical home and/or clinic that focuses on sexual health.[83-85] A searchable directory of PrEP prescribing locations is available at https://www.pleaseprepme.org

Vaccination against infections that can be sexually transmitted, including human papillomavirus (HPV), hepatitis A, and hepatitis B, is important for all youth, and especially for youth at risk for trafficking. HPV vaccine can be administered to patients aged 9 to 26 years if they have not been vaccinated against HPV previously; additional dose schedule recommendations, which are determined by patient age, are available at https://www.cdc.gov/hpv/hcp/schedules-recommendations.html

## Emergency Contraception

It is medically appropriate to offer emergency contraception to a patient at risk for pregnancy who has a negative baseline pregnancy test, depending on the type and timing of recent sexual encounters. Any patient with a uterus at risk for pregnancy should be offered emergency contraception, regardless of the patient's current gender identity. While an intrauterine device is the most effective form of emergency contraception, it may be more practical in the ED setting to dispense ulipristal acetate (Ella®).[86] Ulipristal acetate has a broader window of efficacy than levonorgestrel (Plan B®, Take Action®) and is more effective for patients with an elevated body mass index.[87]

## Connection to Services

Among the most helpful services emergency clinicians can provide to all patients are connections to follow-up healthcare and social services. If a patient has indicators of labor or sex trafficking, clinicians should respond in a supportive manner and allow space for the patient to communicate their experience. An approach that emphasizes universal education and does not rely on disclosure can be helpful; for example: "Because relationship issues, violence, and exploitation are so common, I tell all my patients about how to get help. If you or a friend ever need support, here is a number you can call." If there is an

**Figure 1. PEARR Tool**

# PEARR Tool

Trauma-Informed Approach to Victim Assistance in Health Care Settings

In partnership with HEAL Trafficking and Pacific Survivor Center, CommonSpirit Health developed the PEARR Tool to guide health professionals on how to provide **trauma-informed assistance** to patients who may be experiencing abuse, neglect, or violence. The PEARR Tool is based on a **universal education approach** which focuses on educating patients about violence prior to, or in lieu of, screening patients with questions. The goal is to have an informative, yet developmentally-appropriate, conversation with patients in order to create a natural context for patients to share their own experiences and possibly accept further assistance.

**A double asterisk indicates points at which this conversation may end. Refer to the bottom of this page for additional steps. The patient's immediate needs (e.g., emergency medical care) should be addressed before use of this tool.

**P PROVIDE PRIVACY**

1. Discuss sensitive topics **alone** and in **safe, private setting** (ideally private room with closed doors). If companion refuses to be separated, this may be an indicator of abuse, neglect, or violence.** Strategies to speak with patient alone: Suggest the need for a private exam. For virtual or telephonic visits, request patient moves to a private space but proceed with caution as patient may not be alone.** **Note: Companions are not appropriate interpreters,** regardless of communication abilities. If patient indicates preference to use companion as interpreter, see your facility's policies.** Also, explain **limits of confidentiality** (e.g., mandated reporting); however, do not discourage patient from disclosing victimization. Patient should feel in control of disclosures. Mandated reporting includes requirements to report concerns of abuse, neglect, or violence to designated state or local agencies.

**E EDUCATE**

2. Educate patient in manner that is **nonjudgmental** and **normalizes sharing of information**. Example: "I educate all of my patients about [fill in the blank] because violence is common in our society, and violence has a big impact on our health, safety, and well-being." **Use brochure or safety card** to review information about abuse, neglect, or violence, and offer brochure/card to patient. [Ideally, this brochure/card will include information about resources (e.g., local service providers, national hotlines)]. Example: "Here are some brochures to take with you in case this is ever an issue for you, or **someone you know.**" If patient declines materials, then respect patient's decision.**

**A ASK**

3. Allow time for discussion with patient. Example: "Is there anything you'd like to share with me? Would you like to speak with [insert advocate/service provider] to receive additional information for you **or someone you know?"**** If physically alone with patient and you observe indicators of victimization, **ASK** about concerns. Example: "I've noticed [insert risk factor/indicator]. You don't have to share details with me, but I'd like to connect you with resources if you're in need of assistance."** **Note:** Limit questions to only those needed to determine patient's safety, to connect patient with resources (e.g., trained victim advocates), and to guide your work (e.g., perform medical exam).

**RR RESPECT & RESPOND**

4. If patient denies victimization or declines assistance, respect patient's wishes. If you have **concerns about patient's safety,** offer hotline card or other information in event of emergency (e.g., local shelter, crisis hotline). Otherwise, if patient accepts/requests assistance, **arrange personal introduction** with local victim advocate/service provider or **assist patient with calling hotline:**** National Domestic Violence Hotline, 1-800-799-SAFE (7233); National Sexual Assault Hotline, 1-800-656-HOPE (4673); National Human Trafficking Hotline, 1-888-373-7888.



immediate safety concern and the patient is a minor, local response protocols should be followed to promote child welfare. Clinicians do not have the authority to detain patients with capacity unless there is an active risk for self-harm or harm to others.

If the patient is a young adult and is amenable, a team can be activated to support the patient with a more detailed trafficking assessment. Social work support should be involved in the care team, if it is available. Many patients with a trafficking experience will not be ready to leave their situation, for a variety of reasons,[88] but may be able to accept other services (eg, drug or alcohol "detox," food assistance, or Medicaid enrollment). Patients should be made to feel welcome to return to the ED for follow-up care at any time; this approach is also useful as a harm-reduction technique, and offers patients another opportunity to nurture their health, develop healthy connections with caring adults, and potentially leave the trafficking situation. Patients who are ready to leave their situation or are seeking trafficking response support should be connected to antitrafficking-specific community-based organizations (CBOs). The National Human Trafficking Hotline maintains a referral directory of programs and organizations that specifically serve people who have experienced trafficking, available at https://humantraffickinghotline.org/training-resources/referral-directory

Clinicians can also call the National Human Trafficking Hotline at 1-888-373-7888 at any time to speak with a specialist about the nonmedical care of a patient. These calls can be made without sharing patient information. Patients with a possible or likely trafficking experience should be referred to antitrafficking CBOs and not to other types of organizations (eg, domestic violence shelters), since antitrafficking CBOs are especially knowledgeable about the nuances of local laws, regulations, and available resources for this population.

Antitrafficking resources vary by region and by the local investment in offering comprehensive services to survivors of all genders and all types of trafficking. This may limit the services available to some or many patients (eg, boys, transgender and gender-diverse minors, youth with a labor trafficking experience), and clinical care teams may need to offer additional support to patients in areas that have insufficient local services.

If patients decline connection to antitrafficking CBOs, they can be advised to contact the National Human Trafficking Hotline at their convenience by calling 1-888-373-7888 or texting "BEFREE" or "HELP" to 233733. It may be helpful to share this resource with patients who are not ready to disclose or leave a situation, for use when they become ready; for example, a clinician could say, "Many of my patients without stable housing find themselves being exploited. If you ever find yourself in this situation, you can call this number and ask for help."

### Mandated Reporting

The trafficking of minors is considered a form of child maltreatment. In the United States, the Child Abuse Prevention and Treatment Act, which was reauthorized in 2015, identifies concerns about "severe forms of trafficking" (including labor and sex trafficking) that affect a minor as reportable situations.[89] The authority to whom these concerns should be reported varies by state; while some states require reporting to their central registry for child abuse, others require that reports be made to law enforcement.[90] Emergency clinicians should familiarize themselves with the mandated reporting requirements of the state(s) in which they practice. Emergency healthcare and stabilization take precedence over immediate mandatory reporting.[91]

Clandestine child welfare reports are not recommended and can harm patient-clinician relationships, as well as patient trust in the healthcare system in general.[92] Some patients will want to participate in the report-making process but others will not. In many states, the paradigm for confronting trafficking is shifting from a criminal-justice approach to a public-health approach, and there is often no need for the clinical care team to involve law enforcement unless the patient would like to file a police report or the state requires child maltreatment to be reported to the police. CBOs can offer patients support around navigating police reports and restraining orders.

## Special Populations

There are a number of pediatric populations that are particularly vulnerable to being trafficked, including but not limited to: children and adolescents who have run away; are lesbian, gay, bisexual, transgender/gender nonbinary, or questioning/queer; are unaccompanied youth; are immigrants, particularly if they are undocumented; have substance-use disorders; or have learning differences.[93] One study found that youth who were homeless or had run away engaged in sex in exchange for things of commercial value to support survival (eg, shelter, food) at rates up to 28%;[94] engagement of minors in survival sex is considered sex trafficking under United States federal law.[18] Data indicate that youth in foster care are vulnerable to exploitation and human trafficking both before and during their time in the foster care system.[95-97] Many minors, and disproportionately minors of color and minors with nontraditional gender and/or sexualities, experience trauma, abuse, and exploitation (including trafficking) while they are in the child welfare and juvenile justice systems.[78,98] Patients who cannot speak or advocate well for themselves, such as children and adolescents with developmental delays, are among the most vulnerable populations, and clinicians should have a low threshold of concern for exploitation or abuse in these patients.[99,100] ED teams should have a plan in place to connect all vulnerable youth

to a medical home that is accustomed to providing continuity and trauma-informed care, and to CBOs that focus on supporting survivors of trafficking.[31,32]

## Controversies and Cutting Edge

### Diagnostic Coding and Documentation

It is challenging to gather reliable data on human trafficking, given its clandestine and criminal nature, as well as the differing state-level responses to trafficking.[101] To help address the paucity of data, the United States Centers for Disease Control and Prevention released codes related to human trafficking for the International Classification of Disease, Tenth Revision (ICD-10) in 2018.[102] However, the best use of these ICD-10 codes is controversial, as there is concern that the codes could inadvertently cause harm to patients, such as if an exploiter sees the diagnosis on discharge paperwork or via an online patient portal.[72] Survivors have expressed concern that diagnoses can disseminate (eg, through EHR tools that facilitate interinstitutional sharing of health information) with potential negative implications for patients, such as increased scrutiny by social services when a patient gives birth.[103]

Some institutions have developed separate, customizable forms (eg, Smart Forms) that can capture discrete data in an EHR to share a patient's trafficking history on a need-to-know basis only with the team members who are actively caring for the patient.[104] This approach was spearheaded by the Human Trafficking Intervention and Prevention program at UCSF Benioff Children's Hospital Oakland. One such EHR system is SafetyNet (created by a team that included a coauthor of this article, Dr. Lela Bachrach). The SafetyNet system includes:

- A confidential documentation tool to record a history of human trafficking and collect data
- Embedded assessment tools that can be used to screen for trafficking[104]
- Facilitated referrals to support services (mental health resources, CBOs, etc)
- An "FYI" flag and a "Best Practice Advisory" banner to alert clinicians to a patient's unique needs if a patient presenting to the ED has previously been identified as being impacted by trafficking

Focus groups of trafficking survivors showed a strong preference for the more contained and confidential SafetyNet EHR system as compared to putting an ICD-10 code for human trafficking on a patient's problem list.[103]

### Additional Screening Tools

The CSE-IT (Commercial Sexual Exploitation-Identification Tool), which is used in the SafetyNet system in a streamlined form, has not yet been validated in ED settings but has been validated in mental health settings and has identified >8200 youth with clear trafficking indicators.[105] **(See Table 4, page 12.)** There is a gap in the literature for a similar robustly developed screening tool for pediatric labor trafficking. An ideal screening tool would screen for both forms of trafficking, to minimize bias in application.

## Disposition

Each patient's disposition will be dictated by their specific medical or psychiatric situation. There may be times when it is useful to admit a patient to the hospital for psychosocial reasons, so that safety planning and harm reduction strategies can be best implemented. Every institution should develop, implement, and evaluate a human trafficking response protocol, including contact information for CBOs and partner agencies that can support patients impacted by trafficking.[106] A human trafficking response protocol developed by UCSF Benioff Children's Hospital Oakland is provided as an example. **(See Figure 2, page 13.)** The first page of the 2-page protocol is a response pathway, while the second page (not shown) provides contact information and additional details on local CBOs and partner agencies.

### 5 Things That Will Change Your Practice

1. Minor patients who are of maturity should be interviewed without visitors, even if a visitor has a socially acceptable relationship to the patient.
2. Trauma-informed care techniques, such as those described in the PEARR tool, provide patients with an opportunity to talk about their experience without pressure or fear that they will be judged.
3. The HEADS-ED adolescent mental health screening tool is a rapid screen that can be used to identify any domains of concern that would prompt a more specific assessment for trafficking risk.
4. If a patient is in a suspected or confirmed trafficking situation, connection to support services should be offered but not forced. Having a trafficking response protocol in place will help clinicians and ED staff navigate these situations.
5. The use of confidential EHR documentation tools to note trafficking history, rather than ICD-10 codes for human trafficking, can help to protect patient privacy and safety.

## Table 4. WestCoast Children's Clinic Commercial Sexual Exploitation Identification Tool – Healthcare Version

**Instructions:**

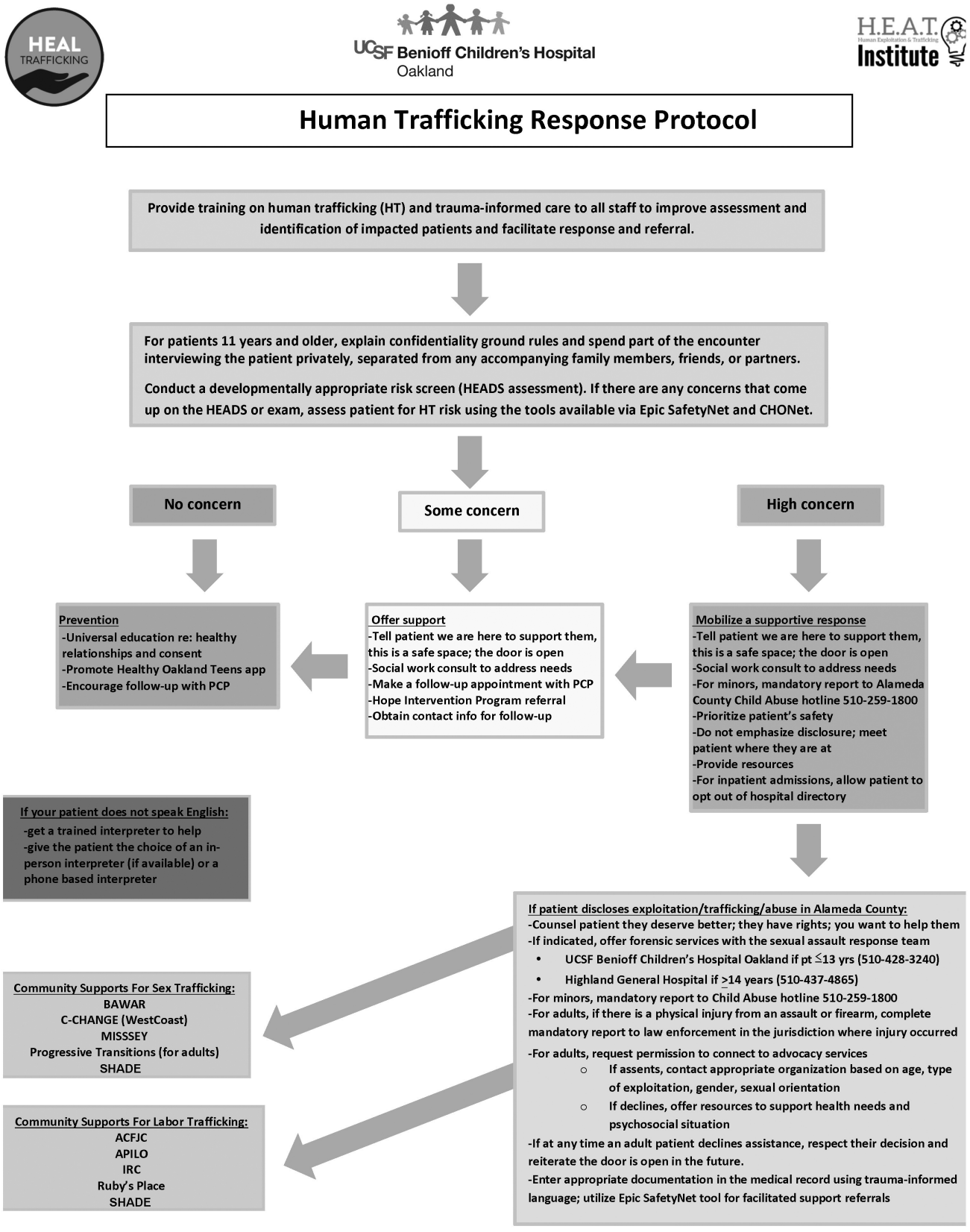
1. Use the checkboxes to indicate if an item is a concern.
2. For each key indicator (grey boxes), circle a score based on your best judgement.
3. Add the indicator scores for a final score.
4. Circle a level of concern based on the final score.

| **1. HOUSING AND CAREGIVING.** The youth experiences housing or caregiving instability for any reason. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 1 | **Clear Concern** 2 |
|---|---|---|---|---|
| ☐ Frequently leaves residence for extended periods of time (overnight, days, weeks)<br>☐ Experiences periods of homelessness<br>☐ Experiences unstable housing, including multiple foster/group home placements | | ☐ Irregular school attendance and/or tardiness<br>☐ Relies on emergency/temporary resources to meet basic needs<br>☐ Past/current involvement with child welfare<br>☐ Parent/caregiver unable to provide adequate supervision | | |
| **2. PRIOR ABUSE OR TRAUMA. The youth** has experienced trauma (not including exploitation). | **No Information** 0 | **No Concern** 0 | **Possible Concern** 2 | **Clear Concern** 3 |
| ☐ Experienced sexual, physical, or emotional abuse or assault | | ☐ Witness to domestic violence | | |
| **3. PHYSICAL HEALTH AND APPEARANCE.** The youth experiences notable changes in health and appearance. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 2 | **Clear Concern** 3 |
| ☐ Significant change in appearance (dress, hygiene, weight)<br>☐ Repeated or concerning sexual health testing or treatment<br>☐ Health problems from sleep deprivation, poor nutrition, or irregular access to meals | | ☐ Serious or dangerous substance abuse<br>☐ Significant change or escalation in substance abuse<br>☐ Tattoos, scarring, or branding, indicating being treated as someone's property | | |
| **4. ENVIRONMENT AND EXPOSURE.** The youth's environment or activities place them at risk of exploitation. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 2 | **Clear Concern** 3 |
| ☐ Spends time with people who are exploited or buy/sell sex<br>☐ Engages in sexual activities that cause harm or place them at risk of victimization | | ☐ Spends time where exploitation is known to occur<br>☐ Uses language that suggests involvement in exploitation<br>☐ Involvement with law enforcement or juvenile justice | | |
| **5. RELATIONSHIPS AND PERSONAL BELONGINGS.** The youth's relationships and belongings are not consistent with their age or circumstances, suggesting possible recruitment by an exploiter. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 2 | **Clear Concern** 3 |
| ☐ Unhealthy, inappropriate, or romantic relationships with adult<br>☐ Receives/has access to unexplained money or resources<br>☐ Explicit photos of the youth on the internet or their phone | | ☐ Several cell phones or cell phone number changes often<br>☐ Meets with contacts they developed over the internet including sex partners or boyfriends/girlfriends | | |
| **6. SIGNS OF CURRENT TRAUMA.** The youth exhibits signs of trauma exposure. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 2 | **Clear Concern** 3 |
| ☐ Appears on edge, preoccupied with safety, or hypervigilant<br>☐ Has difficulty detecting or responding to danger cues | | ☐ Self-harm, self-destructive, aggressive, or risk-taking behavior<br>☐ High level of distress about being available by cell phone | | |
| **7. COERCION.** The youth is being controlled or coerced by another person. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 3 | **Clear Concern** 4 |
| ☐ Abusive or controlling intimate partner<br>☐ Coerced into pregnancy, abortion, or using contraception<br>☐ Someone controls youth's contact with family or friends, leaving the youth socially isolated | | ☐ Travel to places inconsistent with life circumstances<br>☐ The youth or friends, family, acquaintances receive threats<br>☐ Youth gives vague or misleading information about their age, whereabouts, residence, or relationships | | |
| **8. EXPLOITATION.** The youth exchanges sex for money or material goods, including food or shelter. | **No Information** 0 | **No Concern** 0 | **Possible Concern** 4 | **Clear Concern** 8 |
| ☐ Youth has a history of sexual exploitation.<br>☐ Youth exchanges sex for money or material goods, including food or shelter for themselves or someone else. | | ☐ Youth is watched, filmed, or photographed in a sexually explicit manner.<br>☐ Youth forced to give money they earn to another person. | | |

**Total Score**

**0-3: No concern** **4-7: Possible concern** **8-29: Clear concern**

## Figure 2. Sample Human Trafficking Response Protocol




Courtesy of UCSF Benioff Children's Hospital Oakland. The HEAL Trafficking, UCSF Benioff Children's Hospital Oakland, and H.E.A.T. Institute logos are used with permission.

# Case Conclusions

CASE 1

**For the 15-year-old boy with an eye injury…**

A CT scan was reassuring and showed no globe rupture and no residual foreign body, so the ophthalmology consultant recommended supportive care and close outpatient follow-up care. The ED social worker met with the patient with the help of a Mam interpreter, and learned that he had recently come to the United States from Guatemala as an unaccompanied minor. He had been working and living at a construction site, and his employer had been keeping most of his wages for what he "owed." He was not enrolled in school and did not have health insurance coverage. The social worker explained to the patient that he was likely experiencing labor trafficking. The social worker also informed him that the healthcare team was required by federal law to report his situation (child maltreatment) to the state's central registry. The patient was connected with a transitional housing program that served survivors of trafficking, and was offered connection to mental health support services and pro bono legal representation. An appointment for follow-up care was made for him at a local primary care clinic that served a large population of recent immigrants from Central America. The social worker at the clinic was notified that the patient would be coming so that there would be a plan in place if he did not keep his appointment.

CASE 2

**For the 13-year-old girl who presented with dysuria and abdominal pain…**

You suspected the patient was experiencing trafficking due to her history of involvement in the foster care system, significant mental health stressors, and several prior STIs. You reviewed the ground rules of confidentiality with her, assuring her that anything she spoke about would be between her and the medical team unless there was a concern for safety or the need for a mandated report. The patient shared that since she left her last group home, she had been living in a car with a man to whom she is not related, although she called him "uncle." You noticed that she was carrying 2 cell phones. You asked her if she had completed her treatment for chlamydia and she said she was not able to swallow pills easily. You obtained her permission to do a pelvic exam and arranged for a nurse to chaperone. The examination was remarkable for significant cervical motion tenderness and a wet mount sample showed copious white blood cells. You ordered testing for gonorrhea, chlamydia, and trichomoniasis, and the patient agreed to HIV and syphilis screening. Given your concerns about her psychosocial situation and risk for pelvic inflammatory disease in the context of her difficulty with oral antibiotics, you admitted her for parenteral antibiotic treatment and further assessment. Based on multiple indicators of commercial sexual exploitation, you told the patient that you would need to contact child welfare. She responded that she already had a child welfare social worker and provided a phone number. The inpatient team coordinated with child welfare to arrange a new placement for the patient and connected her with an organization that offered case management to youth with a history of sexual exploitation. The registration staff also set up a new patient appointment for her in the teen clinic so she could receive ongoing primary care after discharge.

## Summary

Labor and sex trafficking patients of all ages may seek ED care for illness and injuries related or unrelated to their trafficking experience.[107-109] Pediatric ED patients may be trafficked in a variety of industries and by people of various ages and genders who appear to have a socially acceptable relationship to the patient (eg, parent, legal guardian, older sibling, romantic partner, employer). Minor patients with capacity should always have an opportunity to speak with a clinician alone at some time during the ED visit. If there is a language barrier, a certified interpreter should always be used, even if a patient's visitor offers to interpret. If there is a clinical concern for trafficking, the emergency clinician should speak respectfully with the patient about seeking support from local antitrafficking experts, and should comply with mandated reporting laws.[110,111] Institutions should develop evidence-based trafficking concern and/or response protocols to facilitate care for patients who have a trafficking experience.[45,106]

For a summary of the resources discussed in this issue, see **Table 5, page 16**.

## Time- and Cost-Effective Strategies

- Having a human trafficking response protocol in place, including contact information for local CBOs, will save time and promote optimal care.
- Antibiotic stewardship is generally advisable, but empiric antibiotics and/or postexposure prophylaxis are warranted if there is concern for an STI in a patient who is being trafficked.

# Risk Management Pitfalls for Management of Potentially Trafficked Pediatric Patients

1. **"She said everything was fine and she was born and raised here, so this couldn't be a human trafficking situation."** Clinicians can only diagnose and treat conditions that are on their radar. If a clinician lacks awareness about indicators of human trafficking, they can easily be missed. Validated screening tools should be used when available, as there are risks to the patient when a situation is not properly evaluated.

2. **"He's here with his stepfather, who is a distinguished-looking gentleman. The ED is busy and it will take a while to do a one-on-one history. It's only really necessary when the situation seems suspect."** Do not assume that a patient presenting in what appears to be a socially acceptable relationship is in a safe or healthy situation. Always speak with a patient privately at some point during their evaluation.

3. **"Kids these days don't even really work. Labor trafficking isn't something I'm going to see here."** Do not assume pediatric patients do not experience labor trafficking. Children and adolescents of all ages may experience labor trafficking.

4. **"The patient's aunt speaks English pretty well. They both seem fine with proceeding without an interpreter."** Allow patients to speak for themselves. If there is a language barrier, always work with a certified medical interpreter.

5. **"Now that I know the indicators of a trafficking situation, I will be able to intervene and keep my patient safe. It feels good to rescue victims from scary situations."** Do not plan to "rescue" patients from a situation. The goal is to empower them to use their own agency to promote their health and wellbeing. If the patient is a minor and a mandated report is indicated, this should be done in a collaborative and trauma-informed manner.

6. **"I told her, 'He's not good for you. You're going to end up hurt even worse next time if you don't leave him.'"** Some patients in trafficking situations may not identify as victims; if you identify them that way, it may ruin your rapport with them and put them in danger.

7. **"It's obvious he is being trafficked. I don't know why he's being so secretive about it."** Do not take it personally if a patient does not want to share much about their experience. Disclosure is not the goal; the goal is to offer an open door and a safe place to seek out support during this encounter or a future one.

8. **"I want to avoid conflict, so I'm going to make this report to child welfare and not tell the patient."** Always inform a patient you are a mandated reporter before you gather sensitive information. If you see concerning indicators, make the mandated report in collaboration with the impacted youth, letting the patient know that you are a mandated reporter and that you are hoping to leverage helpful support for them. Do not make clandestine reports.

9. **"She didn't want to get into the other stuff going on, and she implied she had been a victim of violence in the past. I'm not going to chart much about this."** Document clearly and keep in mind that medical records are sometimes used in a court of law. When developmentally appropriate, discuss with the patient the details that can be included in the chart. If a forensic examination is indicated and the patient is willing, have a trained forensic interviewer assist with and document the examination.

10. **"We don't see much human trafficking here. We'll figure it out when the time comes."** All institutions should have protocols in place to serve patients impacted by human trafficking and to keep patients and ED staff safe. This will also make the work more efficient when the situation does arise.

## References

Evidence-based medicine requires a critical appraisal of the literature based upon study methodology and number of subjects. Not all references are equally robust. The findings of a large, prospective, randomized, and blinded trial should carry more weight than a case report.

To help the reader judge the strength of each reference, pertinent information about the study, such as the type of study and the number of patients in the study is included in bold type following the references, where available. The most informative references cited in this paper, as determined by the authors, are noted by an asterisk (*) next to the number of the reference.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## Table 5. Resources for Human Trafficking Recognition and Response

| Resource | Description | Contact Information |
|---|---|---|
| **Screening Tools** | | |
| HEADS-ED | Mental health screening tool for adolescents | https://www.heads-ed.com/en/home |
| Commercial Sexual Exploitation-Identification Tool (CSE-IT) | Screening tool for commercial sexual exploitation in children[a] | https://www.westcoastcc.org/cse-it/ |
| **Resources for Clinicians and Patients** | | |
| Guttmacher Institute | Summary of state laws for consent to reproductive health services | https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law |
| HEAL Trafficking | Trafficking education and resources for clinicians | https://healtrafficking.org |
| National Human Trafficking Hotline | Connection to services and support for patients who are experiencing or have survived trafficking | Call 1-888-373-7888[b]<br>or<br>Text "BEFREE" or "HELP" to 233733 |
| National Human Trafficking Hotline Referral Directory | Searchable database of antitrafficking organizations and programs | https://humantraffickinghotline.org/training-resources/referral-directory |
| PEARR Tool | Trauma-informed care model for clinicians and other healthcare staff | https://www.dignityhealth.org/hello-humankindness/human-trafficking/victim-centered-and-trauma-informed |
| PleasePrEPMe | Searchable database of HIV PrEP providers | https://www.pleaseprepme.org/ |

[a]The CSE-IT has not been validated for use in the emergency department.
[b]Clinicians can also call this number to speak to an antitrafficking specialist about nonmedical concerns.
Abbreviation: PrEP, pre-exposure prophylaxis.

trafficking in the greater Mekong subregion. *JAMA Pediatr.* 2015;169(9):e152278. **(Cross-sectional survey; 387 participants)**

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## CME Questions

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1. **Trauma bonds involve:**
   a. Bondage with handcuffs
   b. A strong sense of loyalty and compassion to an abuser or exploiter
   c. A financial incentive to continue the trauma
   d. An implanted tracker so that an exploiter always knows the whereabouts of the patient

2. **A 14-year-old boy is brought to the ED after swallowing a condom containing cocaine. He tells the ED social worker that he was told his younger sister would be harmed if he didn't hide the drugs. Which of the following statements about this situation is CORRECT?**
   a. This could not be labor trafficking because drug dealing is illegal.
   b. This could be labor trafficking.
   c. This is not trafficking because the boy did not cross any borders.
   d. This is labor exploitation but not trafficking.

3. **A 16-year-old boy presents to the ED with an abscess on his leg. He tells you that since he left his last group home, he has been "couch surfing" and has been trading sex for a place to stay. He reports that he feels safe. Which of the following statements regarding this patient is CORRECT?**
   a. The patient feels safe, so this is not human trafficking.
   b. Because the patient is an adolescent and is choosing to engage in survival sex, this is not commercial sexual exploitation of children (CSEC).
   c. This patient is impacted by CSEC.
   d. There is no force, fraud, or coercion involved, so this cannot be a trafficking situation.

 

4. **Which of the following steps would be appropriate as part of a trauma-informed care approach for a pediatric patient who is potentially impacted by trafficking?**
   a. Obtaining a very detailed history of what happened to the patient during a sexual assault
   b. Performing a thorough pelvic examination
   c. Providing care that is sensitive to the patient's trauma history and is not retraumatizing
   d. Applying restraints so the patient cannot leave against medical advice

5. **An 18-year-old woman who speaks only Arabic presents for suture removal. Her chart indicates that she was advised to have the sutures removed 10 days ago. Using a certified interpreter, she tells you she cut her hand while cooking and that she did not return sooner to have the sutures removed because she does not get many days off. You see in her chart that she originally claimed to have cut her hand while falling down the stairs. Which of the following indicators would be most concerning for trafficking in this case?**
   a. The patient's lack of English proficiency
   b. The patient's inconsistent history and the delay of care
   c. The injury caused by a cooking accident
   d. The fact that the patient is unaccompanied

6. **You are treating a 16-year-old nonbinary patient who uses they/them pronouns. Their chart indicates a history of STIs. After you initiate a social history in private and review the confidentiality ground rules with them, they tell you that they have multiple sex partners. In order to help you understand whether this patient is experiencing commercial sexual exploitation, you should:**
   a. Ask them if they are being trafficked.
   b. Ask about their relationships with each of their sexual partners.
   c. Ask them if they are a prostitute.
   d. Use the trauma-informed care techniques described in the PEARR tool to allow the patient space to tell their story, and consider use of a CSEC screening tool.

7. **What is the first step an emergency clinician should take when concerned for labor and/or sex trafficking in an ill or injured patient?**
   a. Confront the patient.
   b. Call the National Human Trafficking Hotline.
   c. Call the police.
   d. Provide high-quality emergency healthcare.

8. **Your patient, a 12-year-old girl, has shared that she is experiencing sexual exploitation. She states that her last menstrual period was 2 weeks ago and she had unprotected penile-vaginal sex 4 days ago. Her vital signs are stable and her body mass index is 38. In addition to testing and treating for her for any STIs, what is the best next step in the care of this patient?**
   a. Order a pregnancy test; if negative, recommend repeat testing in 2 weeks.
   b. Order a pregnancy test; if negative, offer the patient levonorgestrel.
   c. Order a pregnancy test; if negative, offer the patient ulipristal acetate.
   d. Defer the pregnancy test and place an intrauterine device.

9. **Which of the following harm-reduction techniques should be employed for an 18-year-old patient who is not ready to leave a potential trafficking situation and is not at risk for self-harm or harm to others?**
   a. Threaten to call the police.
   b. Make a clandestine report to Child Protective Services.
   c. Confront the patient's visitor, whom you suspect to be the trafficker.
   d. Set up a follow-up healthcare visit and offer to connect the patient to relevant antitrafficking CBOs.

10. **You are caring for a 13-year-old boy who was born at 28 weeks' gestation with developmental delay, cerebral palsy, and chronic lung disease. He presents to the ED from his residential medical facility with a femur fracture. Which of the following factors puts this patient at risk for exploitation?**
    a. Developmental delay
    b. Chronic lung disease
    c. A femur fracture
    d. History of prematurity

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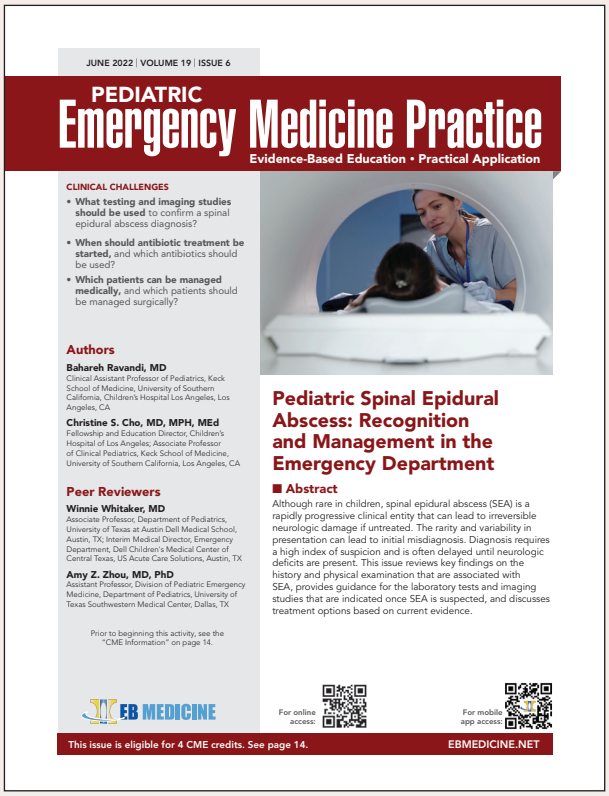


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**Goals:** Upon completion of this activity, you should be able to: (1) identify areas in practice that require modification to be consistent with current evidence in order to improve competence and performance; (2) develop strategies to accurately diagnose and treat both common and critical ED presentations; and (3) demonstrate informed medical decision-making based on the strongest clinical evidence.

**CME Objectives:** Upon completion of this activity, you should be able to (1) recognize risk factors and indicators for human trafficking in pediatric patients; (2) identify and respond to the health and safety needs of survivors of trafficking; and (3) describe best-practice recommendations to care for trafficked patients in a trauma-informed manner and with appropriate connections to support services.

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QUICK READ

# Points & Pearls

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# Human Trafficking of Children and Adolescents: Recognition and Response in the Emergency Department

## Points

- Trafficking does not require transportation away from home or across borders.
- Children and adolescents may be trafficked in legal industries, including agriculture, manufacturing, restaurant, and domestic work, as well as in illegal industries.[22,23]
- Although sex trafficking receives much of the focus in the United States, research indicates that 20% to 50% of youth who experience trafficking specifically experience labor trafficking.[34-37]
- The risk factors for labor and sex trafficking are multifactorial, and current studies have not established association versus causality for risk factors.
- Risk factor conditions may be compounded by larger structural factors such as poverty, racism, transphobia, homophobia, and sexism.
- A patient should always be offered privacy before any sensitive topics are broached, and the ground rules of confidentiality should be reviewed with the patient.
- A trauma-informed care approach gives patients space to tell their stories without feeling pressured or interrogated. **(See Figure 1.)**
- The HEADS-ED can be useful as a rapid screening tool for mental health in adolescent patients who are at risk for trafficking, but it is not specific for trafficking. **(See Table 3.)**
- An occupational injury that seems inconsistent with a safe workplace may be an indicator of labor trafficking.[53,54]
- Physical examination findings that may be indicators of trafficking include malnutrition and/or poor dentition; clothing that is incongruous with the weather or situation; branding or tattoos;[68] or signs of previous traumatic injuries.[8,12]
- Clinicians should not assume the meaning of physical examination findings, and should ask patients about any concerning findings in a nonjudgmental and respectful manner.
- Youth impacted by trafficking have high rates of STIs, so testing should be offered routinely, especially if a patient has a history of sexual assault or exploitation.
- The trafficking of minors is a reportable situation,[89] but law enforcement involvement may not be required, depending on the state. Emergency clinicians should familiarize themselves with the mandated reporting requirements of the state(s) in which they practice.
- Clandestine child welfare reports are not recommended and may discourage patients from seeking healthcare in the future.
- Patients who are ready to leave a trafficking situation should be connected to antitrafficking-specific CBOs in their area.
- Patients who are not ready to disclose or leave a trafficking situation can be advised that they can contact the National Human Trafficking Hotline at their convenience by calling 1-888-373-7888 or texting "BEFREE" or "HELP" to 233733.
- Every institution should develop, implement, and evaluate a human trafficking response protocol, including contact information for CBOs and local partner agencies.[106]

## Pearls

- A visitor with a socially acceptable relationship to the patient (eg, a parent, sibling, partner, or employer) can still be a trafficker.
- A certified interpreter should always be used when there is a language barrier, even if a visitor accompanying the patient offers to interpret without objection from the patient.
- If emergency contraception is indicated, ulipristal acetate (Ella®) has a broader window of efficacy than levonorgestrel (Plan B®, Take Action®) and is more effective for patients with an elevated body mass index.[87]
- Children and adolescents with developmental delays are a vulnerable population and there should be a low threshold of concern for exploitation and abuse in these patients.[99,100]
- It is not the role of the emergency clinician to "rescue" a patient from a trafficking situation. Patients should be offered support and encouraged to use their own agency to promote their health and safety when they are ready.

 