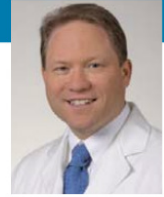


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 HEAL Trafficking

Managing Trafficking in the Pediatric ED

Human trafficking is a hot topic these days, but what is it really and what is the emergency medicine (EM) clinician's role in caring for these patients? According to the Trafficking Victims Protection Act (TVPA), human trafficking is the recruitment, harboring, transportation, obtaining, and/or provision of a person by the use of force, fraud, and/or coercion, for the purpose of labor and/or sexual exploitation.¹ To be clear and despite the moniker, people are "trafficked" without movement across any borders. In the case of those under the age of 18, any type of involvement in the commercial sex industry is considered human trafficking via sexual exploitation.¹ Multiple studies and reports have established that clinicians, including EM practitioners, are seeing patients who have a trafficking experience.^{2,3,4}

Direction on how emergency medicine clinicians should recognize, respond to, and document human trafficking is well described elsewhere. Readers should access instructional resources:

Shandro J, Chisolm-Straker M, Duber HC, Findlay SL, Muñoz J, Schmitz G, Stanzer M, Stoklosa H, Wiener DE, Wingkun N. "Human Trafficking: A Guide to Identification and Approach for the Emergency Physician." Annals of Emergency Medicine, 2016 April; DOI: <http://dx.doi.org/10.1016/j.annemergmed.2016.03.049>

And

Zimmerman C, Borland R (eds). (2009). Caring for Trafficked Persons: Guidance for Health Providers. International Organization for Migration, Geneva Switzerland. Available at: http://publications.iom.int/system/files/pdf/ct_handbook.pdf

The guidance in these resources applies to all patients regardless of their age, but the care of pediatric patients warrants special consideration in the clinical discussion of human trafficking. Here we review two vignettes, based on real patients with a trafficking experience, to highlight some of those important considerations.

(Names and details have been changed to protect trafficking survivors.)

Charlie

On an unremarkable summer afternoon, during a 12-hour shift, a 16-year-old is listed on the electronic tracker to be seen. The chief complaint is "arm pain." I click on the patient, draw a small box, jot down the chair number, last name, and "arm pain" on my scrap paper and

go find the patient. In the general vicinity of the chair, I call out the last name, and I hear the reply come, "Yeah." After a brief bout of Marco-Polo, I locate the source of the voice and color in the box ascribed to this patient. I introduce myself, and ask what brings her in to the ED. Charlie motions to her left arm, in a sling, and raising her eyebrows, frowns. I see this is going to be "one of those" patients. "What happened?" She tells me she was playing basketball and took a hard foul, landing on her left side. She heard a crack, and came to the ED. The triage nurse put her in the sling. After physical exam, it's obvious the arm is broken, and I order the x-rays of her arm, shoulder, and clavicle, and ibuprofen. I ask about her legal guardian, so I can reach them while the evaluation and care progresses. She says her mother is at work, but she'll call for me. To walk over to radiology, I offer to carry her backpack for her but she uses her right hand to snatch it up before I fully bend over. The x-ray shows a mid-shaft fracture of the humerus. I return to "fast track" and tell Charlie her arm is broken. "No kidding," comes her straight-faced reply. I tell her to follow me to a room so the nurse and I can put her in a splint; I offer to carry her bag and again, she quickly refuses. We enter the ED's code room, one of the few that has a curtain and a door, and I gesture that she should have a seat. As we're splinting her arm, I explain the type of fracture she has and ask again how the injury happened. Charlie sucks her teeth and sticks to her initial story. I tell her that the kind of injury she has is not too common, especially for someone her age. Measuring the web-roll, I tell her I chose this job because I want to be useful and I think right now she could use some help. "Honestly? Sometimes I can't fix the real problem, but I can connect people to the services they need. Maybe you're in a situation that I can't keep a secret, maybe someone is hurting you, and I have to tell someone else about it. And maybe that will help you get what you really need." I ask if someone did this to her. Charlie, it turns out, had been selling candy on the subway, but out of her backpack she was selling drugs. She mishandled some money, the dealer broke her arm and told her not to mess up again; he told her if she tried to quit, he'd kill her. She gave me the number to reach her foster mother.

Clinical Care and Discharge

Minors must receive life- or limb-stabilizing care regardless of legal guardian presence or availability in the ED.⁵ While this is not information specific to trafficking situations, it bears reminding that our first priority is NOT mandated reporting (discussed below). Our first duty is apt emergency healthcare. In non-emergency presentations (e.g., cold

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symptoms) of non-mature⁶ minors (not emancipated or seeking sexual or reproductive healthcare⁷) clinicians should try to contact the legal guardian. But clinicians should always remember that legal guardians can and sometimes do, misuse their power; sometimes they are the abusers, exploiters, or traffickers. Hence, it is important that clinicians speak with patients privately when it is age- or maturity-appropriate. Clinicians do not have the authority to detain patients.

Mandated Reporting

Any time I know I will be a mandated reporter,[†] I tell the patient. Sometimes this possibility becomes apparent as I am hearing a history of present illness. Whenever possible, I tell the patient before I hear the reportable information, to give them as much control over the situation as is feasible. Otherwise, as soon as a patient is medically stable (if that happens in the ED), I let them know of my legal obligation and ask if they would like to speak with the relevant officials. For example, if someone presents with a gunshot wound (GSW), I know immediately that I have to report the presentation to law enforcement. I explain to the patient that I have to make the report, regardless of whether they want it done, but that my first priority is always the provision of the high-quality healthcare that they need. Their healthcare is the first thing to which I will attend.

According to the revised Child Abuse and Prevention Treatment Act (CAPTA),⁷ clinicians are mandated reporters for concerns of labor or sex trafficking of children. In New York, reports of concern for child maltreatment should be made to the New York State Central Register of Child Abuse and Maltreatment. Of note, in New York, mandated reporters must file a written report within 48 hours of making an oral report of concern for child maltreatment.⁸

Patients do not have a choice about my mandated report, but they will know about it, and it will be their choice to speak with social services or law enforcement (depending on the report being made), or not. Reporting without our patients' knowledge erodes the trust patients place in us.⁹ They come to us for care not secretive reports; sometimes they come to us for a safe place to sleep, a free sandwich, or connection with services. We are always open, we are always free. If they cannot come to us, and expect honesty, where will they go?

Brendan

On an overnight shift, a 17-year-old boy is brought in by his girlfriend, who says he's "really sick." They were out tonight and he drank too much. She gives his name and date of birth to register him, but he is otherwise too intoxicated to provide a history or meaningfully participate in an exam. Assigned to a room with a one-to-one technician (for elopement risk), with no signs of trauma above the clavicle, normal vital signs, and a normal fingerstick, I leave him to sleep it off. The tech calls me back to the room a few hours before the 7am shift change. Brendan is crying and won't say why. I sit down at the foot of his bed and ask him what's wrong. Initially he tells me that he has a terrible hangover. I press him, saying, "I bet you do, your girlfriend was pretty worried about how much you drank last night. We can help hydrate you, to make the hangover less painful. But is there something else bothering you? You seem pretty upset. Maybe I can't help, maybe someone is hurting you, and I have to make a report about it. But maybe that can help?" I

make no moves to leave and sit in silence with him for a few moments. He sighs, and briefly tells me about the past two years of his life. He ran away from home, after a suicidal gesture when he was 15. He felt he was an embarrassment to his father and couldn't face him. So young, and not out of high school, he had no other viable survival options and started having sex for places to stay, particularly during inclement or severe weather. He really misses his father but can't imagine facing him now, after what he's done. I ask if he wants to go home, and he does. He calls home, and then hands me the phone.

Remember the Definition

Brendan's story is a reminder that trafficking does not always include a buyer or consumer, a "victim," and a "bad guy." By the TVPA trafficking definition,¹ Brendan is a survivor of human trafficking because he is a minor who used survival sex.[‡] Any minor (regardless of emancipation status or third-party facilitation[§]) acting in the commercial sex industry (including "survival sex," "exotic dancing," and child abuse imagery^{**}) is considered a survivor of human trafficking, not a "child prostitute." The Safe Harbor law indicates that these minors should not be arrested^{††} for criminal activity.¹⁰

The definition of trafficking says nothing about the gender of a survivor. This is because people of all genders survive (and perpetrate) human trafficking, despite disproportionate media portrayals of women and girls as those victimized.¹¹ Societal and systemic norms and pressures make some groups more vulnerable to exploitation than others, but gender does not make one immune.^{12,13} Clinicians must practice based on the evidence, not media hype. The data is clear: trafficking impacts all genders.

Screening and Assessment

Patients may present without obvious physical trauma. Blatant red flags, like a controlling visitor, are not always apparent. Brendan presented with alcohol intoxication. Asking the simple question of "Why?" or respectfully trying to better understand how a person arrived in their current state allows them the opportunity to tell their story.

Because trafficking manifests in a multitude of ways and forms, and because the ED clinician's time is limited, a screening tool would be useful. At the time of this writing, there is one trafficking screening tool validated for use in the Emergency Department. The Greenbaum Tool can be used to screen English-speaking 13–17-year-olds with (expert-determined) high-risk chief complaints for sex trafficking experiences; it can also be used in this population based upon clinician gestalt (assuming the clinician is trained on human trafficking).¹³ As yet, there is no clinically validated screening tool for labor trafficking, though it is clear that of young people that experience trafficking, labor trafficking accounts for a significant proportion,^{13,14,15} and labor trafficking is the most common form of human trafficking overall.¹⁶

While aiming to provide better healthcare by addressing underlying causes, clinicians must not focus on gathering information about whether a child (or any patient) is being trafficked. We must create space and opportunities for patients to share this information with us. We do that first and foremost by addressing their chief complaints and emergent health needs respectfully, honestly and with clinical excellence. We do that by using certified interpreters, not family or friends;¹⁷ we do that

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by seeking permission before initiating a physical exam;¹⁸ we do that by asking about the patient's goals of care for the visit; we do that by using available evidence to instruct care provision.

‡*Survival sex is defined as when an adult (18 years or older) engages in commercial sex acts to access basic needs like shelter, clothing, or food, that they believe they cannot otherwise obtain. I use the terms “engage” and “use” when describing survival sex of adults and minors, respectively. These verbs are purposely chosen to indicate the legal conception of agency, or lack thereof, with respect to survival sex. Actors' sense of agency and experiences of trauma may not align with legal definitions.*

§*Effective 13 November 2018, New York State law will align with federal law, such that demonstration of force, fraud, and/or coercion is not necessary to meet the definition of sex trafficking, if the person is a minor (S5988A, signed 15 August 2018 [effective 11/13/18]; Read the bill here: <https://www.nysenate.gov/legislation/bills/2017/s5988/amendment/a>).*

***Formerly known as “child pornography.”*

†*It is important to note that minors can be detained by police, via custodial arrest or temporary protective custody, for survival sex or “prostitution,” though the basis for these detentions oversimplify the complexity of these youths' lives and capacities for agency, and overestimates the government resources dedicated to properly meet the needs of these youth (Connor BM. (2016). In *Loco Aequitatis: The Dangers of “Safe Harbor” Laws for Youth in the Sex Trades. Stanford Journal of Civil Rights & Civil Liberties. 12(43): 45-116*).*

Going “Home”

In these two cases, the young people being trafficked wanted out of their situation, and the clinical care team was able to facilitate that. In these two cases, home or “authorities” were a desirable and safe place for the trafficked minors to turn. That is not always the case.¹⁹ In many cases, pediatric patients for whom clinicians have a trafficking concern will not want to go “home,” and will not want to speak with social services. Often, they have a strong sense of agency in their situation, or know that it is not safe to leave.^{20,21} Clinicians do not have the authority to detain patients.

Patients may not disclose an exploitative or abusive situation, even if properly given the opportunity. This is not a failure of healthcare. Our role is to be ever-present and ever-ready to provide high-quality healthcare. As needed, we should employ patient-centered, harm reduction-principled methods to support health and facilitate safety.^{22,23} That is to say, whenever appropriate and possible, patients should be meaningfully involved in their care and care-decisions, and we should “meet them where they are” to promote the health and safety feasible in their situation. We should facilitate connections to social and legal services when requested. The success is that we provide unbiased, evidence-based care and they seek us out again, knowing we will rightly serve.

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Calendar

December 2018

- 5 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 12 Education Committee Conference Call, 2:45 pm
- 12 Professional Development Conference Call, 3:30 pm
- 13 Practice Management Conference Call, 1:00 pm
- 19 Government Affairs Conference Call, 11:00 am
- 19 Research Committee Conference Call, 3:00 pm
- 20 EMS Committee Conference Call, 2:30 pm

January 2019

- 2 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 9 Education Committee Conference Call, 2:45 pm
- 9 Professional Development Conference Call, 3:30 pm
- 10 Practice Management Conference Call, 1:00 pm
- 16 Government Affairs Conference Call, 11:00 am
- 16 Research Committee Conference Call, 3:00 pm
- 17 EMS Committee Conference Call, 2:30 pm

February 2019

- 6 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 13 Education Committee Conference Call, 2:45 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Practice Management Conference Call, 1:00 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm

March 2019

- 5 Lobby Day, 10:30 am-4:00 pm
- 6 Emergency Medicine Resident Committee Conference Call, 2:00 pm
- 13 Education Committee Conference Call, 2:45 pm
- 13 Professional Development Conference Call, 3:30 pm
- 14 Practice Management Conference Call, 1:00 pm
- 20 Government Affairs Conference Call, 11:00 am
- 20 Research Committee Conference Call, 3:00 pm
- 21 EMS Committee Conference Call, 2:30 pm