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IDENTIFICATION AND TREATMENT OF HUMAN TRAFFICKING VICTIMS IN THE EMERGENCY DEPARTMENT: A CASE REPORT

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Abstract—Background: Human trafficking victims experience extreme exploitation and have unique health needs, yet too often go undetected by physicians and providers in the Emergency Department (ED). We report a clinical case of human trafficking of a white, English-speaking United States citizen and discuss the features of presentation and treatment options for human trafficking victims upon presentation to the ED. **Case Report:** A 29-year-old woman with a past medical history significant for intravenous drug abuse and recent relapse presented to the ED after a reported sexual assault. The patient was discharged that evening and returned to the ED the following day acutely suicidal. The patient divulged that she had been kidnapped and raped at gunpoint by numerous individuals as a result of a debt owed to her drug dealers. **Why Should an Emergency Physician be Aware of This?:** Many human trafficking victims present to an ED during the course of their exploitation. To that end, EDs provide one of a limited set of opportunities to intervene in the human trafficking cycle of exploitation, and physicians as well as other ED staff should be equipped to respond. © 2016 Elsevier Inc.

Keywords—human trafficking; sex trafficking; labor trafficking; human trafficking case report; management of human trafficking victims; substance abuse; opioid abuse

INTRODUCTION

Human trafficking remains a significant public health problem throughout the world, including in the United

States (US). Human trafficking is an umbrella term used to describe “acts involved in recruiting, harboring, transporting, providing, or obtaining a person for compelled service or commercial sex acts through the use of force, fraud, or coercion” (1). US law divides human trafficking into categories of sex and labor trafficking. Children under the age of 18 years engaged in commercial sex work, including pornography and stripping, are considered to be sex trafficked. If the victim is over the age of 18, there must be an element of force, fraud, or coercion (2). In the US, it is estimated that most adolescents who enter into the commercial sex industry do so prior to the age of 15 years (3). Forms of labor trafficking include domestic servitude, agriculture work, or construction work where the individual has been forced, defrauded, or coerced. For example, an individual may have his passport taken from him or may be threatened with physical violence. Despite the connotation of the word “trafficking,” there does not need to be a movement component to human trafficking, and a human trafficking victim may be trafficked within his very own home.

Due to the clandestine nature of human trafficking, it has been difficult for researchers to estimate its prevalence throughout the US. A Congressional Report in 2013 stated that as many as 17,500 people may be trafficked into the US every year, but reports by the Central Intelligence Agency have recorded that this number may actually be as high as 45,000 to 50,000 for just women and children (4).

Although emergency departments (EDs) should be a safe haven for human trafficking victims, as they are for many of society's most vulnerable populations, many human trafficking victims go unrecognized or untreated when they present to the ED (5,6). Here we report a case in which a young, white, female patient presented with the chief complaint of "assault," and ultimately, over the course of two ED visits, reported a complicated and distressing constellation of physical abuse and sexual exploitation, which qualified as sex trafficking. This case challenges common stereotypes around human trafficking, as the individual was a white American, and not foreign born.

CASE REPORT

A 29 year-old homeless white woman with a past medical history significant for intravenous drug abuse was brought to the ED by police officers after a reported sexual assault. The patient was reluctant to discuss specific details, but did reveal that she was held captive at gunpoint and was forced to have sexual intercourse with numerous individuals over the course of several days. She had no other medical complaints and was not taking any medications. Her clinical examination revealed normal vital signs and a well-developed, well-nourished appearance. The physician noted an abrasion to the forehead, which the patient reported was the result of being struck with a pistol 2 days prior. The patient was given sexually transmitted infection prophylaxis and levonorgestrel, but declined a genitourinary examination and an examination by a Sexual Assault Nurse Examiner (SANE). A psychiatry consult was not performed during the visit; however, a brief psychiatric examination described an anxious patient denying any suicidal intentions. The patient politely persisted in her refusal of any further medical assessments or interventions; at her request, she was discharged to stay the night with a friend with whom she felt safe.

The following day, the patient presented again to the ED with acute suicidal ideation and opioid withdrawal symptoms. She stated she would prefer death over returning to her drug dealer or him finding her, and that she was urged to come in at the request of her therapist. A thorough psychiatric consultation and social work evaluation revealed that the patient had a history of abuse as a child, personal drug abuse, and had been in and out of substance abuse treatment programs for a number of years. She had one prior suicide attempt in the past and reported a history of posttraumatic stress disorder (PTSD). Three weeks prior she left a substance abuse rehabilitation center and was discharged on bupropion, hydroxyzine, and quetiapine. She relapsed on heroin and was forced to engage in commercial sex work while locked in a room at gun-

point to pay off debts to her drug dealer. The emergency physician and social worker recognized that her situation was consistent with sex trafficking, and the patient chose to have her abuse reported to the Human Trafficking Division of the Police Department. Later that day she was notified that her traffickers had been arrested, which gave her some reassurance as she had received numerous threats from them during her captivity. Given her presentation of suicidality, she was ultimately transferred to an inpatient psychiatric unit.

DISCUSSION

As evident from this case, emergency medicine clinicians and other ED providers are on the frontlines of human trafficking victim identification and care. Two early studies in the US interviewed survivors of sex trafficking and explored their experiences during their time in captivity. In one study, 28% of the 21 victims had come into contact with a medical professional (7). In the other study, about half of the 12 victims reported that they had received health care during the time they were being exploited (8). These studies are limited by their small sample sizes, but a larger, more recent survey of sex trafficking survivors found that 87.8% (n = 98) had some contact with a health care provider while they were being trafficked. EDs represented the most frequently visited health care setting, with 63.3% of survivors reporting contact there (9). Thus, ED physicians, nurses, social workers, receptionists, and technicians vigilant for patients who display an evident clinical picture of human trafficking exploitation may have a critical opportunity to intervene.

Although this patient was eventually identified as being exploited by a trafficker, many victims pass through the health care system undiscovered. It is therefore important to remain alert for signs of exploitation. As outlined in the International Organization for Migration Manual on Trafficking, the patient presentation may offer a number of warning signs for which providers should be on alert (10). Victims may present with a controlling individual, have a delayed presentation of illness, have a clinical presentation inconsistent with their story, or may be fearful and unaware of where they are. A controlling individual can be male or female and can often provide an important clue, especially if such an individual is present with the patient and is found to be answering questions on the patient's behalf or refusing to let the patient speak for him- or herself under the guise of a friend, partner, or family member. Clinically, patients may present with issues related to their work, such as organophosphate toxicity from agricultural exposures in labor trafficking. In cases of sex trafficking, sexually transmitted infections, vaginal or rectal trauma, as well as retained rectal or vaginal

foreign bodies can be encountered. As in this case, they may present with a chief complaint of sexual assault. A significantly high number of sexual partners or unwanted pregnancies warrants further inquiry (4). Signs of physical abuse such as broken bones, bruises, burns, and scars are common. Moreover, a patient may present with complaints related to substance abuse, PTSD, and suicidality, such as the patient in this case (8,11,12). A more recent meta-analysis by Oram et al. found that headache, back pain, stomach pain, and memory problems were the most commonly encountered physical symptoms of human trafficking victims (13). Anxiety, depression, and PTSD were found in significantly high frequencies, with a relationship between duration of captivity and severity of symptoms reported (13,14).

Human trafficking victims may be of any age, race, or gender. It is important to note that, just as in this case, victims will not always be internationally born. In fact, data from the Department of Justice between January 2008 and July 2010 found 83% of confirmed sex trafficking victims were citizens of the US (15). Runaway youth are at a particular risk of being exploited, and it may be helpful to inquire about a history of childhood sexual abuse because 80–90% of sex trafficked adolescents have reported a history of childhood sexual trauma (4). Other identified vulnerable groups in the US include children in the child welfare and juvenile justice systems, children working in agriculture, American Indians and Alaskan Natives, migrant workers, foreign national domestic workers in diplomatic households, business employees in ethnic communities, persons with limited English proficiency, persons with disabilities, rural populations, and gay, bisexual, and transgender individuals (6). In sum, red flags such as substance abuse, profound fearfulness, mental health issues, presence of controlling individuals, signs of abuse or occupational exposures, extensive sexual history, or inconsistent stories should warrant a high level of suspicion for human trafficking.

The case illustrates the challenges in obtaining a history from a patient who is a potential victim of human trafficking. A comparative analysis by Konstantopoulos et al. found that victims are often reluctant to cooperate with medical personnel due to fear of discriminatory treatment, fear of being reported to immigration officials, or fear of being unable to afford health services (16). In this particular case, fear of retribution from the traffickers was also cited by the patient and may have been a factor in her reluctance to seek treatment on her initial visit. In instances such as these, it is helpful for the clinician to reassure patients that they are in a safe place, to exhibit empathy, and to have an appreciation of the physical and mental trauma that they have endured. This will ultimately increase the likelihood that the victim becomes open to communication about his or her experiences.

Approaching a potential victim of human trafficking in a trauma-informed, empowering, nonjudgmental manner is crucial. The goal should not be disclosure or rescue, but rather creating a safe space and empowerment. It is crucial to interview the patient alone and allow him or her to feel safe. Explaining that it is standard practice in EDs to perform a private examination may help avoid suspicion. Many times, it will be difficult to obtain a one-on-one interview. In these scenarios, it can be helpful to accompany the patient to a restroom or to a private setting for a particular study, such as an x-ray. Though not relevant in our patient's case, human trafficking victims may speak English as a second language and thus require an interpreter. As always, but particularly in the setting of screening for human trafficking, we emphasize the need to use a professional hospital interpreter to minimize the risk of losing important contextual information. Patel et al. reported that patients who are not proficient English speakers showed greater understanding of information presented to them and that more important clinical information is gathered in the presence of an interpreter (17).

There are no validated screening questions for human trafficking to ask in the health care setting, however, questions such as "Can you come and go from your home or work whenever you please? Have you ever been threatened for trying to leave your work? Do you need to ask for permission to eat or use a restroom? Have you ever been denied food, water, or medical care? Have you ever exchanged something of value for sex?" have been reported to be useful for providers to ask (4).

In the crowded ED, the reliance on multidisciplinary clinicians is critical in screening and caring for human trafficking. A growing number of hospitals across the country have human trafficking protocols in place, which incorporate multidisciplinary teams (18). All members of the ED team who interact with the patient, from nurses, technicians, Emergency Medical Services personnel, receptionists, mid-level providers, and physicians may recognize signals that help to identify the patient as trafficked. Social work services should also be utilized, as they may have more time to spend with the patient and build trust. SANE nurses may be an invaluable resource in the appropriate setting due to their additional training in trauma-informed care and should be employed if available in the ED. Altogether, SANE nurses, social work services, and case managers are essential multidisciplinary team members that can provide compassionate care and provide resources, referrals, and safety planning. The National Human Trafficking Resource Center, 1.888.3737.888, is another important resource for clinicians and may be helpful in thinking through screening and referral options.

Once a patient has been identified as a victim of human trafficking or exploitation, it is especially important to

recognize and diagnose potential medical comorbidities for which they are most at risk (e.g., substance abuse, PTSD, anxiety, depression, and suicidality). As mentioned previously, these can range from consequences of physical and mental trauma to infectious disease exposures. For example, sex trafficking victims are at risk for a number of sexually transmitted diseases. The incidence of human immunodeficiency virus among victims of sex trafficking in a South Asian cohort was estimated to be between 22.7% and 45.8% (13). A study in Nepal found high infection rates for syphilis and hepatitis B (20.4% and 3.8%) in a study of 246 women at a health care shelter (19).

In addition to the physical health consequences, the mental health consequences of human trafficking are extensive. A 2010 study found that female victims of sex trafficking were at high risk for depression, anxiety, and PTSD, with severity of symptoms linked to length of time in captivity (20). Lederer and Wetzel found that, among a cohort of US sex trafficking victims, 41.5% had attempted suicide (9). Substance abuse is also a common finding; 84.3% of 102 interviewed survivors used alcohol or drugs during their captivity, either to cope with their situations or because the traffickers used drugs as a means of control (8). Survivors and victims of forced labor also experience a similar pattern of morbidities. One study showed male survivors of human trafficking had a prevalence of 60.7%, 48.4%, and 46.3% for depression, anxiety, and PTSD, respectively (14). Therefore, many human trafficking victims may require extensive and long-term mental health treatment (20).

When a physician recognizes a victim of human trafficking, the next step is a needs evaluation and safety planning. In addition to medical care, a trafficked patient's identified needs may include shelter, substance abuse treatment, legal services, and law enforcement. It is important to recognize that the patient may not be in a place where she recognizes she is being exploited or may not be in a position to leave her trafficker. For example, some traffickers leverage threats against family if a victim tries to escape. Just as in cases of intimate partner violence, the victim will have a better sense of when they are ready for help. It is important for providers to remember that they are not alone and resources exist to help guide them through the process. As discussed previously, The National Human Trafficking Resource Center operates a hotline at 1.888.3737.888 that serves to help guide health care professionals through the process if they believe they have identified a victim of human trafficking. This hotline is an excellent resource for both ED providers and victims, as it is available 24/7, has a texting option, and offers help in more than 200 languages. In addition, the hotline can link to victim resources, including housing, law enforcement, and legal services

in their community if and when they are ready to leave. If the victim is under the age of 18 years, mandated reporting laws should be followed.

Law enforcement involvement should be approached thoughtfully, in partnership with the patient, with consideration of patient and staff safety risks. In the case of our patient, she requested police involvement, and the city police Human Trafficking Unit was contacted. However, law enforcement involvement in other cases may lead to unintended consequences, such as arrest of the patient for outstanding warrants or loss of patient trust. Law enforcement familiarity and training on human trafficking varies widely across the country. If law enforcement is deemed important to contact, connecting with the National Human Trafficking Resource Center Hotline may help in identifying which law enforcement officials would be most appropriate for the case at hand.

This case underscores the importance of identifying human trafficking victims early, ideally upon first presentation. Fortunately, this patient was able to return to the ED to seek treatment. Unfortunately, given the lack of systematic medical training on human trafficking, many victims interface with health care settings without detection. A 2012 survey of ED attending physicians and residents found that a staggering 97.8% (n = 176) reported having never received any formal training on the clinical presentation of human trafficking victims (21). Not surprisingly, among that same group of emergency medicine clinicians, only 4.8% reported feeling confident about their ability to identify a victim of human trafficking. Once a victim is correctly identified, many physicians are unsure how to proceed and what resources to seek for assistance (22). Fortunately, other research has shown that simple training modules, such as audiovisual presentations, on how to identify a potential victim and what to do after a victim is identified can significantly improve the confidence of residents and attending physicians in identifying and treating human trafficking patients; however, the need for a formal, evidence-based curriculum remains (13,23–27). Offering continuing medical education credits to health care professionals for reviewing human trafficking-related education materials or offering grand rounds on the issue also has the potential to be an effective starting point for educating the medical community about this issue (21,28). Educating health care providers early in their training will be crucial in raising awareness of human trafficking (29,30). HEAL Trafficking, an international network of professionals leading the health care response to human trafficking, maintains a Web site (healtrafficking.org) that contains a compendium of various educational resources for health care providers, including the International Organization Manual referenced above (30,31).

WHY SHOULD AN EMERGENCY PHYSICIAN BE AWARE OF THIS?

In the context of managing multiple medical emergencies in acutely ill patients, emergency clinicians may miss important signs indicating a patient's basic human rights are being violated, as is the case with human trafficking victims. Emergency clinicians play a crucial role in identifying human trafficking victims, treating their physical and mental needs, and linking to services in a trauma-informed, a victim-centered, culturally relevant, evidence-based, gender-responsive manner. Although victims may be difficult to identify due to their complexity and the time constraints placed on ED providers, it is nonetheless vitally important to maintain a high level of suspicion for human trafficking in the proper context. Traffickers often have more than one victim. Consequently, identifying one victim may indirectly benefit many other victims. If the diagnosis is never considered, an enormous opportunity to remove the victim from exploitation is lost.

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