Sex Trafficking Assessment and Resources (STAR) for Pediatric Attendings in Rhode Island

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ABSTRACT

BACKGROUND: Domestic minor sex trafficking (DMST) victims have unique medical and mental health needs and present frequently for medical attention. Little is known about the reported training, screening, comfort and knowledge of DMST among pediatricians in Rhode Island who likely encounter these patient victims without knowing.

METHODS: An anonymous electronic survey sent to Rhode Island Hospital staff physicians from November 2014 through January 2015.

RESULTS: Of the 109 participants, the majority reported no training, screened no patients for DMST in the past year, did not know any resources available and had limited knowledge and comfort with this pediatric patient population.

CONCLUSIONS: Rhode Island pediatricians of various specialties do not feel adequately prepared to identify and respond to a DMST patient population. These findings inform the need for increased training and education on DMST in our medical community.

KEYWORDS: domestic minor sex trafficking; commercial sexual exploitation of children; victim; training

INTRODUCTION

The commercial sexual exploitation of children (CSEC) has become an increasingly recognized manifestation of child sexual abuse. It has profound physical and mental health effects for children domestically and abroad. CSEC is defined as the "recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" in exchange for an item of value, such as money, food, shelter or drugs.[1] Sexual acts include trafficking for sexual purposes, prostitution, sex tourism, pornography, stripping, and survival sex.[2]

When CSEC involves United States citizens or legal residents being victimized on U.S. territory, this is known as domestic minor sex trafficking (DMST).[3] It is conservatively estimated that at least 100,000 American juveniles are victimized through sex trafficking each year,[4,5] and over 325,000 U.S. children are at risk.[4,6] Rhode Island's geographic proximity to two major metropolitan areas (New York City and Boston) and easy access to a major interstate highway increases the likelihood of sex trafficking. While the Interstate 95 corridor has traditionally been used for drug trafficking, it also is used for human trafficking and specifically to sex traffic both local and non-local youth in and out of Rhode Island.

In response to the prevalence of this issue in our state, the RI human trafficking task force (HTTF) comprised of community service providers, criminal justice, medical and child welfare professionals was initiated in 2013 to develop a statewide plan to address all aspects of sex trafficking. The Lawrence A. Aubin Sr. Child Protection Program (The Aubin Center) at Hasbro Children's Hospital is a part of this multidisciplinary team and is the only child protection program in the state of Rhode Island where patients are evaluated by board-certified child abuse pediatricians. Aubin Center physicians, medical support staff and social workers collaborate with referring medical and non-medical providers to address the complex healthcare and psycho-social needs of these youth.

Over the past few years, the Aubin Center has seen a significant increase in the number of patients referred for the evaluation of DMST in the outpatient clinic and emergency department. Due to the physically and emotionally abusive nature of sex trafficking, victims seek medical care frequently and have adverse health consequences (e.g. injuries, substance abuse, unsafe sexual practice).[7,8] Therefore, pediatricians and other clinicians have the unique opportunity to identify and effectively intervene on behalf of these vulnerable youth.

Previous studies have identified low levels of knowledge, comfort and training of providers in regard to child abuse,[9,10] and more recently child sex trafficking,[11,12,13] but have not specifically examined pediatricians practicing in RI. The objective of the present study was to describe the reported training, screening, comfort and knowledge of DMST among pediatric physicians in Rhode Island. Our goal was to identify the impediments to the care of DMST patients in our medical community in order to inform education and training needs.

METHODS

We developed an anonymous survey modeled on a previously established survey that assessed the knowledge,

training and comfort medical providers face when interacting with child abuse patients,[9] and from clinical experience. Experts in survey development and experienced physicians in DMST reviewed the survey. Research Electronic Data Capture (REDCap) software, a free, secure, Web-based application, was used to create and distribute the survey.[14]

The survey was titled "Sex Trafficking Assessment and Resources Survey (STAR)". Participation in the study was voluntary and anonymous. The survey was distributed from November 2014 through January 2015 via e-mail to all pediatric attending physicians listed in the Rhode Island Hospital staff services and/or the department of pediatrics at Rhode Island Hospital. Surveys were targeted specifically to pediatricians who had completed their training; therefore, medical students, residents and fellows were excluded. All research procedures were approved by the Rhode Island Hospital Institutional Review Board. Descriptive statistics were calculated and the averages were computed using SAS Software 9.4. (SAS Inc., Cary, NC).

Table 1. Respondent Demographics and Experience

	n (%)
Completed survey	109 (41)
Female	67 (61)
Male	39 (36)
Unknown	3 (3)
Medical Specialty	
General Pediatrics	49 (45)
Pediatric Subspecialists	42 (39)
Internal Medicine Pediatrics	10 (9)
Other	8 (7)
Clinical setting	
Private/Community	42 (39)
Hospital based clinic	29 (27)
Emergency Department	18 (17)
Hospital Inpatient	14 (13)
Other	4 (4)

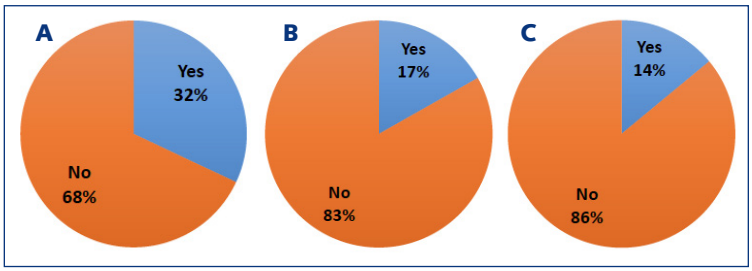
RESULTS

The survey was sent to 267 pediatric attending physicians in Rhode Island and a total of 109 responded (response rate 41%). **Table 1** describes the demographics of participants.

Figure 1 depicts the responses to three questions that assessed participants' experience with DMST and knowledge of re-sources available for these patients. The majority of participants reported limited experience.

Figure 2 displays the average responses in regard to the knowledge of and discomfort with patients who may be involved in sex trafficking.

Figure 1.
A. Have you screened any patients for DMST in the past 12 months?
B. Have you received any training on DMST?
C. Do you know of resources available for DMST patients?

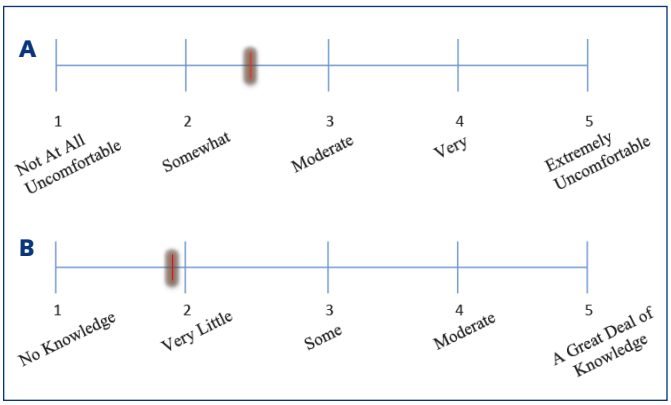


DISCUSSION

The findings from the current study reveal that Rhode Island pediatric attending physicians of various specialties do not feel adequately prepared to identify and respond to a DMST patient population. The majority of participants reported limited knowledge, training and comfort in regard to screening, managing, and identifying resources for high-risk and involved patients. These findings are problematic, as previous studies indicate the severity of health consequences and outcomes associated with sex trafficking.[7,8] Our survey highlights the potential need for education and training among all pediatricians in RI to subsequently inform effective patient care.

Patients seek medical attention but are often not identified because they infrequently self-disclose involvement to providers and do not consistently present with evidence of involvement (e.g. found trafficking by law enforcement).[4,15,16] Therefore, at-risk or victimized patients are treated solely for their immediate health issues (e.g. drug/alcohol abuse, STIs), only to be at continued risk for DMST

Figure 2.
A. On a discomfort scale ranging from not at all (1) to extremely uncomfortable (5), on average participants reported somewhat to moderate (2.4) discomfort
B. On a knowledge scale ranging from no (1) to a great deal of knowledge (5), ona verage participants reported very little (1.87) knowledge



victimization.[15,16] Youth who are not recognized within a medical setting represent missed opportunities for identification and intervention.

The overwhelming majority of Rhode Island pediatricians (86%) who responded to the survey described having received zero hours of training on DMST. In a recent survey study by Beck and colleagues, 67% of providers with no training were more likely to have lower levels of knowledge on sex trafficking and noted less confidence in their ability to identify victims.[11] In conjunction with limited training, our survey found that the majority of participants had an average of "very little" perceived knowledge and reported "somewhat" to "moderate" discomfort pertaining to the screening, medical management, and identification of resources for DMST patients, and when to report these youth.

A lack of training in, knowledge of and comfort with DMST may hinder appropriate and necessary patient care. The current study found that 68% of RI pediatricians who responded have not screened any patients for DMST in the past year. Moreover, our participants reported having "very little" knowledge of the resources available for DMST patients, and the majority (86%) reported not knowing about any resources. Of the 14% who did identify knowing at least one resource, participants most commonly listed the Aubin Center, followed by DCYF, homeland security, and Day One. To provide for the many medical and non-medical needs of these vulnerable youth, it is imperative for medical providers to be aware of current RI and national resources available (See **Table 2**).

Table 2. Resources Available for DMST Patients

Rhode Island Resources[a]	National Resources
• Aubin Center (401)-444-3996 • Day One (401)-421-4100 http://www.dayoneri.org • Department of Child, Youth and Families (DCYF) (401) 528-3502 http://www.dcyf.ri.gov • Family Service of RI (401)-331-1350 http://www.familyserviceri.org • Gateway Healthcare (401)-724-8400 http://www.gatewayhealth.org • Project Renew (401)-272-0220 http://www.amoshouse.com • Project Weber (401)-383-4888 http://projectweber.org • Saint Mary's Home for Children, The Shepherd Program (401)-353-3900 http://www.smhfc.org/Outpatient.htm	• AAP Guidelines http://pediatrics.aappublications.org/content/pediatrics/135/3/566.full.pdf • GEMS http://www.gems-girls.org • Homeland Security 1-(800) 973-2867 • Love 146 https://love146.org • My Life My Choice http://www.fightingexploitation.org • National Human Trafficking Resource Center (NHTRC) hotline 1-(888)-373-7888 http://traffickingresourcecenter.org • The National Center for Missing and Exploited Children 1-(800)-843-5678 http://www.missingkids.org/home

a. RI community agencies listed have established specific resources for victims of DMST

A limitation of this study is that we focused on pediatric physicians in Rhode Island, and therefore findings likely cannot be applied to all medical providers and medical settings in the U.S. In addition, respondents were asked to identify the number of hours they have completed training, but were not asked about the specifics of their training. Future studies should explore differences among pediatric subspecialists regarding knowledge, comfort, training and medical decision making for DMST victims.

These data support the need for a structured standardized approach to training and education about DMST for all pediatricians to improve identification and medical management. Educational programs for sexual abuse, domestic violence and substance abuse might serve as examples of how to train clinicians on DMST. Collaboration between medical providers, investigators, and other community organizations can provide opportunities to educate community partners about the unique medical and mental health needs of this population.

CONCLUSION

Over the last few years, DMST in Rhode Island has been increasingly recognized. As with other forms of child maltreatment, a multidisciplinary approach to identify and effectively intervene on behalf of these patients is recommended. As leaders in child advocacy, pediatricians play an essential role in addressing the complex issues faced by victims of DMST. Pediatricians can work to increase recognition of DMST, provide direct care and guidance, and engage in collaborative efforts with medical and non-medical providers. Through clinical based training and education regarding community resources, pediatricians will be more prepared to help address the complex needs of this vulnerable pediatric patient population.

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