

Domestic Minor Sex Trafficking: Medical Follow-up for Victimized and High-Risk Youth

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ABSTRACT

Domestic minor sex trafficking (DMST) has become an increasingly recognized issue associated with both immediate and long-term physical and mental health consequences. Guidelines have focused on potential risk factors, recruitment practices, and health consequences for these youth assisting in identification and intervention efforts. However, recommendations have not been established for continuous medical intervention and follow-up for this vulnerable patient population that includes both patients involved in and at high risk for DMST. Our goal is to highlight preliminary recommendations for and the importance of medical visits for these youth. A comprehensive physical examination, STI testing and treatment, and pregnancy prevention options are important to address the patients' concerns for their body and identify acute and chronic injuries. Further, collaborating with other medical and non-medical providers can provide essential resources for the multifaceted needs of DMST patients.

KEYWORDS: domestic minor sex trafficking (DMST), follow-up, physical examination, sexually transmitted infection (STI)

Domestic minor sex trafficking (DMST) is the commercial sexual exploitation of American children within U.S. borders. These crimes are defined as the "recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" where the person is under the age of 18 years. DMST is emerging as a newly recognized subset of child sexual abuse and a major public health issue of pre-adolescents and adolescents in the U.S. Given the exceptional challenges of victim identification, the epidemiology of this issue is unknown.¹⁻³

Barron and colleagues found that an overwhelming majority (86%) of Rhode Island pediatricians never received training on how to properly care for DMST patients, including initial and ongoing medical visits.⁴ Sex trafficking is a major public health issue in Rhode Island; this may be due to its geographic proximity to New York City, Boston and access to a major interstate highway. While local and non-local victims are trafficked in and out of Rhode Island via the

Interstate, victims may also be trafficked within neighborhoods of the state. Within the setting of the state's only outpatient child abuse pediatrics clinic, The Lawrence A. Aubin Sr. Child Protection Center at Hasbro Children's Hospital has evaluated 75 patients for DMST involvement since August 2013.

The American Academy of Pediatrics (AAP) and the American Professional Society on the Abuse of Children (APSAC) published clinical guidelines regarding risk factors, recruitment practices, possible indicators of commercial sexual exploitation, and common medical and behavioral health problems to assist in victim identification and intervention efforts.^{1,2} Follow-up care for victims of DMST has not been a focus within these guidelines possibly because of the transient living conditions of these youth that may complicate medical follow-up. Consequentially, there remains a dearth of specific recommendations for follow-up medical care after identification, and this component of care for this population still remains challenging.

Comprehensive medical protocols that address the plethora of medical, psychiatric and safety issues related to DMST during the initial evaluation and follow-up medical visits do not exist. Guidelines have been utilized similar to those currently used for victims of acute sexual assault.^{1,2} However, these guidelines do not take into account the significant differences between these two populations. Unlike victims of an acute sexual assault, youth involved in DMST have continuous high-risk exposures. Further, Varma and colleagues found that suspected sex trafficking patients were more likely to have histories of substance use, STIs, pregnancy, runaway behavior, and child protective service (CPS) involvement as compared to sexual abuse/sexual assault victims.⁵ Thus, extensive ongoing medical care that considers mental health and safety planning, while concurrently ensuring physical health with STI testing, treatment, and pregnancy prevention specifically for DMST patients is of paramount importance.

The cornerstone of treating this patient population is to build a foundation of trust that develops over time with multiple interactions. Establishing trust may pose significant challenges for clinicians, as many victims have an overwhelming distrust of authority figures based on histories of child maltreatment, abandonment by caregivers, and prior involvement with CPS and/or law enforcement.⁶ Further, it

is possible that youth involved in DMST have developed a fear of their trafficker, being labeled a ‘prostitute’, criminalization, and returning to a poor living situation, which could include a group or an unsafe family environment⁶ Due to these reasons, DMST patients may not be inclined to communicate openly about their involvement.^{1,7} Medical providers must take time to demonstrate that they can be trusted and nonjudgmental professionals with the patient’s health and safety as their priority. This may be difficult when confronted with oppositional or withdrawn adolescents; these are behaviors seen in typically developing adolescents and may be heightened in youth at risk for DMST.⁸ Probing or investigative questions related to their exploitation should be avoided. Further, information should be accepted from the patient without disputing facts or seeking to gain more specific information.

The patient should be reassured that regardless of his/her involvement in DMST, he/she can return for care without judgment. Balancing this nonjudgmental approach with the obligation to meet mandatory reporting requirements to both child protective services (CPS) and law enforcement is important. Ideally, CPS and law enforcement involvement should occur after informing the child of the report. Providers should become familiar with their state’s mandatory reporting laws as some states include reporting DMST, while other states do not. It is also important to identify which states have Safe Harbor Laws, which impacts the focus of youth involved in DMST as victims and not criminals.⁸

Providing a full physical examination and communicating with the patient about the physical findings can begin to address the patient’s concern that their body is damaged or abnormal after the repeated physical and sexual trauma associated with their involvement. A comprehensive examination should include a thorough inspection for inflicted sexual injury, testing for STIs, physical findings (e.g. injuries inflicted by others, self-inflicted cutting, tattoos that may represent branding), substance abuse, malnutrition, and dental neglect.² A genital examination, with the patient’s assent, should be part of follow-up medical visits to check for acute and chronic anogenital injuries (e.g. lacerations, bleeding, abrasions, transections).

The APSAC and AAP recommend STI testing and providing prophylaxis for pregnancy and STIs during medical visits given the transient living conditions and the decreased likelihood of follow-up for victims of DMST.^{1,2} However, these guidelines do not advise providers on STI testing and treatment for DMST patients who present for follow-up visits, nor do they address ongoing and high-risk exposures inherent to these youth. Follow-up visits provide a crucial opportunity to 1) detect new infections acquired during or after the initial evaluation; 2) build rapport with patients to acknowledge concerns for their physical and specifically sexual health; 3) monitor side effects and adherence to post-exposure prophylactic medication, if indicated (See Tables).^{8,9}

Table 1.

Recommendations for DMST Follow-up
<ul style="list-style-type: none"> • Build a foundation of trust that develops over time with multiple interactions • Collaborate with involved outside agencies (e.g. child welfare, law enforcement and transitional social service agencies for adolescents ageing out of state custody) • Accept information from the patient without disputing facts or seeking to gain more specific information • Meet state-specific mandatory reporting requirements to both child protective services (CPS) and law enforcement • Provide a full physical examination and communicate with the patient about the physical findings • Monitor side effects and adherence to post-exposure prophylactic medication, if indicated • Provide follow-up testing and treatment for STIs, including N. gonorrhea, C. trachomatis, trichomonas, HIV, syphilis, hepatitis B and C based on 2015 CDC STD Guidelines and patient request • Offer patients the option of various forms of contraception, with an emphasis on long-acting, reversible contraception (LARC) methods • Enable the patient to have access to the provider who can see the patient emergently or refer to another member of their care team

Table 2.

Follow-up testing and treatment for DMST Patients
<ul style="list-style-type: none"> • STI testing should include N. gonorrhea, C. trachomatis, trichomonas, HIV, syphilis, hepatitis B and C based on 2015 CDC STD Guidelines • Provider should consider patient request for testing • Balance testing parameters and limitations while informing patients of the uncertainty regarding the test results if the patient is having ongoing unprotected sex -(e.g. C. trachomatis will remain positive up to 3 weeks and N. gonorrhea up to 2 weeks with nucleic acid amplification testing despite adequate treatment) • The provision of STI, pregnancy, and HIV prophylaxis should be evaluated on a case-by-case basis during follow-up visits • Review if and when the patient received prophylaxis during a prior medical visit, complete a risk assessment, and communicate openly with the patient about his/her adherence to determine medication provision. • Consult an infectious disease specialist and child abuse pediatrician to help make this determination

Comparable to STI vulnerability, this population is susceptible to unplanned pregnancy. Offering patients the option of various forms of contraception, with an emphasis on long-acting, reversible contraception (LARC) methods is an important component of medical follow-up. Due to the transient living conditions of patients involved in DMST, there is increased risk for poor compliance with daily

medications, making options with extended protection an ideal choice for birth control in this population.⁸

Establishing collaborative relationships between providers and outside agencies (i.e. a multidisciplinary team) offers resources for the medical and non-medical needs of these youth in follow-up visits.¹ Advocacy for this patient population is broad, variable and includes finding educational opportunities, appropriate housing and guardianship, specialized medical care (e.g. psychiatry, dental), mental health counseling, and legal assistance. Ongoing medical visits allow for the opportunity to connect victims to appropriate resources and referrals that can provide direct services for these youth (i.e. child protective services and other community providers).

CONCLUSION

Follow-up visits for DMST youth provide the opportunity to address the multifaceted and long-term needs of patient victims. Guidance surrounding ongoing medical care after identification and the initial evaluation has not been established. Based on clinical experience, our preliminary recommendations for follow-up visits include: STI/HIV testing and treatment, pregnancy prevention with LARCs, mental health assessment and subsequent referrals to and collaboration with other community professionals. These aforementioned interventions allow providers to demonstrate the patient's health and well-being as a main priority, and develop an ongoing trusting relationship, regardless of continued DMST involvement. Despite the transient living conditions of DMST victims, healthcare professionals have a responsibility to encourage all victimized and high-risk adolescents to attend follow-up visits; this allows for appropriate safety planning, health care, and advocacy for this vulnerable patient population.

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