The Journal of Emergency Medicine, Vol. 50, No. 5, pp. 715–719, 2016
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0736-4679/$ - see front matter

http://dx.doi.org/10.1016/j.jemermed.2016.01.004

Original Contributions

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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).

RECEIVED: 2 September 2015; FINAL SUBMISSION RECEIVED: 22 December 2015;
ACCEPTED: 7 January 2016

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 gunpoint 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

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