Human Sex Trafficking- Recognizing The Signs: Education for Paramedics

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Clinical Scenario:
Paramedics are dispatched to a 13 year old male patient in a residence who is complaining of pain in their left leg. The patient is tachypneic and is avoiding making eye contact. Patient seems anxious. There is an older male present, approximately in his 30s, who mentions that he is the guardian of the child. You assess the childs leg where he is feeling the pain and notice that his ankle is broken. When you ask what happened, he gives you what seems to be a rehearsed answer about how he was just playing outside and fell. You ask the child for consent to do a secondary body assessment but the guardian denies it by saying that it is enough. You ask the child for his health card but the guardian mentions they had misplaced it. You recognize that this is a peculiar situation and you find way to persuade the guardian by saying it is important to do the secondary assessment to make sure nothing else is injured and to see the extent of the broken ankle. During the secondary assessment you notice some ecchymosis around the childs' wrists and some just on the posterior portion of his knees. The guardian is getting visibly angry and is telling you to hurry up. At this time the child is looking down away from you. You complete your assessments and once back in the truck you call Victim Services as you believe this child is a victim of child sex trafficking. They put you in touch with the appropriate resources.

Background:
Looking at current training in place for HCPs in spotting signs of CST and current screening tools for determining what is CST and how it can be translated to other health care professions and modified to their needs.

Review question:
Does the training of paramedics about recognizing the signs of human sex trafficking result in higher quality care and early intervening into the crisis?

Search strategy (Basic): ((paramedic OR ems OR emergency medical service OR prehospital OR ambulance OR emergency medical technician OR emt) AND (sex trafficking OR OR sex trafficking training OR human trafficking OR human trafficking training))

Limits: last 5 years, english, humans, prehospital care, paramedics, minors or children.

Databases searched: PUBMED.GOV 109 results, Fanshawe Library 62 results.

Search results: Studies must include information about child sex trafficking: be composed of training data about minors (under the age of 18); be in relation to education and training of paramedics; and be conducted in, or relevant to, an emergency prehospital setting.

Included for review: 3 articles will be looked at for the purposes of this CAT.

Title, author, year	Study design & LOE	Population	Intervention	Outcomes	Results	Weaknesses & Strengths
Development and Assessment of an Online Training for the Medical Response to Sex Trafficking of Minors Hansen, Sydney Melzer-Lange, Marlene Nugent, Melodee Yan, Ke Rabbitt, Angela 2018	Online training modules (75 mins) plus 3 surveys (pre-, post-, and 3-month follow-up) developed to assess changes. To identify "1) knowledge, awareness, and confidence in the identification and medical response and 2) the impact of the training on practice" Listening sessions of first hand accounts of at CST (child sex trafficking) were provided to medical professionals so they can learn to provide better care. LOE 3	HCPs 99 subjects completed the pretest. 66 completed all 3 surveys: 33 providers and 33 medical students.	Providers felt that they had limited level of education to help this vulnerable population. Medical providers preferred receiving the training independently with online modules. CST would feel more comfortable and welcomed to seek help if the provider "communication style is nonjudgmental and genuinely caring"	Providers are unaware of the extent of trauma with CST pts. Providers were unaware that this is a local issue.	Providers believe that this should this training should be a standardized practice. Learned about CST screening questions, "increased their overall confidence in caring for youth victimized by ST" Would like periodic refreshers of information.	+ training improved confidence and awareness + Improved clinical communication strategies + Because it is online it is easy to integrate it into a busy student schedule. - study size was small and therefore results seemed limited. - Not everyone took the 3 surveys and just completed the pretest.

Title, author, year	Study design & LOE	Population	Intervention	Outcomes	Results	Weaknesses & Strengths
Evaluation of a Tool to Identify Child Sex Trafficking Victims in Multiple Healthcare Settings Greenbaum, V. Jordan Livings, Michelle S. Lai, Betty S. Edinburgh, Laurel Baikie, Peggy Grant, Sophia R. Kondis, Jamie Petska, Hillary W. Bowman, Mary Jo Legano, Lori 2018	Pt completed self-report questionnaire regarding high-risk behaviours HCPs asked pt follow-up questions about their self-report questionnaire 17 questions: either fully complete or partially complete (if yes to one group of questions then move to the next set of questions) - if 2 or more questions had "yes" - considered a positive screen. - this is later followed up with routine questions to get further detail LOE 4	Different health care settings where most of the receiving calls are coming from. 16 U.S. healthcare facilities, including 5 pediatric EDs, 6 child advocacy centers and 5 teen clinics, all in urban areas. Criteria for participants: -English speaking, within age range: 11–13 years min; 17 years max -chief complaint: acute sexual assault/ abuse, or concern for CST -excluded: extreme developmental delays, intoxicated or marked distress, those who declined to answer questions, or those deemed unable to answer questions accurately by the examiner. - 930 pt participated.	CST victims can be feel many emotions when it comes to speaking with a HCP. Responsibility of HCP to complete survey Current screening tools take to too long to complete in a medical situation, want to develop a shorter screening method	81% of participants, HCP were able to determine CST status 19% HCP were not able to provide an answer.	Able to refine what CST status is that is beyond the current federal definition "HCP in teen clinics serving high-risk populations need to be vigilant about considering the possibility of CST when caring for adolescent pt" Modified screening tool can be used in other health care professions, adapted to their needs	-only looked at English speaking pt -relied on info from HCP at time visit: some youth were identified incorrectly (CST but not exploited) - because "real world" info is needed, there are no research coordinators - Some pt didn't want to answer questions or the HCP didn't have time to present the study to them +first brief screening tool for busy health care centers. + 81% improvement from existing situation, where victims move through healthcare facilities largely unidentified

Title, author, year	Study design & LOE	Population	Intervention	Outcomes	Results	Weaknesses & Strengths
Evaluation of a Screening Tool for Child Sex Trafficking Among Patients With High−Risk Chief Complaints in a Pediatric Emergency Department Kaltiso, Sheri-Ann O. Greenbaum, Jordan V. Agarwal, Maneesha McCracken, Courtney Zmitrovich, April Harper, Elizabeth Simon, Harold K. October 31, 2018	Previously used 6 item screening tool was administered verbally to participants. Positive screen: if 2 positive answers from 6 items: "true" CST victim by federal definition. LOE 4	Study completed in PED of a free−standing, inner−city children's hospital, age range from 10 to 18 years old. Chief complaints related to high−risk social or sexual behaviours 203 agreed to participate meeting chief complaint and criteria.	Apply and evaluate screening tool to identify CST victims pediatric emergency department (PED) population Evaluate the utility of the CST screening tool in a high−risk pt population presenting to a large inner−city PED	100 screened positive "total number of identified CST victims was 11, yielding a prevalence rate of 5.4% (95% CI = 2.88%–8.9%)" "The mean age of CST victims was 15.9 years (range = 13–18 years"	pts identified as positive for CST were referred to social services and received the current standard of care Since only two positives are needed, tool is used with higher sensitivity from HCP in high risk areas.	+ tool is short and can be easily administered in the busy setting of an ED - only when a researcher was present in the ED, survey was completed. - a history of sexual abuse and patient identification as LGBTQ - possible misdiagnosis due to using the federal definition of CST.

Comments:

A common topic among the articles I have reviewed is the mentioning of the federal definition of what children sex trafficking is. Understanding that will decipher what these articles meant by misdiagnosis of CST status. Since some of these articles are American, I am using the United States Department of Justice definition: "Child sex trafficking refers to the recruitment, harbouring, transportation, provision, obtaining, patronizing, or soliciting of a minor for the purpose of a commercial sex act. Offenders of this crime who are commonly referred to as traffickers, or pimps, target vulnerable children and gain control over them using a variety of

manipulative methods. Victims frequently fall prey to traffickers who lure them in with an offer of food, clothes, attention, friendship, love, and a seemingly safe place to sleep. After cultivating a relationship with the child and engendering a false sense of trust, the trafficker will begin engaging the child in prostitution, and use physical, emotional, and psychological abuse to keep the child trapped in a life of prostitution. It is common for traffickers to isolate victims by moving them far away from friends and family, altering their physical appearances, or continuously moving them to new locations. Victims are heavily conditioned to remain loyal to the trafficker and to distrust law enforcement. No child is immune to becoming a victim of child sex trafficking, regardless of the child's race, age, socioeconomic status, or location, and every child involved in this form of commercial sexual exploitation is a victim."

This definition is quite broad and it does not discuss the matter of consent. What about those children that had to leave a dangerous situation back home and met someone who can provide them with opportunities? They consent to the activities yet they are under the age of 13 and therefore they cannot properly consent. They can also consent because they want to help this person as they have helped them. I feel like those children are falling under the radar because they might have negative test results because many of the questions pertain to being forced to doing something. While they may not be forced, they are still unable to consent due to capacity of age. As a result, they are missing the opportunities of receiving the help they can benefit from.

Another concept I have not seen much about in my research is on those HCPs conducting the survey. This a traumatic experience for those to become victim to CST and possibly participating in a study could be triggering for them. They may be feel shame for falling victim to a situation like this among many other emotions, thus it is important for the HCP to obtain a level of empathy when conducting these surveys. They need to be nonjudgemental and approachable. It is up to the HCP to obtain this information as someone with an undetermined CST status may not willingly want to speak to someone. The articles I have found looked at how to make the survey more efficient but glimpsed over how the survey should be conducted- in reference to the environment the study took place, and the empathy levels of the HCP conducting the survey. The last study I looked at there was a research conductor that was present when the survey was being done. I feel that this is setting things up for a biased testing result rather than one where it would result in "real world" answers. The first study I looked at, does cover training for HCPs on expanding their sense on what CST is and reversing any myths about it; however, along with the other studies I reviewed that train HCPs to give higher sensitivity surveys, the topic of the empathy is not covered. This is a heavy matter where approach is crucial and without this empathic approach the survey should not be conducted as it may lose its efficiency in some cases.

Lastly, I want to comment on how effectively I was able to find information on this topic. I initially started to look for any specific training in a prehospital setting but I was not able to find anything. Then I broadened the topic and looked at other HCPs. I could only find one that I felt tackled this topic. I was going to change topics but then I decided to take this into account and look at the screening

tool currently in place and how effective it was. It was interesting to see that researchers are trying to update it as it was not practical to be done in a busy hospital environment. The second journal I've listed explains how creating a more time efficient screening tool can later be applied to other health care professions and adapted to their needs. I feel this is a start, perhaps with a more condensed screening tool in place, this could lead to more training around how it can used in a prehospital setting.

Considerations:
One limitation I have noticed in my research is that sample size is quite limited. Perhaps it was done to be efficient on time since the study of CST is a broad topic where many aspects of it can be covered. For example, the last two studies I looked at only covered patients that had a chief complaint of high risk sexual behaviours. The second journal listed only used English speaking participants which seems limited as some CST victims can be from different ethnic backgrounds. Moreover, trying to get CST patients to participate in these types of studies can be difficult as some may still be dealing with the trauma or afraid to be re-traumatized, which hinders the sample size as well.

The first listed article mentions that not all HCPs completed the surveys that came after the training modules- that only the pretest was completed. I understand the perspective that this profession can be not only be stressful but time consuming. It is sometimes difficult to have other responsibilities added on to our lives. I feel that the modified screening tool can help fix this issue by directing the training in a more specialized manner rather than broad training that covers areas that may not apply to the specific profession.

Clinical bottom line:
The efficiency of the current screening tool in place: how to improve it based on time and sensitivity. How to improve the direction of care and rectify misdiagnoses. Lastly, to bring awareness to HCPs that CST is something happening in local areas and how important it is to identify the risk factors as well as to be able to identify a CST victim for early intervention.

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