Foundations of Emergency Medicine
Foundations III: Guided Small Group Experience

Session 19: "Sex Based Crimes"
Unit: Special Populations

- **Agenda and Learning Objectives**
  - Case Part I – Sexual Assault (20 min)
    - Identify more subtle presentations of sexual assault
    - Discuss disease transmission risks after sexual assault
    - Discuss PEP in the context of sexual assault
    - Discuss best practices for charting of sexual assault cases
  - Case Part II – Sex Trafficking (20 min)
    - Learn to identify victims of sex trafficking
    - Learn how to manage and treat victims
    - Discuss resources for patients and medical providers
  - Case Concludes (10 min)
    - Review Session Teaching Points

- **Note to Facilitators**

  This is a session that begins with a sexual assault case and then asks the learners to identify human trafficking. It is a 50-minute large group question led discussion and does not require any additional materials to run the session. It may be helpful for the facilitators to review local resources for victims of sexual assault and human trafficking prior to facilitating this session

- **Case Part I –** Sexual Assault (20 min)

  - *DD is a 25-year old female who checks in to your Emergency Department for abdominal pain. Her vital signs are normal and her triage note says "here for generalized abdominal pain for a week". When you see her, she is very vague in her description of the pain stating "I don't know, it's all over and comes and goes". She is not able to provide much other history and she seems pre-occupied, looking several times at her phone and at the door while you are talking. She startles when the nurse opens the door to check her vitals. She also occasionally answers your questions with suspicion asking you "why do you need to know that?" when you ask her about sexual history.*

- **Discussion Questions with Teaching Points**
  - **What concerns do you have about this patient's presentation?**
    - Vague complaint and patient that is not particularly forthcoming
    - A patient that seems overly pre-occupied

- Particular complaints in females in particular should prompt investigation for red flags including abdominal pain especially if vague and generalized, headache and vaginal bleeding/pain

- **What questions can you ask to further investigate your concerns?**
  - There are many ways to tackle this but here are some ideas to get the conversation started
    - "You seem to be waiting for someone, can I try to find someone for you?"
    - "Sometimes when people don't want to talk about why they initially said they were here, they actually have another problem they want to talk about. Do you have anything else you want to talk about?"
    - "Are you feeling unsafe? You seem scared."
  - Involve the rest of your team, discuss your concerns in a private area with the nurse or social worker (if you can invent a reason for them to see the patient) → obtaining collateral and offering another safe space can often get to the bottom of these concerns
    - This is true in cases concerning for child abuse and neglect also

❖ **Case Part I Continues**

- *You ask DD if she has anything else she's like to talk about. You pause for a minute, which seems like forever to you, but then she starts to talk and states she was sexually assaulted 4 days ago and "just wants to get checked out". She refuses to discuss much of the details of the assault but denies physical complaints including vaginal discharge, bleeding or pain.*

❖ **Discussion Questions with Teaching Points**

- **Let's spend a minute talking about sexual assault. How common is it? How much does it cost our country? Why are these rates so high? What about false reporting of rapes?**
  - 1 in 6 women and 1 in 20 men in the US are the victims of sexual assault in their lifetime
  - It costs 450 billion dollars a year in both direct and indirect costs (ie lost wages, unintended pregnancies etc)
  - It is estimated that only about 40% of sexual assaults are reported, 25% of sexual assaults go to trial and 15% are convicted
  - There is a common misconception that false reporting rates for sexual assault is particularly high → this driven by popular news outlets preferentially running stories as they sell copy and make money → in fact the false accusation rate is about 7% which is the same as any other major crime (ie murder, burglary, physical assault)

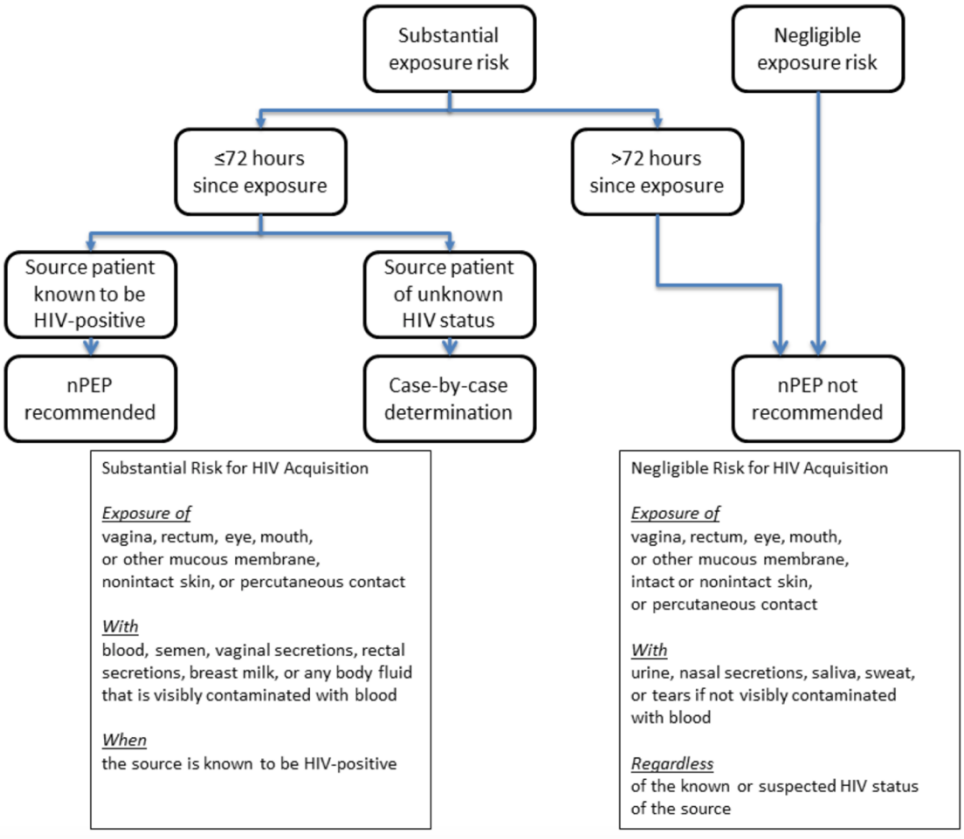
- **Let's talk about some basics of caring for the survivor of sexual assault? What should you do before you make contact with the patient? What can you do during the encounter to support your patient?**

- Start simply by believing your patient → they have undergone severe trauma and unfortunately, many will encounter disbelief and maltreatment by first responders and even medical providers
- Before you make contact, activate your resources → this is usually a victim advocate to support the patient and a SANE (sexual assault nurse examiner) if a forensic exam is being considered
- Consider waiting to fully interview the patient until the advocate is with the patient
    - We recommend meeting the patient briefly, assessing for any other serious injuries and offering them a victim advocate → please encourage the victim to have an advocate even if the advocate just sits with the patient in silence but respect their wishes if they do not want one
    - If they agree to having an advocate, explain that you will wait to fully interview and examine them until the advocate is present (and/or the SANE nurse depending on your institution)
- Remember that many (if not most) sexual assaults in the US are facilitated by drugs or alcohol (it is difficult to force a sexual act on an awake, fighting adult) → just because your patient is drunk or otherwise intoxicated doesn't mean they weren't raped!
    - Wait until they are sober to allow them to make an informed decision regarding their care
- The rate of sexual assault for marginalized members of society, those with mental illness and/or homelessness is staggering → a recent study showed that 13% of homeless women in their cohort had been raped in the last year and half of those women had been raped twice or more
    - Keep in mind that many of your homeless women, especially those with mental illness, have been raped in their life and sadly, many of them have been raped more than once
- Give your patient time and control over the medical encounter → they have just lost control over the most vital aspect of their person, their body, so allow them as much control back as you can give them
- Let your team know that you have a sexual assault case to minimize interruptions during your encounter

- **How do you determine the risk of disease transmission in this patient? For sexual assaults in general?**
    - Risk of transmission is highly dependent on the nature of the assault → traumatic assaults (ie with bleeding or other trauma), anal intercourse, lack of use of barrier protection and multiple assailants place the patient at higher risk[1]
    - Bacterial STI → dependent on the prevalence of STI in your community, however antibiotic treatment is extremely effective for prophylaxis so it should be offered
        - Gonorrhea
        - Chlamydia
        - Trichomonas

- Syphilis* (prophylaxis only if high risk in your community)

- Pregnancy
  - Highest risk concern → risk of pregnancy in a young woman after one episode of unprotected vaginal intercourse is about 2.5%
- HIV
  - Overall risk is low though has been reported in patients whose only risk factor is sexual assault
  - Risk of transmission from a consensual sex act in a known HIV positive patient is 0.1-0.2% for vaginal intercourse and 0.5-3% for receptive anal intercourse[1]
  - The risk for other sex acts, ie oral sex, is much lower
  - The risk for sexual assault is likely higher than these numbers as there is often trauma involved
- Hepatitis B
  - Transmission risk of hepatitis B is much higher than HIV (15x)
  - 1-2M people in the US are thought to be infected with chronic hepatitis B
- Hepatitis C
  - 3.5M people in the US are thought to be infected with hepatitis C
  - It is much less transmittable than Hepatitis B with a sex act (usually transmitted by needle sharing)



Source: CDC. Antiretroviral HIV postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. MMWR Recomm Rep 2005;54(No. RR-02):1–20.

- **What are the risks of PEP? How good are they at preventing disease transmission?**
  - HIV
    - Risks: GI upset, headache and myalgias (most common up to 20%), serious side effects including hepatitis and pancreatitis are rare (<0.5%)
      - Most patients are able to complete their PEP → give Zofran!
    - Efficacy: Extrapolated from health care worker exposure from needlesticks but studies show a 81% reduction of HIV conversion with nPEP
      - The earlier the medication is started the better it works, generally recommended within 72 hours
  - Hepatitis B
    - Risks: Negligent (injection site pain, allergy) → no reported cases of GB
    - Efficacy: Unknown for prevention of acute transmission but still recommended as HBV is 15x more infectious than HIV and the vaccine is low risk
      - 90% of patients will become immune after vaccination series
  - Pregnancy
    - Risks: Few significant side effects, can have GI side effects (nausea, vomiting, diarrhea) and cause irregularity in menses
    - Efficacy: Plan B (Levonorgestrel) or Ella (Ulipristal)
      - 95% effective within 24 hours, 89% effective within 72 hours but offer up to 5 days
      - Ella is slightly more effective than Plan B
  - HPV
    - Risks: Negligent (injection site pain, allergy) → no confirmed cases of GB
    - Efficacy: High

- **What medications would you offer this patient?**
  - Follow-up is poor overall for survivors of sexual assault (< 30%) so offer as many medications at the initial encounter as you can
  - Be clear with the need for follow up and why → importance of repeat testing and completion of vaccination series
  - Start with Zofran 4-8 mg PO because even with this, many patients will vomit!
  - Bacterial STI
    - Flagyl 2 mg PO for trichomonas prophylaxis
    - Ceftriaxone 250 mg IM for gonorrhea prophylaxis
    - Azithromycin 1 g PO for chlamydia prophylaxis
    - Consider IM PCN G 2.4million U if syphilis is prevalent in your community
  - Pregnancy
    - There are twp options (Plan B, Ella) both of which are effective for up to 5 days
  - HIV
    - This is based on the risk stratification as above → it is difficult when patients will not disclose full details

- If the patient doesn't disclose full details, we advocate having a hypothetical conversation with them about risk for both HIV and hepatitis B
  - "I understand you are having trouble talking about the details of what was done to you and I can completely understand that. I want you to know that certain types of assault carry more risk in terms of getting a disease like HIV or hepatitis. Assaults by multiple partners, those with anal penetration or traumatic vaginal intercourse are all higher risk. Do you feel like your assault was high risk in any of these ways?"
  - If so, discuss the risks and benefits of HIV PEP as above
- You can get further expert help about prophylaxis from the CDC at the National Clinician's Post Exposure Prophylaxis Hotline at (888) 448-4911
- Give your patient at least a week of medications and include Zofran as there are significant GI side effects

- Hepatitis B
  - Risk factors for hepatitis B transmission are similar to those for HIV as above
  - Hepatitis B is much more infectious than HIV
  - If unvaccinated, begin the vaccination series → repeat dosing will depend on the vaccine used but is generally within 1-2 months
  - Up to 10% of vaccinated individuals will not become immune to hepatitis B so if high risk, offer a Hep B booster and consider sending titers to confirm immunity (or refer for testing though be aware follow-up is poor)
  - No need for hepatitis B immunoglobulin
- HPV
  - Recommended for all unvaccinated female survivors between 9-26 and men 9-21 (unless MSM when it is recommended up to 26)
  - Need second dose at 1-2 months and again 6 months later

- **Would you offer a forensic exam to this patient? What about reporting to police?**
  - No, the patient is greater than 72 hours from the assault so a forensic exam will no longer be useful
    - This is state dependent but most states use 72 hours as the cutoff
  - Forensic evidence collection is highest yield in the first 24 hours and before bathing but should be offered up to 72 hours after the assault
  - If you do complete a forensic exam it is best done by a specially trained provider → this is usually a SANE nurse (sexual assault nurse examiner) but if that is not available, any ED provider can perform the exam
    - Each kit has instructions contained in it, if you do not have access to SANE nurses become familiar with the kit prior to completing an exam
    - Many hospitals have transfer agreements to facilitate patient transfer to designated "rape centers" which centralizes rape care within their system

- If you do perform a forensic exam and collect evidence, remember the chain of evidence → someone must be in physical contact with the kit to ensure there is no tampering until it is collected by the police

- **Would labs would you send on this patient?**
  - A pregnancy test
  - CMP and baseline HIV testing if you are starting HIV PEP
  - Consider Hepatitis B titers if the patient was previously vaccinated to determine if they will need to complete the series again (ie they are a vaccine non-responder)
  - Most would advocate **not** testing for GC at the index visit and just treating cervicitis or PID if you find it on exam (remember you are treating GC anyway with the prophylaxis medications) → we advocate not testing because if positive, these tests are often entered into court as evidence of the victim's promiscuity and prior bad behavior to call into question their moral character

- **What charting considerations should you have for sexual assault cases?**
  - Be specific in your physical exam and vague in your history
  - This is because your chart will become a part of the criminal investigation and discrepancies in details can call into question the victim's credibility
    - Remember that trauma profoundly effects memory formation and often makes it difficult to recall certain details
    - An example of this is charting "multiple assailants" as opposed to "three assailants"
  - In contrast, the physical exam (including bruising, scars, lacerations, abrasions or other signs of trauma as well as old scars, moles etc) can help a victim prosecute and will lend credibility to your chart → in fact, those assaults with objective physical findings are much more likely to be successfully prosecuted
  - Remember this may become a legal document so make sure to include who was in the room during your encounter → especially if you perform a forensic exam

- **Do you need to report this crime to the police?**
  - This varies by state so know your local law → some states require health care providers to report any sexual assault to the police (ie California) but the victim is not required to speak to the police or file a report → please warn your patients if this is the case!
  - If the patient is a minor, most states require reporting
  - The response of police in terms of support or the sensitivity of their questioning can vary greatly depending on the training of your local police force → please support your patients as much as possible while they are giving their statement → this would be a good time to have the victim advocate at bedside also if the patient desires

- **Who could you call to support this patient?**
  - Even if you are not performing a forensic exam, sexual assault hotlines are available and many communities have volunteers known as victim advocates who will come to the ED to support the patient
  - Make sure to ask the patient if they want support prior to calling though we advocate encouraging the patient to have an advocate as they are a wonderful resource → they can always ask the advocate to leave if they feel uncomfortable
  - These victim advocates are well trained and can be a significant source of support to the patient both in the acute setting as well as for follow up including providing resources and even counseling appointments → many will reach out to the patient in the days and weeks following the assault

- **What follow up does this patient need?**
  - As stated above, follow up for victims of sexual assault is poor (< 30%)
  - Most patients that re-present have a somatic complaint
  - Depression, anxiety and PTSD is common after sexual assault as is engagement in risky behavior
  - Please refer your patients to someone that is well trained in post assault care → link to resources within your hospital usually in the Ob/Gyn department for female victims
  - Encourage staying in touch with the rape victim advocate → they are a wonderful asset to help encourage follow-up
  - If HIV PEP was started the patient should follow up in a week to ensure medication compliance and consideration of follow-up labs → provide them enough medications (including Zofran) until they are able to follow-up
  - If HIV PEP was not started, the patient should follow up in 6 weeks at the latest for repeat HIV and Hepatitis testing, women should also be encouraged to repeat a pregnancy test also either at home or in follow-up
  - Remember the patient will need booster vaccines → this will depend on each patient and their individual circumstances but many of the vaccine series require the second vaccine between 1-2 months → discuss this with the patient
  - Sometimes you are the only provider the victim trusts, if you feel comfortable consider offering them a "follow-up" with you in the ED in a few weeks during a future shift → this can make an indescribable difference to some patients and their trust in the medical system

❖ **Case Part II – Human Trafficking (25 min)**

- *Just as you are finishing giving DD her medications, a man arrives to triage demanding to see her. He is rude and loud at triage so you are called to see him. You get his name and ask DD if she wants him to come back. She says "of course, he's my fiancé" but she seems scared when you tell her.*

- **Discussion Questions with Teaching Points**
  - **What additional concerns do you have about your patient now?**
    - You might be concerned this is the patient's assailant, that she is a sex worker or even the victim of sex trafficking

  - **What is sex trafficking?**
    - The federal definition that comes from the Trafficking Victims Protection Act of 2000
      - "Sex trafficking is the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age (*22 USC § 7102*)."

  - **How is coercion defined by federal law?**
    - Threats of serious harm to or physical restraint against any person
    - Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person
    - The abuse or threatened abuse of the legal process → this is especially pertinent for patients concerned about deportation

  - **What is meant by the term commercial sex act?**
    - The term "commercial sex act" means any sex act on account of which anything of value is given to or received by any person

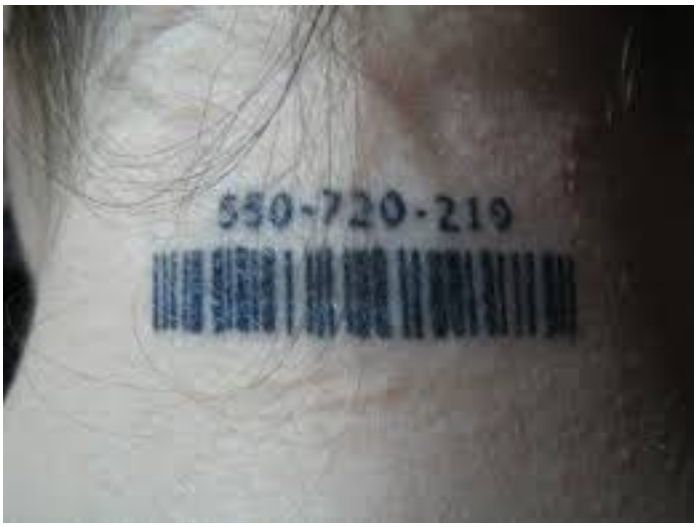
  - **When you think of a trafficker, what image comes to mind?**
    - Data is sparse concerning what an average trafficker looks like
    - **Face of a trafficker**
      - Most of us think of a male, but it is important to remember that traffickers can be any gender → this is important to remember in the ED as victims often present with their trafficker and if we only think of them as male we will miss some
      - They can be family members, friends, partners or a person that the victim does not know
    - **Victim becomes trafficker**
      - We often have this idea that traffickers have always been bad people who do bad things but it can be complicated
      - In some cases, those who were initially victims of trafficking may be promoted to new roles
        - For example, a victim of sex trafficking may be "promoted" to the role of recruiting new sex workers or being in charge of the girls in the brothel → they may find themselves in charge of others, but also under supervision from traffickers higher in the hierocracy

- **What are concerning initial patient presentations that should prompt further evaluation to determine if the patient is a potential victim of trafficking?**
  - No personal documentation or documentation does not fit appeared age of patient
  - Patient is unaware of her/his surroundings, location, current date, or time
  - Someone is speaking for the patient
  - Patient appears anxious, submissive, or tense
  - Patient may have difficulty maintaining follow-ups
  - Frequent messaging or calls on a cell phone during the encounter

- **What are some concerning red flags in a person's past medical history that may be concerning for sex trafficking?**
  - Encounters related to high risk sexual encounters
    - High number of sexual encounters
    - Multiple STI/STDs/UTIs
    - Multiple miscarriages or abortions
    - Unintended pregnancies
  - Encounters related to increased vulnerability
    - Drug and alcohol abuse: Frequent visits for intoxications and overdoses (intentional and unintentional)
    - Previous suicide attempts, uncontrolled mental health conditions
    - History of sexual/physical/emotional abuse
  - Encounters with suspicious injury patters
    - Multiple visits for trauma related injuries
    - Injuries related to violence such as gun, knifes, strangulation etc
  - Encounters related to multiple visits for non-emergent and chronic illness related conditions, aka frequent flyers
  - Inconsistent or changing history, history does not match injury
  - Unfamiliar with area that they are in, indicators of having not been in town long or not getting out much

- **What are concerning physical exam findings that can be found in victims of sex trafficking?**
  - It is important to remember that many victims of human trafficking will not have **any** physical signs of abuse → in some cases it may only be noticed in well healed scars, their non-verbal behaviors, and medical history
  - Many of these findings are common in the ED, the goal of this session is to heighten your awareness when patients with one or more of these findings presents for care
  - **Signs of physical abuse**
    - Bruising in different stages, fractures and dislocations, burn marks, broken and missing teeth, marks concerning for ligature or strangulation, poorly healed fractures, poor repair of lacerations
  - **Sexual abuse**
    - Trauma to the genitalia or rectum, packing found in vagina

- **Mental health**
  - Signs of a suicide attempt, anxiety, depression, PTSD, poor eye contact, emotional lability
- **Signs of alcohol and drug abuse**
  - Needle marks, drug paraphernalia, malnutrition, brought in by the police for evaluation of alcohol or drug intoxication
- **Signs of control**
  - Tattoos used for branding, findings related to untreated chronic medical conditions, uncooperative or avoidant of the examination



https://commons.wikimedia.org/wiki/File:Neck_barcode_tattoo.jpg

- **Anyone can be a victim a human trafficking, but there are some populations that are more at risk to be exploited. What populations are at highest risk of human trafficking?**
  - Most marginalized populations are at risk for trafficking
  - Children in the welfare or juvenile system
  - Runaway Youth & Homeless youth
    - Many teens will engage in survival sex but by definition and law, individuals under the age of 18 cannot consent to commercial sex acts and are considered victims of human trafficking
  - Children Working agriculture
  - American Indians and Alaska Natives
  - Migrant labors
  - Foreign national domestic workers
  - Employees of business in ethnic communities
  - Populations with limited English
  - Person with disabilities

- LGBTQ

- **What are the steps of caring for patients who are victims of human trafficking?**
  - Involve you team, communicate any concerns you have with your nursing staff who can help further investigate and try to get the patient alone
  - **Think of the 5 C's**
    - **Care** for all medical needs first, which includes mental health emergencies
    - **Consider** red flags of human trafficking
      - You may need to hand off your concerns to the next provider → times of acute psychosis, intoxication or critical illnesses are likely not the time to discuss your concerns of human trafficking with the patient
    - **Communicate** with the patient about your concern for their well-being → it is important to establish that healthcare is a place of safety and non-judgement
      - Remember that many patients will not identify as a victim of human trafficking
      - Try to get the patient alone (see below)
      - Sometimes, our role is to plant the seed that there are people who care, that the ED is safe and that they are worthy of being cared for
      - Tell them that you are concerned that their situation does not seem safe
      - Ask the patient if it is ok if social work or someone speaks to them further about their current situation
      - Remember that these conversations should be based on a trauma informed approach and will likely take time → making them feel safe, starting the conversation and planting the seed is the first step
      - It is advisable to have a system in place that designates who will further evaluate the patient for concerns of human trafficking as this will take time (in most institutions this is a role for the social worker)
      - If you are comfortable and have the time to fully evaluate the patient's needs, remember to limit distractions and monitor the patient for signs of stress → they may need breaks during the evaluation
    - **Contact** social work and support services to further evaluate the patient needs, only if patient agreeable
      - If there is a concern for a mandatory report, discuss with your social workers, hospital legal and co-workers
      - Please advise patient of the reasons why social work and services must be contacted
      - Many victims of human trafficking may be fearful of interactions with law enforcement
      - Only speak with law enforcement if the patient desires law enforcement assistance.
    - **Connect** patient to resources and set-up follow-up appointments as needed
      - Remember to always inform patients that can return to the ED for assistance

- **What are some strategies for getting the patient alone?**
  - These are some ideas, obviously there are many others as the trafficker is often very reluctant to leave the victim alone → invoking hospital "protocols" can be very useful
    - Order a XR and meet the patient in radiology
    - If a pelvic is needed, tell anyone in the room that hospital protocol states they must be alone
    - As above, discuss with your nurses and other ancillary staff → they can help obtain collateral information and get the patient in a private space

- **What is the goal of the encounter?**
  - **Create a safe healthcare environment**
    - The goal of the encounter is to establish that healthcare is a safe and non-judgmental place to come to at any time
    - The goal is not to get the individual to disclose their situation as it often takes several visits for someone to disclose
    - Remember, it is not a failure on our parts if someone that we are highly suspicious is a victim of human trafficking does not disclose → we succeed when we offer compassionate care and start the conversation!
  - **Understand why some people may not want to disclose**
    This is not an all-inclusive list, but does contain common reasons someone would not want to disclose their situation
    - Fear of harm from trafficker
    - Fear of deportation
    - Concerned about legal actions against them for charges like prostitution, petty theft, drug possession, etc
    - Fear that their children may be taken away from them
    - May not have trust in healthcare providers as some victims of traffickers had "clients" who were healthcare providers.
    - Complicated relationship with trafficker. Often times, the initial relationship between a victim and human trafficking began with a courting phase.
    - Shame from their situation

- **How do I document a suspected or confirmed cases of human trafficking?**
  - These are charts that should be read twice for errors and clarity as they could become a part of a legal case
  - **HPI**
    - Keep the history clear, concise and medically relevant
    - Remember how trauma may affect memory formation and keep specific details to a minimum (ie exact times, locations etc)
      - It is important to remember that patients who have been through a traumatic event (including both of the events discussed in this session) may not be able to recall the event well due to the effects that stress has on memory formation

        - As a consequence, the patient may describe the event with slight variations
        - These slight variations can sometimes lead people to doubt the credibly of the victim so writing your HPI keep this in mind → do not get caught up in small details and keep your HPI medically related (see sexual assault above)
    - **Physical Exam**
        - The physical examination on the other hand should be very detailed
        - It is important to document old scars, surgical scars, recognizable birthmarks, tattoos, etc. → if obtaining photographs remember to obtain consent
        - Don't forget to document the mental health examination
        - Consider leaving out your estimate of the age of ecchymosis → there are many factors in the way people heal (this goes to the point above)
    - **Assessment**
        - Discuss your concerns of trafficking and why
            - Is the patient's story or perhaps even the accompanying persons description consistent or inconsistent with your examination?
        - Describe what resources were offered and if the patient accepted any resources.
    - **ICD-10 Codes**
        - As of October 1st, 2018, there are 16 particular codes for victims of human trafficking including adults and minor

- **What special considerations are needed when working with minors?**
    - **First of all, there is no such thing as a teen prostitute!**
    - Based on federal anti-human trafficking laws, individuals under the age of 18 cannot consent to commercial sex work
    - Minors, even if they state they are participating in sex work by choice, are victims of commercial sexual exploitation
    - Unfortunately, we are sometimes all too often quick to judge and label our patients as promiscuous and bad decision makers
    - Moreover, some states are still able to charge teens as prostitutes
    - When you have a minor engage in risky sexual behaviors, please remember to take a trauma informed approach and look beyond just the behaviors to how the patient came into those situations!
    - Remember, caregivers can be traffickers

- **What about reporting cases of suspected sex trafficking in a minor?**
    - If the situation is clearly a case of sex trafficking, then the case is subject to mandatory reporting
    - However, the presentation may not be clear from the initial interactions → these are some examples
        - Multiple visits: It may only begin to evident when the patient presents multiple times with concerning history and exams that as providers we begin to recognize signs of trafficking

- Sexual Assault: Another case in particular that can be difficult to determine is when a minor presents with a sexual assault and features that are also concerning for human trafficking
    - Making this distinction has important implications
    - Teens often have the right to control their medical care including the disclosure of the assault to police and their parents and we have the obligation to protect their medical privacy in these instances. State laws can vary considerably in terms of mandatory reporting based on the ages of all parties and whether or not a caregiver is involved. Please be familiar with your state laws.
    - When the situation is not clear, be sure to use any available resources to help determine if the case is a mandatory report –> this can include social workers, state victim assistance hotlines and the National Hotline for Human Trafficking (available 24/7 for consults)
    - It is extremely important to inform the teen why you need to make a mandatory report or you will severely jeopardize their trust in the medical system moving forward
    - Remember, mandatory reporting for child abuse and exploitation does NOT require a full disclosure. It is considered a mandatory report when there is ***sufficient*** concern about the situation.
- Family: Family members can also be the victim's trafficker → this can further complicate identification of victims of trafficking because as providers we don't usually think of family members as threats → try to get the patient alone!

- **What resources are available to providers?**
    - National Human Trafficking Hotline: 888-373-7888
    - State Victim Crisis hotline numbers
    - Human Trafficking Hospital Protocols → if your hospital does not have one, the National Human Trafficking Center/Polaris Project has one that can be used as a guide at https://humantraffickinghotline.org/audience/service-providers
    - SANE/SART programs
        - These programs have the benefit of well-trained providers in forensic examination and understanding of the chain of evidence. They also often have access to patient advocates for support of the victim of sexual abuse even if not in the acute setting (ie patient is not presenting for active sexual assault complaints)
    - Social workers → often have a great understanding of state laws, mandatory reports and community resources that the patient may need

- **What resources should be offered to victims and survivors of human trafficking?**
    - It is important to identify any community resources that have experience working with victims and survivors of human trafficking

- Ask the patient how they would like the information given to them → remember, it may be a dangerous situation for the victim of human trafficking to be found by their trafficker with helpline numbers, shelter addresses, etc.
- Consider offering the following resources
    - Shelter: Patient need a safe place stay or safety plan for when they are ready to leave
    - Food: Local food banks and community assistance in the area
    - Medical: Need a primary care physician and mental health provider to follow them for their medical needs
    - Addiction treatment: Many victims and survivors will need assistance with addiction from alcohol and drugs
    - Legal: Some individuals need help with immigration concerns and prosecution of traffickers
    - Support groups: Any local groups and the National Survivor Network https://nationalsurvivornetwork.org/

❖ **Case Concludes (10 min)**

- *You get DD alone by informing the man with her that you need to perform a sensitive exam and no one but yourself and the nurse is allowed in the room. He argues some but finally gives in and leaves. You ask her some follow up questions including "is there anyone in your life that makes you feel unsafe?". She finally nods yes and haltingly tells you she is from Colorado and met the man she is with while trying to buy drugs from him. He offered her to try the "goods" and when she woke up she was in a car and had no idea where she was. Since then he's been driving her long distances across state lines and forcing her to have sex in exchange for money or drugs. The man she was with today fell asleep while they were together and she was able to leave to come to your ED. You offer her help including calling the police but she says no and won't tell you why. You reinforce that the ED is always a safe place and she can come back at any time. She thanks you for listening, asks for her discharge paper work and leaves several minutes later. You feel as if you should have been able to do more for her but take comfort in that at least you were able to start the conversation and hopefully she will feel the ED is a safe place in the future. She does not return to your hospital system.*

❖ **Case Teaching Points Summary**

- Sexual Assault
    - Sexual assault is shockingly common in the United States → statistics are difficult to track as many are not reported but it is estimated that 1 out of 6 women and 1 out of 20 men in the US are assaulted during their lifetime
    - Diseases that should be considered for prophylaxis after a sexual assault include pregnancy, HIV, HBV, GC and syphilis
    - The nature of the assault will help determine the need for prophylaxis → bacteria STI treatment should almost always be offered, pregnancy prophylaxis should be offered for

vaginal assaults and HBV and HIV should be offered for high risk assaults (traumatic, multiple assailants etc)
- The earlier prophylaxis is offered the more effective it is
- The earlier the forensic exam is done the more likely it will be to find evidence of the assault
- Be vague in your charting of events as discrepancies can call into question the victim's credibility → remember that trauma has been shown to affect memory formation especially and it is not uncommon for our trauma patients to struggle to piece together events
- Be specific in charting your physical exam (both with signs of trauma and other skin findings) and consider pictures (always obtain consent!)
- Call on your resources to support your victims → this includes SANEs and victim advocates which are available in most communities
- Remember to believe your patients → don't add to their trauma by questioning what happened to them and remember most assaults are facilitated with drugs and alcohol
- Our most vulnerable populations, drug and alcohol addicted, homeless and those with mental illnesses, face exceedingly high rates of violence including sexual assault

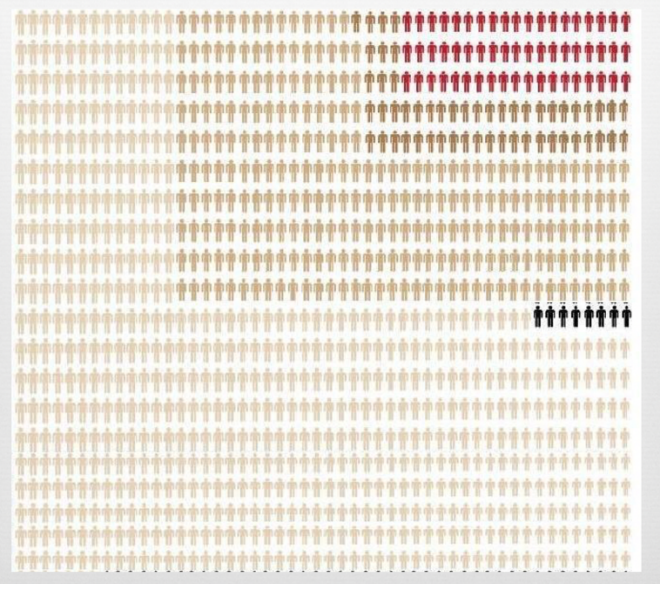
- Human Trafficking
  - Victims of sex trafficking can be anyone from anywhere with any background. The same is true for the trafficker who present with them.
  - Identifying sex trafficking can be difficult. It requires a high index of suspicion and often involves difficult to work with patients; such as frequent flyers, psychiatric related presentations, and drug/alcohol encounters. It's presentation may also be hidden in trauma related cases or sexual assaults. If you don't think about it, you won't identify it.
  - Remember the 5 C's. **Care** for all medical needs first. **Consider** Human Trafficking Red Flags. **Communicate** your concerns with the patient and healthcare staff. **Contact** social work and support services, like SANE/SART to help further evaluate the patient. **Connect** the patient with resources.
  - Disclosure is not the goal. The goal is instead focused on the 5C's, which means creating a safe healthcare environment and supporting the patient's goals of the encounter. Use a trauma informed approach to ask more questions when red flags are present.
  - Only involve law enforcement with the consent of the patient or when mandatory reporting incidents require this action.
  - Remember teens cannot engaged in consensual prostitution → they are victims of commercial sex trafficking!

❖ **Facilitator Background Information**

Sexual Assault

Sexual assault is shockingly common in the United States. Though tracking statistics is difficult as many assaults are not reported, it is estimated that 1 in 6 women in the US will be victims of sexual assault during their lifetime. Males are also at risk with an estimated 1 in 20 experiencing assault. Homosexual men are thought to be generally at higher risk. The sequela of sexual assault are extensive on both the personal and societal level with high levels of anxiety, depression and PTSD seen after the assault. It is estimated that sexual assaults cost the United States 450 BILLION dollars a year in direct and indirect costs.

Societal views also heavily effect how sexual assaults are handled and processed in the United States and statistics are difficult to track as there are many confounders including attrition through the court system and under-reporting. The figure below is a visual representation of the outcomes of sexual assault cases in the United States using the best data available. The total figures represent 400 cases of sexual assault, the medium tan figures represent the number reported (40%), the darker tan figures represent the number of cases that go to trial (25%) and the red figures represent those cases that lead to conviction (15%). The black figures are the number of false accusations (about 7%). There is a misperception in the public regarding the incidence of false rape accusations which further affects survivor's willingness to come forward after an assault. Based on Department of Justice data, false accusations of rape are as common as false accusations of any other serious other crime including at about 5-7%.



Caring for victims of sexual assault in the Emergency Department can be extremely challenging. These patients are traumatized and require delicate management which is best handled by a multi-disciplinary

team approach. ED practitioners should be well versed in the local resources available to their patients including rape advocates to provide support during the ED encounter. These resources should be mobilized early in the patients care. From a medical perspective, the patient should be evaluated for other signs of trauma first to ensure they are stable to undergo a forensic exam. Forensic exams are most useful the earlier they are performed and should generally only be offered if the assault occurred < 72 hours prior (this will vary by state). Forensic exams should be performed by specially trained providers if available, in most systems this will be a SANE nurse (Sexual Assault Nurse Examiner). However, if a SANE is not available, any ED provider is able to do evidence collection. Once the "rape kit" is collected, it is important to remember chain of evidence, someone needs to be physically responsible for the kit at all times until it is collected by the police.

From a medical standpoint, the most pressing question in sexual assault will be prophylaxis for disease transmission, namely HIV, hepatitis B, STIs including gonorrhea, chlamydia and syphilis and finally pregnancy prophylaxis. The nature of the assault, if known, will help the provider determine the need for prophylaxis. Higher risk assaults include those with anal penetration, other GU trauma or multiple assailants. These high-risk features increase the chances of disease transmission. Overall, it is thought that the average risk of transmission of HIV from consensual vaginal intercourse is 0.1-0.2% while it can be up to 5% for receptive anal intercourse. It is thought that these rates are higher in nonconsensual intercourse as there is more likely to be trauma. HIV PEP should be offered as early as possible in high risk encounters but can be offered up to 72 hours after the assault. HIV prophylaxis is effective up to 85% of the time in preventing disease transmission (extrapolated from post-exposure data) and serious side effects, generally hepatitis or pancreatitis, are rare (< 0.5%). ED providers should give patients at least 7 days-worth of medications and refer them for follow-up to ensure compliance and monitoring. Make sure to discharge your patients with Zofran also to offset the common GI side effects.

Hepatitis B is up to 15x more transmissible than HIV and prophylaxis for HBV should also be considered especially in high risk assault. Offer Hep B vaccination for all non-vaccinated patients, they will need to continue their series in follow-up, and consider drawing titers on vaccinated individuals (or referring for follow-up titers and offering a booster at the index visit) as there is up to a 10% non-responder rate for the primary hepatitis B vaccination series. HPV vaccination should also be offered to all unvaccinated females up to 26 years, all males up to 21 years and MSM up to 26 years.

Prophylaxis for bacterial STIs should be almost universally offered for sexual assaults. This includes IM ceftriaxone, PO flagyl and PO azithromycin. These treatments are very effective though patients should still be counseled to undergo a test of cure. Remember, these medications are tough to take so offer Zofran!

Finally, pregnancy prophylaxis should be offered to any victims of sexual assault with receptive vaginal intercourse. These medications are also most effective the earlier they are given but can be offered up to 5 days later. Ella (ulipristal) and Plan B (levonorgestrel) are both options with Ella being slightly more effective than Plan B. Pregnancy testing should be obtained at the index visit.

Testing in the ED is variable depending on the nature of the assault. Pregnancy testing should be done in all female victims to ensure the safety of subsequent medications given. Generally, we advocate that GC testing NOT be sent as this will often be introduced into evidence at a trial of the patient's sexual behavior. The patient will be receiving treatment for GC as prophylaxis regardless so we advocate for simply treating what you find on exam (ie give doxycycline if you find PID). If it is a high-risk assault and you are prescribing HIV prophylaxis, a baseline HIV test should be sent in addition to LFTs and a BMP. In a high-risk assault, you can also consider sending hepatitis B titers on your previously vaccinated individuals to ensure they are a vaccine responder. You could also simply give them a booster as there is little risk to this and have them follow up for formal titers. As a general resource, the following website can be shared with patients to search for local STI testing (https://gettested.cdc.gov/search_results).

Finally, a word on charting. If the patient's case goes to court, so will your chart. Be sparse in the description of the event as if there are discrepancies in your reporting and other statements, it will call into question the victim's reliability. Remember that trauma has been shown to affect memory and it is common for victims of trauma, sexual assault as well as others, to have trouble piecing together events in precise detail especially in their initial visit. Document only what is medically necessary and use non-precise language (ie "multiple assailants" instead of "3 assailants"). Conversely, use the opposite approach when documenting your physical exam. Be as specific as possible with signs of trauma including bruising, bite marks or ligature marks and include other skin findings, scars, moles etc as this will lend credibility to your chart. Often the police will take pictures but if not, consider getting consent to take picture of any injuries you find for inclusion in the chart.

Follow up should be encouraged though generally follow-up is poor with less than 30% of victims seeking care after the index visit. Try to find providers in your community that are trained in the follow-up care of sexual assault patients as these encounters are very difficult for survivors. Write down all follow-up instructions as well as the importance of why follow up is being recommended (test of cure for STIs, lab testing for HIV prophylaxis etc) in detail as much of the verbal information will be lost in the post-traumatic setting.

Victims of sexual assault are an extremely vulnerable population. Their trust has been shattered and unfortunately, they often face disbelief about their trauma even from medical providers and first responders. You are not part of the legal team and it is not your job to figure out what happened except as needed to provide medical care. Please begin the medical encounter by just believing your patients and calling on your local resources to provide support to them in an extremely difficult time. Remember, most sexual assaults are facilitated by drugs and alcohol. Allow your intoxicated patients time to make informed decisions about their care, including forensic exams, and start by simply believing them.

Human Trafficking

Human trafficking (HT) affects individuals of all ages, genders, races, sexual orientations, and socioeconomic levels, which makes it difficult to identify potential victims of HT. Trafficking occurs every day in large cities and rural towns throughout America and involves individuals manipulated and

coerced into exploited roles in both labor and sex work. As a consequence of their situation, survivors of HT often have significant mental health and medical problems.

As emergency health care professionals, we are in a unique role to identify and assist victims and survivors of human trafficking. Studies have shown that between 28-88% of victims of HT seek medical care during the time when they are being trafficked. Nevertheless, only 5% of EM physicians feel comfortable identifying and treating possible victims of HT. The purpose of this protocol is to assist providers with resources to increase their comfort with evaluating and treating patients who are suspected survivors of human trafficking.

It is important to remember the goal of each encounter is to create a safe health care environment for the patient and staff. Disclosure of incidents of human trafficking should not be the priority. Instead our focus is to assist victims of HT with their medical needs and connect them to safe housing, counseling support, legal assistance, and additional resources as wanted and needed.

Please remember to use a trauma informed care approach and to utilize all health care and community resources. Patients should understand that they are safe in the emergency department and that they are in control of how the encounter goes. They should know that you will work with them to address their medical problems or with anything else that they need. Many victims will not be ready to ask for help. They should not be forced to accept resources, nor should you feel like you have failed if they are not ready to disclose their situation. If they understand that the Emergency Department is a safe place that they can come to at any time, that is enough. Whenever possible, involve a social worker early to assist with any potential cases of HT, especially when there is concern for mandatory reporting. Only contact law enforcement when appropriate.

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- **Author:** Dr. Shannon Findlay and Dr. Natasha Wheaton
- **Expert content provided by**: Dr. Carolyn Sachs (UCLA Domestic Violence Committee Chair)
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