PERSPECTIVES

Domestic Minor Sex Trafficking: Guidance for Communicating With Patients

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Domestic minor sex trafficking (DMST) is the "recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" within domestic borders in which the person is a US citizen or lawful permanent resident <18 years of age.[1] Over recent years, the perceived paradigm of youth involved in sex trafficking as mainly international criminals and prostitutes has shifted to domestic victims in need of services; this shift has been the result of increased knowledge and research. Potential indicators linked to DMST involvement are described in existing literature, such as runaway behaviors, substance use and/or abuse, dysfunctional home environments, and histories of child sexual abuse.[1,2] Moreover, victimization is associated with health consequences, such as recurrent sexually transmitted infections (STIs), unwanted pregnancies, and untreated chronic medical conditions.[1,2]

In an effort to enhance prevention and identification, researchers have attempted to develop screening tools; however, there are limitations, such as small sample sizes, a lack of generalizability (eg, single geographic area), and no current valid and reliable tools.[3] A separate list of screening questions specifically for DMST may be seen by providers as time consuming, irrelevant, and disruptive in their practices. It is also not clearly defined which patients should be screened given that predictive validity of risk factors in the literature does not exist and true prevalence rates of DMST are unknown.[4] Patients may have unanticipated features of a trafficked minor (eg, living at home and doing well in school) and therefore are not screened.[2] Subpopulations of DMST-involved youth (ie, boys; lesbian, gay, bisexual, transgender, and queer youth; and preadolescents) may also be particularly difficult to identify.[5]

Given these significant challenges, when a physician uses a universal adolescent risk screening tool (eg, HEADSS, the home education, employment activities, drugs, sexuality, and suicide screening tool), a conversation about DMST may be considered concurrently.[6] If a preadolescent or adolescent has a positive screen result for high-risk factors (Table 1), the following is a recommended guide for a conversation about DMST in the medical setting.

Screening questions should be prefaced by establishing a bridge of understanding between the provider and patient. Researchers in a qualitative study who interviewed 21 sex-trafficking survivors identified that providers should normalize the situation through a nonjudgmental approach to remove stigma and shame from the trafficked person.[7] For example, a useful technique is leading with, "I have patients who are involved in selling or trading sex for things like (blank)." This blank can then be filled in with commodities that the evaluator deems potentially relevant to each youth on the basis of the evaluation. For instance, clinicians may discuss a place to stay if evaluating a patient who has run away or money for a minor who express financial concern.

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TABLE 1 Potential High-risk Factors of DMST

Social-Environmental	Psychological
Homelessness, running away from home	Substance use and/or abuse: drugs and alcohol
Child protective service involvement	History of psychiatric diagnosis (eg, depression and anxiety)
Unexplained or multiple absences from home, school, or group home	Suicidal ideation
LGBTQ status	Self-injurious behaviors
Family dysfunction (eg, domestic violence)	
Developmental delays	
History of maltreatment	
High-risk sexual behavior	

LGBTQ, lesbian, gay, bisexual, transgender, and queer.

The patient should then be asked if he or she is aware of or familiar with such exchanges involving sex and something of value (ie, sex trafficking). Female sex-trafficking survivors recommend that professionals be direct when asking about sex-trafficking involvement, similar to how other health-related questions are asked.[7] If the child acknowledges knowing about trafficking, the evaluator might then ask a follow-up question that is more proximal to the patient, such as whether the patient knows an acquaintance or a friend who has engaged in this activity. An appropriate question may include, "Have any of your friends been asked to have sex in exchange for something they wanted or needed?" If the patient answers affirmatively again, then the clinician can move on to asking more specific questions regarding the patient's potential involvement.

Beginning with a general discussion about sex trafficking and asking increasingly proximal questions in this manner is often referred to as a funnel approach. Providers should begin this discussion by defining sex-

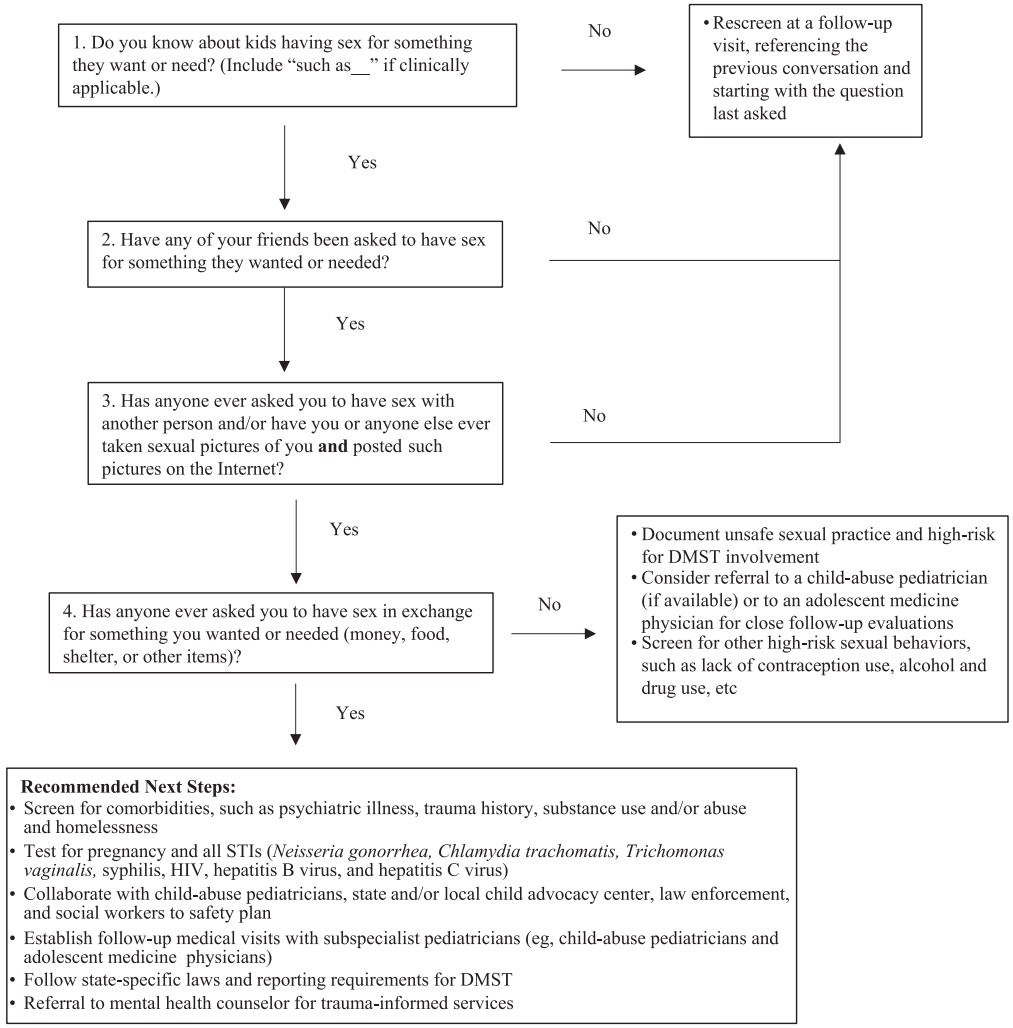

FIGURE 1 Flow diagram guide for conversation about DMST.

trafficking involvement to the youth. Similar to screening for sexual abuse and other sensitive matters, the aforementioned method can be particularly effective in diminishing discomfort, shame, and guilt for the potential victim, thereby facilitating a discussion and potentially disclosure. Furthermore, the clinician can gauge the amount of knowledge the patient has about DMST and establish his or her level of risk. Engaging in an open, nonjudgmental conversation with the youth pertaining to specific issues relevant to the patient as opposed to using a list of screening questions is recommended; the clinician should focus on how questions are asked (Fig 1).

Importantly, if the patient acknowledges knowing about sex trafficking and/or knowing someone who has been involved but denies personal involvement, there is an opportunity to provide early, preventive education about the consequences of involvement. Engaging the patient in a discussion about sex trafficking, which is potentially viewed by the patient as a stigmatizing and intimidating topic, establishes that the clinician is a safe clinical resource for future discussion. The clinician should note responses to these questions to inform follow-up medical encounters and future DMST screening. Other health care providers (eg, in the emergency department and adolescent medicine) may adjust future medical practice (eg, STI prophylaxis) on the basis of documented discussions with the patient about DMST.

There are no DMST-specific interventions or uniform guidelines available should a patient screen positive for involvement or be at considerable risk. However, physicians can begin to address comorbidities of DMST, including trauma histories, homelessness, and substance abuse. Establishing collaborative relationships with direct communication with outside agencies and providers who offer resources for the medical and nonmedical needs of these youth is important.[5] For instance, referrals can be made to mental health counseling, such as trauma-focused behavioral therapy and substance-abuse treatment. Follow-up medical visits should be made with subspecialist pediatricians, such as child-abuse pediatricians and adolescent medicine physicians. Safety planning for involved or at-risk youth should be discussed with law enforcement, the state and/or local child advocacy center, and social workers. Additionally, the patient should be tested for pregnancy and all STIs and be offered prophylaxis. Advocacy for this patient population is broad and individualized and includes identifying educational opportunities (eg, alternative educational settings with smaller classes), appropriate housing and guardianship, specialized medical care (eg, psychiatry and dental), mental health counseling, and legal assistance.[1,2,5] By participating actively with a multidisciplinary team of providers with frequent and bidirectional communication, physicians can begin to address the multifaceted needs of these youth.

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