CASE REPORT

Through the looking glass: A second chance at identifying victims of human trafficking

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ABSTRACT

It has been estimated that around 37%-50% of trafficked persons encounter healthcare professionals during their captivity, with one extensively studied report finding as many as 88% of trafficked persons having contact with a healthcare provider during their exploitation. The purpose of this study is to identify common "red flags" and provide resources, on a case-by-case basis, for possible or confirmed victims of human trafficking. Methods: Institutional review board approval was re-ceived and a retrospective chart review was done, of patients who were evaluated and/or treated by psychiatry in an acute care setting. Multiple patients had exhibited "red flags" for human trafficking. However, due to lack of adequate training to screen for human trafficking, some patients were discharged with inadequate resources to assist with improving their quality of life. There should be more training for health care workers, particularly in Psychiatry, on how to screen for human trafficking and on various resources that are available for a safe disposition.

Key Words: *human trafficking; psychiatry; health care; screening for trafficking; red flags for human trafficking; emergency psychiatry*

INTRODUCTION

There are over 29.8 million victims of modern slavery in the world today. This means that approximately 1 in every 236 people are b-eing trafficked [1]. Victims of human trafficking include US-born and naturalized citizens, permanent residents, legal visitors, and undocumented immigrants. They are trafficked in commercial sex and myriad forms of labor settings, including domestic work, agricultural work, and construction work [2]. From the clothes we wear, the food we consume, the services we indulge in like manicure, to the hotel room we stay in during our vacations, the implications of modern slavery in our daily lives are widespread.

Over 87.8% of trafficking survivors have reported contact with healthcare providers while they were being trafficked, of which over 63% report this encounter was in an emergency room setting. In a study of 192 trafficking survivors, 63% of survivors reported 10 or more concurrent somatic symptoms, the most common of which included headaches (82%), fatigue (81%), dizzy spells (70%), back pain (89%), memory difficulty (62%), stomach pain (61%), pelvic pain (59%), and gynecologic infections (56%). Other health problems associated with trafficking include complications from unsafe pregnancy terminations, chronic pelvic pain, unexplained weight loss, poor dentition, anxiety, depression, posttraumatic stress disorder, and suicidal ideation [3].

New York (NY) is considered the "New Capital of the World" and a fertile ground for human trafficking. It is the fourth state (after California, Texas, and Florida), with over 2,000 children trafficked each year (Polaris, 2019 Statistics from the National Human Trafficking Hotline.). Brooklyn, and especially Sunset Park, is one of the biggest destinations for trafficked women. Per an article written in April 2018, NYPD rescued one person a week from sex slavery and caught 228 traffickers while working on 265 sex trafficking cases, which was more than double the number in 2016. At that time, the Department of Justice convicted a total of 439 human traffickers, which increased to 691 with 1024 investigations in 2019 (Department of Homeland Security) [4]. Traditionally, human trafficking was a problem to be solved by law enforcement, but more and more it is becoming a public health issue, with a public health potential solution. Despite this widespread problem there are few coordinated health care efforts to identify these victims at the point of entry (usually the emergency room), partially because victims "look" different depending on the community they are from, and are forced to work in. In order to help pinpoint the specifics of our community and therefore better identify and help these individuals, the study team decided to compile a case series, to identify similarities in presentation and red flag signs. Healthcare providers, and even more those involved in the area of emergency work and mental health, need training in working with this vulnerable population.

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It is imperative to be prepared to identify, offer treatment and resources to victims of human trafficking, even when they might not be ready at that moment to take any additional steps. Human trafficking has unfortunately become an "industry" and as healthcare providers, we can make a significant change in their lives.

METHODS

Over the course of a year and a half, the team identified a number of adult patients who were either suspected of being trafficked or confirmed victims of human trafficking. IRB approval was obtained to retrospectively access their electronic medical records. Based on certain red flags, we selected 6 patients that met our inclusion criteria: confirmed or very high suspicion of being trafficked, from or working in our community, context that could not be better explained by other mental health conditions or psychosocial stressors. Children were excluded from this study due to the different particularities of this population, as well as the difficulties of obtaining consent without compromising safety and confidentiality. Only vague demographics were included in the cases below, to eliminate any specific identifying information from the write-up. A thorough literature review was conducted in preparation for this manuscript and a selection of red flags and specific characteristics were identified that match our patient population (highlighted in "italics" in the text).

CASES

Case 1

Ms. A is a young middle aged Spanish speaking female, immigrating from South America, 37 weeks pregnant, who had been transferred from a different emergency room, for having a high PHQ9 score and disclosing suicidal thoughts with a plan to hang herself or overdose on medication, and an aborted attempt at hanging prior to presentation. She also disclosed a history of verbal and physical abuse. She has three children whom she left behind in her home country and moved to USA less than a year ago. She met her current partner on Facebook and has been with him since arrival to this country. At times she would refer to him as the father of her unborn child but would deny it at other times. She reports moving to USA for work, and worked at a nail salon for 2 months, before she became pregnant. Her partner was intrusive, unconcerned about the patient's admission and presentation and was demanding for her to be discharged. On evaluation alone, she adamantly denied all symptoms of depression, including suicidality, and asked repeatedly to be discharged. PHQ9 was repeated and was unremarkable. She answered negatively to all questions screening for human trafficking and any safety concerns.

Case 2

Miss B is a young Hispanic woman, who has a history of Post-traumatic stress disorder and borderline personality disorder, one prior suicide attempt, self-harm, and multiple psychiatric hospitalizations. She was transferred to the inpatient psychiatric unit, for depression and post traumatic symptoms, after a recent escape from unlawful abduction. She presented with complaints of low mood, increased anxiety, difficulty sleeping, fluctuations in energy level and active suicidality with a plan to cut her throat but denied having intent to act on this. While on the inpatient unit, patient reported similar symptoms of depression and PTSD, but denied suicidality. She dropped out of high-school due to sex trafficking and reports other episodes of molestation during her childhood. She also has history of multiple arrests for violence and assault. She disclosed that she had been abducted by a trafficker who forced her to take $200 worth of cocaine daily or be assaulted for refusing and was sex trafficked for around three months. The kidnapper was still looking for her and her mother with the intent to kill them. During the course of her admission, she asked many times to be arrested instead of being in the hospital. After a period of stabilization and a family meeting with the mother the patient was discharged home, with referral to outpatient rehabilitation.

Case 3

Ms. C is a middle-aged Mandarin-speaking woman, has multiple hospitalizations in inpatient psychiatry with a diagnosis of bipolar disorder vs. substance induced mood disorder. She was brought in following an aborted suicide attempt with her boyfriend; they were attempting to commit suicide together with knives. In the ED she was agitated, responding to internal stimuli, disorganized, uncooperative, erratic, and required medications and physical restraints. Her urine toxicology positive for methamphetamines. Previously the patient has been positive for methadone, amphetamines, and reported using "ice". She had several admissions at the hospital. She reported going to see a psychiatrist as her "husband makes her" but unclear whether she actually follows up outpatient. On chart review, her initial admission was in context of an assault by boyfriend at the time. On physical exam, she had signs of physical and sexual abuse and had a positive pregnancy test. She reported being married for a green card and boyfriend had control of all her savings. On a subsequent visit, she reported borrowing 40k to 50k from people who were now harassing her for the money and there was suspicion for prostitution.

Case 4

Ms. D is an African American woman in her 30s, with a history of polysubstance use (alcohol and MDMA), cluster B traits, supplements income with sex, and reportedly lives with her "pimp" with other girls. Presented to ED with suicidal ideation. On chart review, patient has multiple presentation during which she shared about using drugs for sex (MDMA provided by her clients), being a prostitute, and wanting to "return to her pimp". Social worker was called to discuss options. Patient refused to report trafficking, referrals to shelters and was not willing to report her pimp at this time. She was discharged with a referral to a substance use disorder clinic.

Case 5

Ms. E is an Asian woman in her early 30s, she presented to the ER for disorganized behavior in the community. She had no reported psychiatric history, admitted to using "ice". When obtaining history, she mentions being the daughter of the Chinese president and was given "morphine" by someone who brought her to America. She also reports working in a massage parlour for no pay because she has a child in China. She also reported being sexually abused. There was no identification on her person, however she had a lighter as well as well as a knife. She required medications and was re-evaluated later. On sobriety, she was evasive and didn't report any of the information she did the previous day. She was discharged with a referral to a clinic. On a subsequent visit, she presented with suicidal ideation. She mentioned being depressed and having suicidal thoughts. Toxicology was positive for amphetamines. She also mentioned having a "new face" and becoming beautiful thanks to "the United States". Again, she was held overnight for re-evaluation and the following day denied all symptoms, refused rehabilitation, and was discharged with follow up.

Case 6

Ms. F is an Asian woman in her 40s who presented to the emergency room from the psychiatrist' office for evaluation. She reported being followed by people in her neighborhood and that "they call me a pro-

-stitute" and "they are controlling me". She states they won't let her leave the state or the country. She makes statements like "I miss my sons". Her husband reported that they moved here for a "better life" from their country, and she has become depressed since being away from her sons. He states she used to work in a restaurant but stopped going as she believed her colleagues didn't like her. Thereafter she started to report that she was being called a prostitute by people. She also started to isolate herself and not care for herself. She was admitted to the inpatient unit for concerns of major depressive disorder with psychotic features. In the inpatient unit, she was non adherent with medications and believed people were attempting to poison her. Treatment over objection was pursued and she was given paliperidone with good effect. Family meeting was held with husband, and she was determined to be at baseline and discharged.

DISCUSSION

Psychiatrists have a unique role to play in screening and caring for victims of human trafficking. Often, emergency rooms have separate spaces for psychiatric services, especially in larger cities. Even if they are a part of the general emergency room, psychiatric assessments are often conducted privately and therefore asking for a psychiatric consult can make it easier to isolate patients from their alleged traffickers without raising too much suspicion. Additionally, as described in the cases presented, victims often have psychiatric comorbidities such as substance use disorders, major depressive disorder, post-traumatic stress disorder, etc., which makes a psychiatric consult essential, if possible. Furthermore, victims of trafficking often require a trauma focused approach and mental health professionals are especially sensitive to these needs. Lastly, the nature of psychiatric services makes them less rushed and more comprehensive, therefore can give these patients the time that they need. In the cases discussed, we have found some common red flags that raise suspicion for the patient being a victim of human trafficking. Several patients identified in the case series report/tested positive for psychoactive substances that are frequently associated with the "party" scene or used as "date-rape" drugs due to their dissociative effects like "ice" (ketamine) or methamphetamines. Miss C, D and E tested positive for substances. In some instances, perpetrators tend to force victims to become addicted and dependent on illicit substances, in order to have control over them by making the victim dependent on the perpetrator and providing them substances in exchange for labour or sex. Some of the patient's also report being given drugs to enable them to perform sexual acts or bring them to America. Patients are not always forthcoming about their symptoms, and some were more revealing in a state of intoxication - alluding to things that may indicate they are being trafficked. This could be attributed to the disinhibition and impaired judgment from using substances, which should be taken into consideration, while screening for trafficking. However, it can also be attributed to thought disorder and delusional thinking that may indicate decompensation of primary psychiatric disorders. For example Ms. A, E and F report leaving their children behind in their country or missing their children, Ms. F reports coming to America for a better life however, they deny or aren't reporting the same things once they sober up. Other commonalities seen, based on our literature review of screening tools being used for human trafficking, include refusal to use an interpreter; people accompanying the patient refusing to allow the patient to be evaluated alone and answering questions on their behalf; not having identifying documents or autonomy over finances, multiple physical injuries at different stages of healing; tattoos that are concerning (e.g. show signs of branding by perpetrator, patient is hesitant to explain the tattoos further) multiple unintended pregnancies/miscarriages; several sexual partners; signs of malnourishment; being unaware of their location or time; and ambiguous, inconsistent or scripted answers. Evaluation of items they possess on arrival to the hospital setting can also be helpful to screen for trafficking. For example, Miss E did not have identifying documents on her, however possessed a knife and a lighter, possibly for self-defense.

Despite there being substantial overlap in the questions used to screen patients in this population, we also recognized certain characteristics that were unique to our hospital setting and location. Given that Sunset Park is home to multiple immigrants and also is notoriously known for high rates of human trafficking, race, ethnicity and immigration status are important screening questions. This is because victims, particularly women, have lower social standing in many cultures, which makes them more vulnerable to being hidden from society. Certain occupations seen more frequently associated with trafficking are nail salons and massage parlours, which are found in abundance in this neighborhood. Due to the multi diverse culture, the possibility of victims not being able to speak English is high. However, it is important to speak with them in their native language (with the use of an interpreter that is not the person accompanying the patient or any other person they might know) and assess their knowledge on their location and surroundings, details about their occupation, safety at home and workplace and determine presence of coercion.

Management for this vulnerable population should be adjusted by catering to their needs and meeting their needs based on where they are at. Most of these victims have been instilled with immense fear by perpetrators: fear of deportation or being arrested if they go to the police or any type of law enforcement involvement, and fear of placing their family in danger if they reach out to medical facilities for help. Due to the extensive history of trauma experienced by these patients, it is important to implement trauma informed care and use a multidisciplinary approach. Trauma informed care involves avoiding using any type of force e.g. restraints, admitting them into a closed psychiatric unit against their will, giving them intramuscular injections for agitation before trying verbal redirection. Some of the above coercive measures might need to be used if the safety of the patient and/ or staff is at risk, as in two of the cases we described, but we advocate for these to be used only as a last resort measure. A multidisciplinary approach includes integrating case managers and social workers to help with housing and shelter referrals, as well as substance use referrals to detox or rehabilitation treatment centers. If the patients are ready and willing to press charges the local special victims' unit or trafficking unit should be contacted. Some of the significant limitations of our case series are due to the exclusion of minors and the fact that all cases were selected from patients identified in the emergency room. While these considerations were intentional, as the scope of the series is to better identify potential adult victims at the point of entry, it is conceivable that additional information would be obtained in an outpatient setting that would allow for further help and engagement with mental health providers. Also, given the legal implications of trafficking minors, we excluded them, as no similar mandatory reporting exists for adults, limiting the avenues for intervention.

CONCLUSION

Majority of the victims of human trafficking, in addition to physical symptoms, have comorbid psychiatric disorders including depression, generalized anxiety disorder, panic disorder, acute stress disorder, post-traumatic stress disorder and polysubstance use/dependence. These psychiatric comorbidities must be addressed, in order for them to have an optimum quality of life. Hence, a large proportion of this population encounters health care workers, in both acute care and outpatient settings.

Given the severity and prevalence of psychiatric disorders and having been trained on how to engage, assess, and provide trauma informed care for these patients, mental health professionals are crucial in identifying these patients. Although all patients may not admit to being trafficked or want further help, just providing support, ensuring they are in a safe and confidential environment in the hospital and providing them even one resource for when they are ready, such as the national trafficking hotline information or knowing that they could return and speak with a health care professional when they are ready, can assist in decreasing rates of trafficking and increase the number of survivors.

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