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Medical First Responders and Child Sexual Exploitation: Needs, Efforts, and Next Steps

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ABSTRACT

Victims of commercial sexual exploitation of children (CSEC) often have medical needs requiring emergency care. Medical first responders (MFRs), such as ambulatory care providers and firefighters, have enormous potential to both identify these victims and link them to a host of services. Unfortunately, little is known about the MFR's awareness of CSEC, or the range of strategies and procedures MFRs use with CSEC victims. The purpose of this study was to assess MFRs current needs and ongoing efforts to combat CSEC. To this end, a total of 210 MFRs completed a survey examining departmental awareness of CSEC, perceived scope, departmental preparedness, and comfort with both identifying and connecting CSEC victims to appropriate services. Approximately a third (37.1%) of respondents indicated their department had no awareness of CSEC. Most participants indicated that while CSEC was a "very large" issue in the United States (80.9%), it was not an issue in their community (51.2%). Participants noted a lack of community resources and feeling largely unprepared for the CSEC cases they had previously encountered. Overwhelmingly, results suggest that MFRs need training and support around CSEC identification and service needs. Next steps, including multidisciplinary teams inclusive of MRFs and screening protocols, are discussed.

KEYWORDS

CSEC; first responders; training; children and youth

Introduction

The commercial sexual exploitation of children (CSEC) in the United States – also known as domestic minor sex trafficking (DMST) or child sex trafficking – is the recruitment, harboring, transportation, provision, or obtaining of U.S. minors for the purposes of commercial sex (Varma et al., 2015). CSEC victims are especially vulnerable. Most victims have complex histories of abuse and trauma, and over 80% of identified cases demonstrate pressing healthcare needs (Curtis et al., 2008; Judge et al., 2018). Such needs are often met by emergency medical service teams. Emergency medical service (EMS) teams include medical first responders (MFRs) (e.g., ambulance services, fire rescue, ocean safety, and emergency medical technicians) as well as hospital/healthcare professionals such as doctors, nurses, physician assistants, and therapists (Donahue et al., 2019; Klimley et al., 2018). As active members of first-responder teams and emergency calls, MFRs have enormous potential to both identify CSEC victims and link them to a host of services, with the goal of improving child well-being. Unfortunately, little is known about the MFR's awareness of CSEC, or the range of strategies and procedures MFRs use with children and youth who they suspect may be CSEC victims.

Due to the complex victimization histories and the nature of their exploitation, CSEC victims often have imminent health concerns. Extant literature and interventions have begun to focus on how CSEC victims present in hospital emergency room settings (Hurst et al., 2021; Kaltiso et al., 2018). Specifically,

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common health complaints from CSEC victims in hospital emergency rooms settings include sexually transmitted infections (STIs), pregnancy, self-harm, gynecological concerns, back pain, abdominal pain, and psychiatric concerns that include high stress, depression, anxiety, and PTSD (Beck et al., 2015; Goldberg et al., 2017; V. J. Greenbaum, 2017; Mukherji, 2015; Sprang & Cole, 2018; Titchen et al., 2016). In addition to these health conditions, CSEC victims may also present with what may appear as unrelated health concerns such as seizures, diabetes, and respiratory issues (J. Greenbaum, 2016). Commonly referred services include mental health treatment, forensic interviews, and/or trauma focused therapy (J. Greenbaum, 2016). While it is important to acknowledge how CSEC victims in hospital emergency room settings may present, it is equally important to note that youth experiencing CSEC victimization may be unwilling or unable to enter a formal medical facility due to shame, fear, or restrictions placed on them by their trafficker (Greenbaum et al., 2015). MFRs respond to emergency calls in the community that may- or may not- have explicitly reported medical needs. For example, MFRs respond to calls related to a gunshot, even if it was unclear whether a person has been injured. Given the physical risks inherent to CSEC victimization, as well as the criminogenic activities that surround exploitation (e.g., drug use; Greenbaum et al., 2015), it is likely that many CSEC victims encounter MFRs for reasons disparate from their victimization. Accordingly, it is reasonable to assume that MFRs may be key in both identifying pressing medical concerns and connecting victimized youth to area services.

The current study sought to explore the current needs and efforts of MFRs working outside of hospital settings to combat CSEC. Within the purview of this broad topic, we sought to determine MFRs familiarity with local resources for CSEC victims, departmental protocols, perceived comfort with both identifying and connecting suspected CSEC victims to appropriate services, and perceived scope of CSEC victimization.

Methods

Participants

A convenience sample of participants including emergency medical services prehospital personnel (e.g., firefighters, ambulance services, emergency medical technicians) from the across the United States completed a survey about their department's experiences with confirmed or suspected CSEC cases. Participants were recruited from the National Directory of Fire Chiefs and EMS Administrators which consists of 35,107 departments (30,453 Fire Departments and 4,654 EMS Departments). Of these, 52.1% (n = 18,281) had e-mail addresses which were used to recruit participants for the current study. From the 18,281 identified e-mail addresses, 1,511 bounced back and 21 were identified as duplicates. Of the 16,749 valid e-mail addresses, 15 were potential participants who read the consent and declined to participate, 232 began the survey, and 226 finished the survey. We set a survey completion standard of 70% of the survey to be included in the final sample. A total of 16 participants completed less than 70% of the survey and were therefore dropped from the final sample. The final sample consisted of 210 participants. Details of the final sample are depicted in Table 1.

Procedure

Participants completed a confidential survey hosted through Qualtrics, an online survey data collection system. Participants were told the aim of the study was to help us better understand MFRs needs and current efforts to combat CSEC. E-Mails were sent out in waves from September 18, 2019 to December 12, 2019. All participants who reached the end of the survey were provided with resources to learn more about CSEC, including documents provided by the Centers for Disease Control and Prevention, the Department of Justice, Shared Hope International, the National Human Trafficking Hotline, and the National Center for Missing and Exploited Children. These participants were provided with the option to be redirected to a separate webpage where they could enter a raffle to win one of ten $50 Amazon gifts cards. All data was collected under the approval of the *[masked named*] Institutional Review Board.

Table 1. Demographic characteristics (n = 210).

Characteristic	n	%
Current job description [a]		
Firefighter	157	74.8
Paramedic	54	25.7
EMT	82	39.0
EMS	78	37.1
Both medical professional and firefighter	100	47.6
Years in current position		
Less than 1 year	9	4.3
2–10 years	96	45.7
11–20 years	34	16.2
More than 20 years	52	24.8
Missing data	19	9.0
Gender		
Male	167	79.5
Female	24	11.4
Missing data	19	9.0
Race [a]		
Black or African American	3	1.4
White	182	86.7
Asian American	3	1.4
Indian or Alaska Native	3	1.4
Native Hawaiian or Other Pacific Islander	0	0
Hispanic or Latino ethnicity		
Yes	6	2.9
No	185	88.1
Missing data	19	9.0

[a]Multiple responses were possible.

Measures

Given the lack of research on MFRs and CSEC, all items were developed for the current study with expert feedback from MFRs.

CSEC awareness and perceived scope. Respondents were asked their impressions of their agency's general awareness of CSEC, how prepared they believed their agency was to both identify and respond to CSEC victims, as well as their perceptions of scope. Questions asked about current departmental awareness of CSEC, how that awareness had changed over the past 3 years, and any department/agency-wide trainings inclusive of CSEC. Scope questions asked respondents to consider how "large of a problem" CSEC was in their community, in their state, and within the United States. Responses options ranged from 1–4, with higher number indicating larger scope. Respondents were able to respond qualitatively to questions regarding awareness and scope by checking the response option "Other."

Departmental protocols. Respondents were also asked about agency or departmental protocols related to CSEC. Questions asked whether protocols existed for providing assistance to suspected or confirmed victims of child sexual abuse, whether protocols existed for providing assistance to suspected or confirmed victims of CSEC, whether those protocols were widely known and understood by EMPs, and whether/how confirmed or suspected cases of CSEC were recorded into electronic medical records using specific codes/keywords. Respondents were able to respond qualitatively to questions regarding protocols, as well as details about whether/how cases of CSEC were recorded by checking the response option "Other."

CSEC-related calls. Respondents were asked questions about the number of calls their department receives in a year (on average) that involve suspected- or confirmed- CSEC. They were asked to rank the top three most common reasons they had been called to the scene where confirmed of suspected CSEC had occurred. Response options included: injuries related to sexual

exploitation (e.g., sexual trauma), drug use/overdose, community violence (e.g., gunshot wounds, physical fights), other injury (e.g., broken bone), domestic or partner violence, gang violence, or other reasons.

Community response. A series of questions asked about community response to child sexual abuse generally, and CSEC in particular. Participants were asked whether their department or agency was part of a multi-disciplinary team (MDT) to combat either child sexual abuse or CSEC, what agencies were represented on the MDT, and how often the MDT met. In addition, respondents were asked about the availability of different resources for CSEC victims including rape crisis centers, child advocacy centers, human trafficking coalitions, domestic violence shelters, runaway shelters, and SANE nurses/health care providers. Respondents were able to respond qualitatively to questions regarding community response by checking the response option "Other."

Department and respondent information. Respondents were asked a series of questions about their professional role and their department. Questions included the respondent's current position (e.g., firefighter, paramedic, EMT); job title; whether their EMS is affiliated with an agency (e.g., a hospital or fire station); whether there is a specific unit dedicated to responding to child abuse and/or sexual violence; and respondent characteristics (e.g., years in current position, age, sex, race).

Data Analysis

Given the exploratory nature of this research, analyses were descriptive in nature. All missing data are reported directly in the tables. We first provide descriptive statistics in the form of the percentage of participants reporting awareness of CSEC within their department, any CSEC-involved call in the past year, the main reasons their department are called to the scene for CSEC, and personal training on this topic. Next, we report on the participants' perception of how big a problem CSEC is in their community, state, and across the U.S. Finally, we report on the participants' perception of departmental preparedness for helping these victims as well as multidisciplinary team support in their community. Qualitative responses provided by participants were analyzed using an open-coding approach. Themes and representative quotes are provided to add nuance to quantitative findings.

Results

Departmental Awareness of CSEC

Over half (52.9%) said their department had some level of awareness about CSEC; while 37.1% said there was no awareness (Table 2). Level of awareness over the past three years had improved for 31.0% of departments but most (65.7%) said there was no change. Nearly half (45%) said there was no protocol in their department for providing assistance to sexual abuse victims more broadly. Clear protocols about CSEC more specifically were reported by 31.4% of participants. Almost half (43.8%) said they personally had received training on CSEC. Of these, 34.8% received this training in the past year. Trainings were most typically EMS-specific. Other trainings endorsed by respondents included multidisciplinary team training (34.8%) and community-based training (26.1%). Few (12.9%) said their department had received any CSEC-involved calls in the past year. The main reasons the department was called to the scene in these few cases (n = 22) was for drug use/overdose (40.9%), sexual trauma injuries (31.8%) or other injuries (e.g., broken bones; 13.6%; Figure 1). Few departments (3.1%) have specific codes for calls that involve suspected or confirmed CSEC. Over half (51.3%) said it would not be easy to identify these calls in their record keeping system.

Table 2. CSEC awareness and experience (n = 210).

Characteristic	n	%
CSEC awareness level of department		
Very aware	14	6.7
Aware	97	46.2
Not aware	78	37.1
Not an issue in our community	7	3.3
Unsure	11	5.2
Missing data	3	1.4
Change in department's awareness in past 3 years		
More aware	65	31.0
Less aware	1	0.5
No change	138	65.7
Unsure	6	2.0
Department has protocol for providing assistance to sexual abuse victims		
Yes, clear protocol	98	46.7
No protocol	95	45.2
Unsure	3	1.4
Yes, but unclear what it is	14	6.7
Department has protocol for providing assistance to CSEC victims		
Yes, clear protocol	66	31.4
Yes, but unclear what it is	14	6.7
No protocol	124	59.0
Unsure	6	2.9
Personally received training on CSEC		
Yes	92	43.8
No	116	55.2
Unsure	2	1.0
Recency of training (n = 92)		
Past year	32	34.8
Past 2–3 years	48	52.2
Longer than 3 years	12	13.0
Type of training (n = 92) [a]		
Multidisciplinary team	32	34.8
EMS-specific	65	70.7
Community-based	24	26.1
Other	11	12.0
Any CSEC calls in past year (n = 210)		
Yes	27	12.9
No	156	74.3
Unsure	27	12.9
Code for calls involving CSEC (n = 191)	6	3.1
Yes	176	92.1
No	9	4.7
Unsure	11	5.8
Ease of identifying CSEC calls in their record keeping system (n = 191)	18	9.4
Extremely easy	35	18.3
Very easily	98	51.3
Somewhat easy	29	15.2
Not at all easily		
Not sure		

[a]Multiple responses were possible.

Qualitative responses highlighted the varied awareness and protocols of respondents on the issue of CSEC. Protocols around record keeping, in particular, were a struggle. When asked what words might be used to identify calls involving confirmed or suspected CSEC victims, 16 disparate qualitative responses were provided. One participant reported that their protocols allowed them to mark calls as "human trafficking, and then domestic minor sex trafficking." Other departments reported their protocols were vague. One participant reported, "We mark the call sheet with a star." Another respondent noted, "The narratives would likely not ID the issue at all."

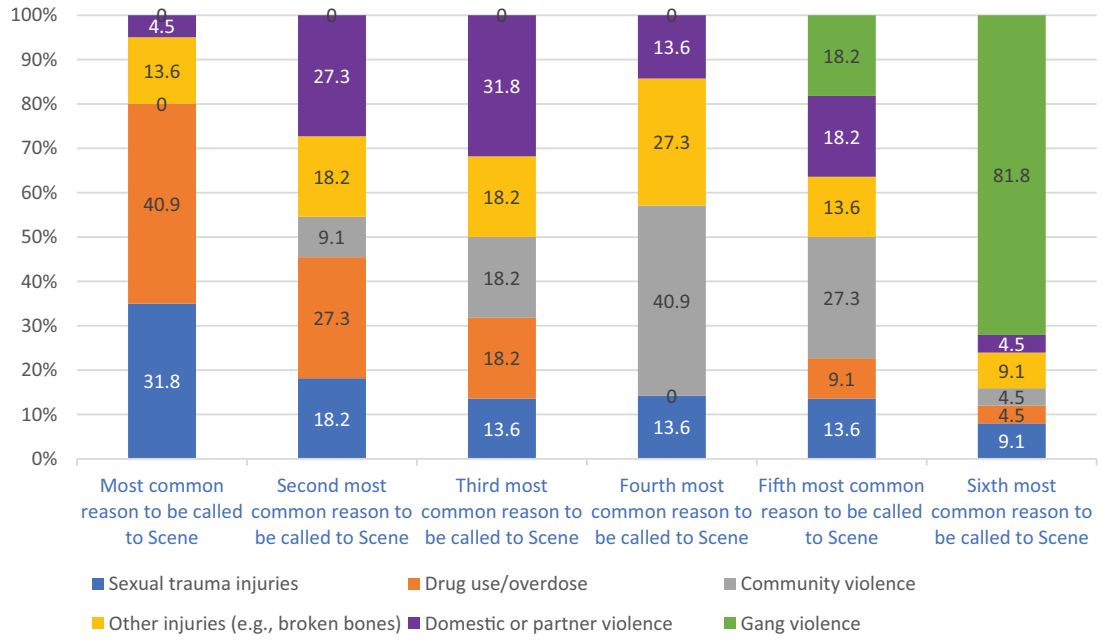

Figure 1. Rankings of main reasons department called on the scene (n = 22).

Perception of CSEC as a Problem

The participants' perceptions of how big a problem CSEC is in their community, state and across the U.S. varied (Figure 2). Most (80.9%) said it was a very large problem in the country, 41.8% in their state, and 8.2% in their community. Alternatively, no one said it was not a problem in the country, 3.2% not a problem in their state, and 51.9% in their community. Qualitative results highlighted the role of training in perceptions of scope. For example, in a sentiment echoed by many, one respondent

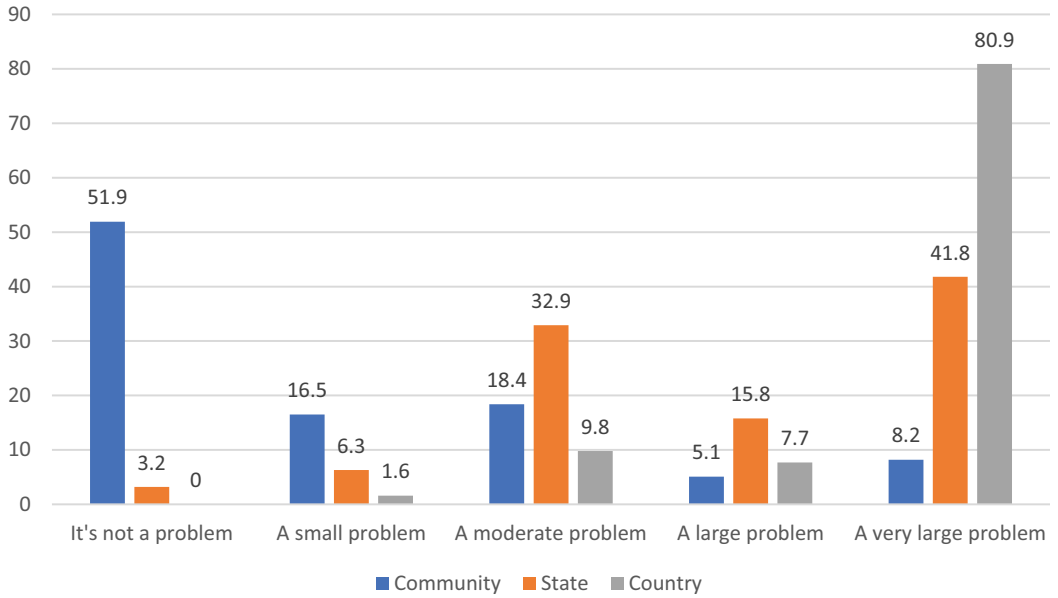

Figure 2. Perception of CSEC prevalence and scope. Note. Chart uses valid data only. Missing data currently: community (n = 52); state (n = 52); country (n = 27).

noted, "Now that we are trained, I suspect it happens more than we know of." Another respondent noted that they felt ill-prepared to comment on scope, stating simply, "I am woefully uninformed on this issue."

CSEC Preparedness of Department

When asked about handling past CSEC calls, no participants claimed their department was very prepared on past CSEC calls, 52.0% said they were somewhat prepared, and 48.0% were somewhat or completely unprepared (Table 3). Over half (56.0%) said their department was at least somewhat prepared to refer victims to needed services and the same percentage said service providers in their community were prepared to help victims. Few participants said there was a MDT prepared to handle CSEC victims in their community – 4.8% had one specific to CSEC while 7.6% said child sexual abuse MDT covered CSEC cases. Almost half of participants (42.4%) were not sure if MDTs were available to handle CSEC cases.

Several participants felt that MDTs were key to service referral. In a statement echoed by many, one participant stated, "The MDT responds to all emergencies where trafficking or sexual abuse is suspected." For participants without an MDT, qualitative results revealed this may have been due to a lack of available services, rather than a lack of interest or initiative. As one participant noted, "We have none of these [service provider types] to include in an MDT." Another similarly stated, "We have no resources for these victims in our community."

Table 3. Identifying CSEC in department and referrals.

Characteristic	n	%
	(n=25)	
Department preparedness on past CSEC calls to handle the situation		
Very prepared	0	0
Somewhat prepared	13	52.0
Somewhat unprepared	4	16.0
Unprepared	8	32.0
Preparedness to refer victims to needed services		
Very prepared	3	12.0
Somewhat prepared	11	44.0
Somewhat unprepared	5	20.0
Unprepared	5	20.0
Preparedness of service providers in community to help victims		
Very prepared	3	12.0
Somewhat prepared	11	44.0
Somewhat unprepared	4	16.0
Unprepared	7	28.0
Multidisciplinary team for CSEC in community	(n=210)	
Yes, specific to CSEC	10	4.8
Yes, child sexual abuse MDT covers CSEC	16	7.6
No	92	43.8
Unsure	89	42.4
Missing data	3	1.4

Discussion

Research suggests that a significant number of known CSEC victims have pressing medical needs (Curtis et al., 2008; Judge et al., 2018), yet little is known about the awareness medical first responders (MFRs) have regarding CSEC, or the range of strategies and procedures MFRs use when they interact with sexually exploited youth. Such awareness is vital to CSEC victim identification, in connecting CSEC victims to services, and to better understand the scope of the problem (Roney & Villano, 2020).

Accordingly, the purpose of the present exploratory study was to assess MFRs current needs and efforts to combat CSEC, including awareness of CSEC; their current means of CSEC victim identification including agency or departmental protocols; and their perceptions of community response. Findings from the current study offer meaningful next steps for future training and advocacy, with the goal of preventing (re)victimization, and improving child well-being. Specifically, results indicate that additional trainings for MFRs on the topic of CSEC are needed, as are response protocols to ensure known or suspected CSEC victims are identified and connected to appropriate community services.

Overall, MFRs in the current study indicated they had felt largely unprepared for CSEC-related calls, and that most departments/agencies were without clear CSEC-related protocols. Without clear protocols, the responsibility of victim identification and referral rests on the knowledge of one or more MFRs responding to an individual call, rather than the department or agency as a whole. Accordingly, identification and referral patterns are inconsistent and highly individualized reflecting team member's interpersonal connections, rather than a system of best practice. If an MFR called to a case is not familiar with how CSEC victimization presents or what organizations serve this population, the victim's odds of successful referral are low. Furthermore, without standardized protocols in place and a network of partners to assist in referrals, CSEC victims may go unidentified.

Relatedly, many MFRs in the current study noted that CSEC-related services in their community were either unavailable or unknown to them. Importantly, this has important implications for identification. For example, CSEC victim identification can incur substantial risk to the victim. If a victim is identified and supports are not provided to keep the victim safe, identification becomes a barrier to- rather than a facilitator of- child well-being and safety. Multi-disciplinary teams (MDTs) have been proposed as one way to help ensure victims of abuse have the services they need across medical and social service sectors (Connolly, 2012; MacLeod, 2016). The current study suggests this, too, is an area where improvements can be made as the majority of communities in the current sample either did not have an MDT, did not have an MDT covering CSEC cases, or respondents were unsure whether an MDT existed. MDTs that include all MFRs would undoubtedly strengthen victim identification as well as facilitate holistic service provision.

In terms of their interactions with CSEC victims, most respondents said their department had not responded to any CSEC-related calls in the last year. It is important to note that it is possible this assessment is correct- there may be some communities in the United States where human trafficking-inclusive of CSEC victimization- is relatively rare (National Human Trafficking Hotline, 2021). However, it is also possible that some departments did respond to calls related to CSEC, but the MFRs were unaware and unable to identify CSEC victims due to a lack of training, standardized identification tools, and/or CSEC-related protocols. Consistent with past literature on CSEC victims presenting in emergency departments (Goldberg et al., 2017; McClain & Garrity, 2011), most calls related to CSEC victims were for initially for drug use/overdose or sexual trauma injuries. However, even if victims are recognized or suspected as having CSEC indicators, the overwhelming majority of respondents (93%) said their teams do not use a code to indicate this in their record keeping. It is unsurprising then that approximately half said they could not easily find records related to CSEC. The lack of searchable records related to CSEC is concerning in that information about CSEC remains elusive. To address this need, a ICD-10 code specific to human trafficking was developed in June,2018 (American Hospital Association, 2018). Unfortunately, use of these codes is inconsistent among medical providers (Greenbaum et al., 2021). Instead, many health care providers code instances of CSEC as "sexual abuse" or "sexual assault," even though these codes fail to fully capture the individual's victimization experience (Greenbaum & Stoklosa, 2019). When human trafficking victim information- including CSEC victim information- is not coded/recorded purposively, any data used to draw conclusions about how victims present to providers, the needs they have, and trafficking characteristics, are inherently inconclusive.

Strengths and Limitations

There are notable limitations in the present study. First, the sample represents a small subsample of national MFRs- firefighters, emergency medical technicians, and ambulatory care providers. Though the sample offers diverse geographic participation, it is not nationally representative, and thus should not be used to make sweeping assumptions of MFRs' perceptions and experiences. Importantly, the survey was sent specifically to individuals in leadership positions. While we asked individuals to consider these questions in relation to the agency or department holistically, it is possible that those in leadership positions have a skewed understanding. Further, it is likely that those who chose to participate have at least some interest or experience in working with CSEC victims. Finally, as a cross-sectional, descriptive study, the results should be interpreted as a snapshot of the current landscape. Despite these limitations, the study adds to the extant CSEC-related literature about the perceptions and experiences of MFRs regarding this population. Further, the findings presented here highlight gaps that can be addressed to increase MFRs' confidence in responding to calls where CSEC-victimization is likely, as well as to increase the network that CSEC victims interface with in the future.

Conclusion

Our findings suggest that MFRs need more training and support around CSEC identification and victim service needs. It is important that MFRs receive regular, up-to-date, standardized training to learn how to identify CSEC victims- as well as how to respond when working with them- from a trauma-informed perspective. Fortunately, this does not require starting from scratch. Nationally, community stakeholders are already leading trainings and sharing resources related to human trafficking, inclusive of CSEC victimization. Examples of such trainings include the Stop Observe Ask Respond (SOAR) curriculum series (National Human Trafficking Training and Technical Assistance Center, 2022), the American Medical Women's Association (AMWA) trainings (e.g., PATH trainings; American Medical Women's Association, 2022), and Common Spirit Human Trafficking 101 (Common Spirit, 2020). Trainings on human trafficking among medical professionals have been shown to be both feasible and efficacious (Lee et al., 2021; Stoklosa et al., 2017). MFRs should be integrated into these training opportunities. Lessons from sexual violence prevention efforts suggest CSEC-related concerns should be addressed through MDTs (Stover et al., 2010). Accordingly, members of these MDTs should attend regular trainings on topics around CSEC identification, criminal investigation, and intervention efforts. These trainings may also be an opportunity for various entities to come together to strategize about best practices.

CSEC victims will often not self-identify as being exploited. As such, it is important that healthcare professionals have the tools they need to facilitate identification in a trauma-informed manner inclusive of many different trafficking experiences. Ideally, MFRs will feel empowered to identify CSEC victims through an easy-to-use protocol. As part of the identification process, MFRs should have a consistent trafficking code to input into their systems to flag a minor victim as having suspected or confirmed CSEC involvement. From there, MFRs can collaborate with anti-trafficking stakeholders and researchers to identify trends as well as what to best lobby for to support the victim's needs. It is crucial that these protocols are developed in conjunction with trainings that dispel myths and assumptions related to CSEC so that these codes are not used to discriminate against minor victims or criminalize any behaviors inherent to their victimization. As with the trainings described above, protocols for medical professionals related to CSEC need not be started from scratch. Multidisciplinary professional organizations focused on human trafficking offer guidance (e.g., Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings; Baldwin et al., 2017), and some states have published their protocols to aid others in development (e.g., Project Respect and the Washington State Model Protocol for Commercially Sexually Exploited Children; Saltiel, 2013)

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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