Knowledge and Attitudes of Physicians in Kansas Regarding Domestic Minor Sex Trafficking

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Abstract

Introduction. Domestic minor sex trafficking (DMST) has been reported increasingly in the news as a problem in Kansas. It is essential that healthcare providers are educated about the topic and feel confident in their ability to identify and report a victim. The purpose of this study was to explore Kansas physicians' knowledge, attitude, and training regarding DMST.

Methodology. A 20-question survey was e-mailed to 1,668 physicians registered with the Kansas Board of Healing Arts in the specialties: family medicine, pediatrics, obstetrics/ gynecology, and emergency medicine.

Results. Of those emailed, 69 (4%) responded to the survey. Those that responded agreed that DMST was a problem in the US (86%; n = 59) and Kansas (80%; n = 55). Of the respondents, only 12% (n = 8) felt confident in identifying a victim and only 11% (n = 8) screened patients for DMST. Over half (61%; n = 42) reported encountering possible signs of DMST in patients, however, only few suspected DMST.

Conclusion. Physicians reported encountering victims of DMST in their practices, which indicated the existence of DMST in Kansas. Survey respondents were lacking in knowledge regarding DMST. Further, their suspicion of DMST victimization (based on presentation), was rarely followed through with reporting. Training, for symptom recognition, victim identification, and proper reporting, is necessary for Kansas physicians as they are often the only professional to come in contact with DMST victims.

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Introduction

Background. Sex trafficking refers to those who have been coerced or forced into providing commercial sex acts.[1,2] Sex trafficking is different from prostitution, which is a conscious decision to provide commercial sex acts and the freedom to stop. Victims of sex trafficking do not have the ability to quit whenever they choose,[3] but rather are manipulated by means such as debt bondage, isolation from public/family/ friends, control of victims' money, or sedation with drugs.[4]

Sex trafficking that involves the commercial sexual exploitation of minors against their will within a national border formally is titled domestic minor sex trafficking (DMST).[5] Minors are the most vulnerable population to be victimized and DMST has been identified as a growing problem in the US.[6] The US Department of Justice estimated that there are up to 293,000 American youths at risk of becoming victims of DMST.[7] Street children constitute the largest victim group. These children are commonly runaways or throwaways who have been abandoned by their parents.[8] Females are at highest risk with the average age of entry being between

11 and 14, but some are as young as 5 years of age.[6]

Sex trafficking is just as much of a local problem as a national problem. A 2009 article of *The Wichita Eagle*[9] stated that a national FBI initiative had rescued 900 children and led to 510 convictions of traffickers and their associates. A Wichita Police Captain stated to *The Hutchinson News* that the Midwest has become a hub for domestic sex trafficking.[10] Approximately 2,300 children become victims to commercial sexual exploitation each year.[11] *KWCH* news quoted experts who said Wichita is ranked among the top 5 cities where traffickers come to take girls.[12]

The US Department of Health and Human Services identified primary care, urgent care, obstetrics and gynecology, mental health, and inpatient care as the most likely settings where healthcare providers may encounter a victim.[13] Victims of DMST present with a variety of health concerns including sexually transmitted infections, infectious diseases, pelvic inflammatory disease, pregnancy, food deprivation, poor nutrition, headaches, head and neck traumas, dental or oral problems, respiratory illnesses, gastrointestinal problems, memory loss, broken bones, and chronic pain.[13] However, they are less likely to receive immediate treatment and are at high risk for chronic conditions.

Healthcare providers have a unique role when interacting with DMST victims and may be the only professional contact during their captivity.[4] A European study of trafficked women revealed that at least 28% of those questioned had been evaluated by a healthcare professional during their exploitation.[1] Therefore, healthcare providers may have the unique opportunity to identify and report victims providing a means of escape from a life-threatening situation. Moreover, reporting of DMST is mandatory by law.[14]

Many victims are difficult to identify because they often deny being a victim and consequently are not identified by the untrained provider.[4] Healthcare providers should seek training on how to identify and report these victims. It is essential that healthcare providers realize that DMST victims are in potentially life-threatening situations. The Rescue and Restore Campaign and the National Human Trafficking Resource Center provide training resources as well as phone consultation for healthcare professionals. In addition, the Christian Medical and Dental Association has developed a continuing medical education (CME) online tutorial that educates healthcare providers about the issue.[13]

Research regarding DMST is scarce due to the underground nature of the problem. Thus, the level of knowledge of healthcare providers regarding DMST is not well documented. A survey with 110 respondents including physicians, mid-level providers, and nurses conducted in two US emergency departments revealed that 76% of emergency room healthcare providers knew what human trafficking was, but only 13% felt either confident or very confident that they could identify a trafficked victim.[15] The specific aim of this study was to determine Kansas physicians' current level of DMST knowledge, attitudes regarding DMST, and self-perceived level of competence regarding the identification of DMST victims.

Methods

Study design and study population. This descriptive, cross-sectional study utilized a 20-question survey emailed to Kansas physicians registered with the Kansas Board of Healing Arts in the specialties of family medicine, pediatrics, obstetrics/gynecology, and emergency medicine. Highly specialized physicians were less likely to encounter

DMST victims and were excluded. Recipients included physicians practicing in both rural and urban settings. The list provided by the Kansas Board of Healing Arts contained addresses outside of Kansas. These addresses were excluded with the exception of those in the greater Kansas City area. There were 1,668 physicians that fit the inclusion criteria. A link to an online survey was sent electronically in November 2011 and re-sent to non-respondents after four- and eight-week intervals.

The survey, designed specifically for this study, included questions on belief, knowledge, experience, training, and current practice regarding DMST,[5] as well as demographics. Questions consisted of multiple choice (1 item), yes/no (3 items), true/false (1 item), Likert scale (1 item), multiple choice-multiple answer (4 items), and fill in the blank (4 items). Prior to distributing the survey to physicians, it was administered to three individuals, testing for content and clarity. Responding to the survey implied consent. Descriptive statistics were used to analyze survey results. This study was approved by the Wichita State University Institutional Review Board.

Results

Of the 1,668 email addresses provided, 69 physicians responded to the survey for a response rate of 4%. Of those, there were 42 (60.9%) females and 27 (39.1%) males with a mean age of 47 years. The mean number of years in practice was 17.1 (SD = 11) with a range of 2 to 47 years. Over half (55.1%; n = 38) of respondents practiced in a city with a population greater than 300,000. The primary clinical settings most reported were private practice (43.5%; n = 30) and emergency department (23.2%; n = 16). The predominant specialties reported were family practice (49.2%; n = 32) and pediatrics (30.8%; n = 20; Table 1). Five of the 69 survey respondents reported encountering a victim in their practice. These five physicians encountered a total of 24 cases, yet only 22 cases were reported. While more than 65% (n = 45) of respondents indicated that they had not encountered a victim, 28% (n = 19) stated that they did not know whether they had encountered a victim or not (Table 2).

Table 3 illustrates respondents' answers to questions assessing their beliefs about DMST. The majority of respondents reported believing that DMST is a problem in the United States (85.5%; n = 59) and in Kansas (79.7%; n = 55). Most (76.8%; n = 53) reported not feeling comfortable in identifying a victim in their practice. Over half of the respondents agreed that DMST is a problem that should receive state funding for treatment of victims (68.1%; n = 47) and for public education (69.6%; n = 48). Respondents agreed young female patients should be educated about DMST (81.2%; n = 56) and 63.8% (n = 44) agreed they should be educated by physicians at annual physicals.

Table 4 highlights respondents' answers to factual questions about DMST. Knowledge responses were varied: over half (60.9%; n = 42) responded that DMST occurs in small towns and was associated with a shorter life expectancy (73.9%; n = 51). Fewer associated DMST with starvation (46.4%; n = 32). Most (78.3%; n = 54) correctly answered that even if a trafficked girl is compensated (e.g., food, shelter, drugs, money), it is still considered DMST. Over half (63.8%; n = 44) knew that it is mandatory for a physician to report anyone he/she suspects to be a victim of DMST. Respondents recognition of potential DMST indications were low: controlling boyfriend (5.8%; n = 4), branding (tattoo/jewelry; 1.4%; n = 1), lying about age (1.4%; n = 1), lack of community knowledge (1.4%; n = 1), avoiding eye contact (4.8%; n = 4),

revealing/short/tight clothing (4.3%; n = 3), chronic drug use (2.9%; n = 2), or defensive/rude/ evasive/aggressive behavior (1.4%; n = 1). (See Figure 1.)

Table 1. Respondent demographics.

	Total (N = 69)
Age, years (mean, SD)	47.1 (11.1)
Years in practice (mean, SD)	17.1 (11.1)
Age	
0 – 29	1 (1.4)
30 – 59	55 (79.7)
60 and over	9 (13.0)
Gender	
Male	27 (39.1)
Female	42 (60.9)
Specialty	
Family Practice	32 (49.2)
Pediatrics	20 (30.8)
Obstetrics/Gynecology	4 (6.2)
Emergency/Trauma	9 (13.8)
Other	8 (11.6)
Years in Practice	
0 - 19	41 (59.4)
20 and greater	27 (39.1)
Primary Clinical Setting*	
Private Practice	30 (43.5)
Hospital Inpatient	9 (13.0)
Emergency Department	16 (23.2)
Urgent Care	4 (5.8)
Community Health Center/Low Income Clinic	10 (14.5)
Population	
Less than 10,000	9 (13.0)
10,000 - 49,999 (not close to metro area)	4 (5.8)
10,000 - 49,999 (close to metro area)	4 (5.8)
50,000 - 99,999	2 (2.9)
100,000 - 299,999	12 (17.4)
Greater than 300,000	38 (55.1)

*Primary Clinical Setting defined as location of most clinical hours.
Note: Percentages may not equal 100 due to missing data. Data reported as *f* (*%*), unless otherwise noted.

Table 2. DMST victim encounters and reporting.

	Total (N=69)	Private Practice 30 (43.5)	Hospital Inpatient 9 (13.0)	Emergency Department 16 (23.2)	Urgent Care 4 (5.8)	Community Health/Low Income Clinic 10 (14.5)	*p**
DMST Victims Encountered							0.520
0	45 (65.2)	21 (70.0)	7 (77.8)	9 (56.2)	1 (25.0)	7 (70.0)	
1	2 (2.9)	2 (6.7)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
2	1 (1.4)	1 (3.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
5	1 (1.4)	1 (3.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
15	1 (1.4)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.4)	
Unknown	19 (27.5)	5 (16.7)	2 (22.2)	7 (43.8)	3 (75.0)	2 (20.0)	
Reported DMST Cases (based off of encounters)							0.598
0	60 (95.2)	26 (96.3)	9 (100.0)	13 (92.9)	3 (100.0)	9 (14.3)	
2	1 (1.6)	0 (0.0)	0 (0.0)	1 (7.1)	0 (0.0)	0 (0.0)	
5	1 (1.6)	1 (1.6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
15	1 (1.6)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (10.0)	

Note: Percentages may not equal 100 due to missing data. Data reported as *f* (%), unless otherwise noted.
*Chi-square test.

Table 3. Domestic Minor Sex Trafficking: Beliefs (N = 69).

	Agree	Disagree
DMST is a problem in USA	59 (85.5)	0 (0.0)
DMST is a problem in Kansas	55 (79.7)	5 (7.2)
DMST should receive state funding for treatment of victims	47 (68.1)	6 (8.7)
DMST should receive state funding for public education	48 (69.6)	10 (14.5)
Most victims are not US citizens	19 (27.5)	36 (52.2)
Prostitute is appropriate term for trafficked girls	7 (10.1)	57 (82.6)
Prostitution is a crime in KS, therefore these girls are criminals	2 (2.9)	59 (85.5)
Confident in ability to identifying victims of DMST in practice	8 (11.6)	53 (76.8)
Young female patients should be educated about DMST	56 (81.2)	4 (5.8)
Who should educate young females?		
Media	56 (81.2)	
Physicians at annual physicals	44 (63.8)	
School program	55 (79.7)	
Clergy	29 (42.0)	
Law Enforcement	39 (56.5)	
Public Awareness Campaign	62 (89.9)	
Other	8 (11.6)	

Note: Percentages may not equal 100 due to missing data. Data reported as *f* (*%*), unless otherwise noted.

DMST in Kansas. Out of 69 respondents, 7.2% (n = 5) reported an encounter with at least one victim and 27.5% (n = 19) reported a possible encounter with a victim. Barriers to reporting included not being sure the patient was a victim (73.9%; n = 51), not knowing how to report (30.4%; n = 21), the victim not acting like she needed help (4.3%; n = 3), and not having time (2.9%; n = 2; Figure 2 and Table 5). Some (18.8%; n = 13) were aware of agencies in their area that assist victims of DMST, but only 11.6% (n = 8) reported familiarity with the National Human Trafficking Resource Center (1-888-373-7888).

Kansas physician training on DMST. A few respondents (5.8%; n = 4) had received general training on DMST. Some (10.1%; n = 7 and 13%; n = 9, respectively) have received training on how to identify a victim and how to report a victim. More than half (66.7%; n = 46) of respondents stated they would take part in some type of training. Respondents were most interested in participating in the following forms of training: continuing medical education (CME) presentations, online tutorials, and seminars/conferences (Table 6).

Discussion

Even though there was a very low response rate, five respondents reported encountering a victim(s) in their practice. Further, more respondents indicated they might have treated a victim but were uncertain. These findings indicate that DMST is a valid concern in Kansas, but

Table 4. Domestic Minor Sex Trafficking: Knowledge (N = 69).

Number of Victims of DMST in USA*			
0 - 49,999	10 (14.5)		
50,000 - 99,999	28 (40.6)		
100,000 - 149,999	18 (26.1)		
150,000 - 200,000	13 (18.8)		
Average Age of DMST victim's entry into sexual exploitations†			
6-8	4 (5.8)		
9-11	26 (37.7)		
12-14	38 (55.1)		
15-18	1 (1.4)		
	True	False	I Don't Know
DMST occurs in small towns. (true)	42 (60.9)	2 (2.9)	13 (18.8)
DMST is frequently associated with poor oral health. (true)	33 (47.8)	2 (2.9)	17 (24.6)
DMST is frequently associated with poor vision. (true)	13 (18.8)	9 (13.0)	33 (47.8)
DMST is frequently associated with starvation. (true)	32 (46.4)	3 (4.3)	20 (29.0)
Trafficked girls have shorter life expectancies than general population. (true)	51 (73.9)	0 (0.0)	5 (7.2)
Trafficked girls can walk away from trafficker whenever she chooses. (false)	0 (0.0)	57 (82.6)	1 (1.4)
A trafficked girl is paid for her work. (false)	4 (5.8)	38 (55.1)	11 (15.9)
A trafficked girl is compensated (e.g., food, shelter, drugs, money). (false)	2 (2.9)	54 (78.3)	2 (2.9)
It is common for relatives to be the trafficker/pimp. (true)	33 (47.8)	7 (10.1)	19 (27.5)
It is mandatory for a physician to report suspected DMST. (true)	44 (63.8)	3 (4.3)	14 (20.3)

*US Department of Justice estimation, 2006.

†US Department of Justice, 2009.

Note: Percentages may not equal 100 due to missing data. Data reported as *f* (%), unless otherwise noted.

suggests that physicians are not trained to identify victims. The medical settings in which victims were encountered included emergency medicine, private practice, and a community health/low income clinic. Certain practices/specialties may be more likely to encounter victims and/or recognize them.[13] Practices such as primary care, urgent care, obstetrics/gynecology, mental health, and inpatient care offer a safe, private environment for a victim and is the entry point into the health care system. Urgent care or emergency departments are more likely to see victims due to the prevalence of violence and injuries that may be inflicted on a DMST victim. Although, the majority of respondents for this study were from urban settings (populations

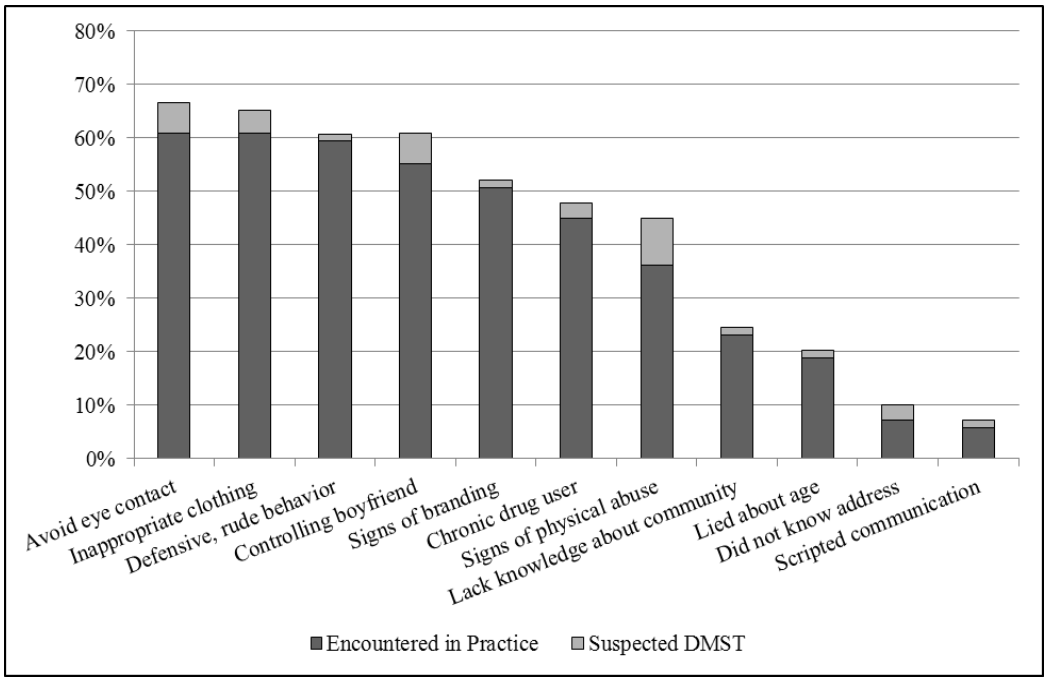

Figure 1. Signs of Domestic Minor Sex Trafficking.

Table 5. Domestic Minor Sex Trafficking: Encounters (N = 69).

DMST Victim Encounters	
0	45 (65.2)
1-10	4 (5.8)
10+	1 (1.4)
Unknown	19 (27.5)
DMST Cases Reported	
0	60 (87.0)
1-10	2 (2.9)
10+	1 (1.4)
Inhibits Reporting DMST	
Did not know to report	21 (30.4)
Did not have time	2 (2.9)
Wasn't sure patient was a victim	51 (73.9)
Victim didn't act like they needed help	3 (4.3)
Other	38 (55.1)
Where Encounters of DMST Patients Occur	
Private Practice	28 (40.6)
Emergency Department	22 (31.9)
Inpatient Hospital	12 (17.4)
Community Health/Low Income Clinic	18 (26.1)
Other	32 (46.4)

Note: Percentages may not equal 100 due to missing data. Data reported as *f* (%), unless otherwise noted.

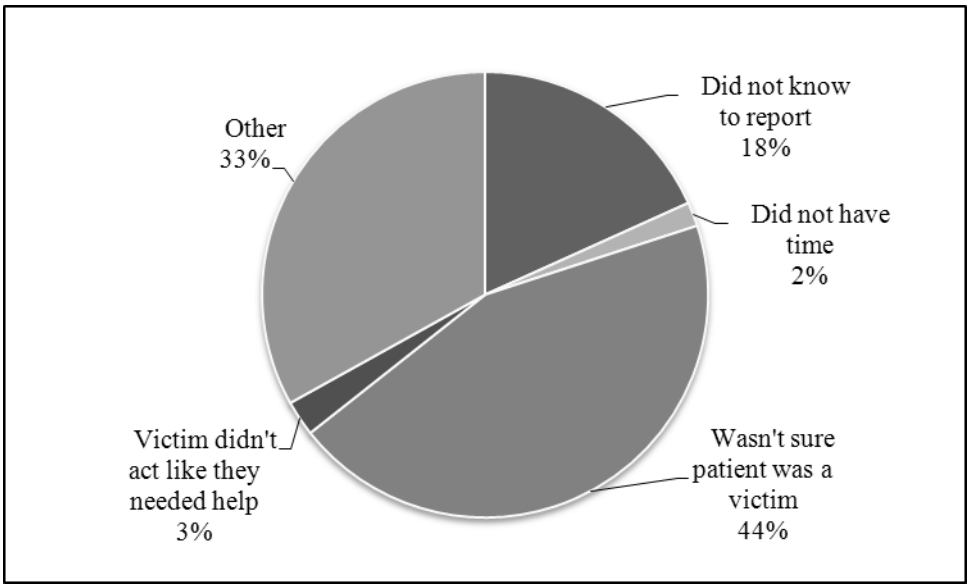

Figure 2. Reasons physicians did not report suspected DMST.

Table 6. Domestic Minor Sex Trafficking: Training (N = 69).

	Training	No Training
Participation in training		
DMST in general	4 (5.8)	54 (78.3)
Victim identification	7 (10.1)	46 (66.7)
Report victim	9 (13.0)	42 (60.9)
Appropriate interaction with victim	6 (8.7)	43 (62.3)
Additional/future training		
Feel healthcare workers should receive more	57 (82.6)	5 (7.2)
Willing to take part in additional DMST training	46 (66.7)	9 (13.0)
Employment should require DMST training	3 (4.3)	50 (72.5)
	Received Training	Interested in Type of Training
Training Preference		
Medical School Curriculum	1 (1.4)	15 (21.7)
CME Presentation	5 (7.2)	54 (78.3)
Seminar/Conference	3 (4.3)	34 (49.3)
Online Tutorial	2 (2.9)	49 (71.0)
Professional Journals	3 (4.3)	27 (39.1)
Newspaper/magazines	2 (2.9)	14 (20.3)
Webinar/Video Conference	1 (1.4)	21 (30.4)
Other	3 (4.3)	2 (2.9)

Note: Percentages may not equal 100 due to missing data. Data reported as *f (%)*, unless otherwise noted.

greater than 300,000); DMST is currently not limited to metropolitan areas. Thus, DMST education and provider training should be prioritized to emergency or urgent care providers in any community setting.

Physicians may not have the tools to identify DMST victims in their practice. Respondents were not aware of signs that identify a DMST victim and acknowledged their lack of confidence to do so. Although respondents reported being aware of the problem in the US and Kansas, they did not have comprehensive knowledge of the topic. Over 85% of respondents had seen patients who displayed possible DMST signs (e.g., not knowing address, scripted communication, or signs of physical abuse).

Many respondents could not identify health hazards associated with DMST correctly, nor were they aware it is mandatory to report suspected DMST victims. Few respondents were aware that the National Human Trafficking Resource Center at 1-888-373-7888 is available to assist callers in determining if a person is a victim and providing local resources to help.[1] These deficits are most likely due to the lack of formal training on DMST and indicated a need for further education for physicians to fulfill their key role of identifying and reporting victims.

Respondents reported that the greatest barrier to reporting was being unsure whether or not the individual was actually a victim and not knowing how to report. Educating physicians about the national human trafficking resource center and its services likely would help overcome some of these barriers. Education should emphasize to physicians that their job is to report suspected cases, not necessarily to investigate. Furthermore, recognition training may result in the reporting of a greater number of cases. While most believed healthcare workers should receive more training, only 6% of respondents had received training on DMST. Over half stated a willingness to take part in some sort of training event. CME presentations, online tutorials, and seminar/conferences were the preferred avenue of training.

Only a small percentage (11.6%) of physicians reported actually screening young female patients for involvement in DMST. Equally few educated their patients about the risk of DMST. Respondents believed that young female patients should receive education about DMST, and over half agreed that this education should be provided by physicians during annual physicals. Physicians believed this to be an important topic to address with their patients and that they were willing to create awareness but also advised other strategies (e.g., media, public awareness campaigns, and school programs).

The results of this study closely mirrored a study performed in US emergency departments, which found only 13% of emergency department providers felt confident identifying a DMST victim.[16] This finding is remarkably similar to the low number (12%) of Kansas physicians who felt confident. These results demonstrated that healthcare providers in Kansas and even nationally may lack the training and tools to identify victims effectively.

Study limitations. Survey results should be interpreted with caution due to several limitations. The first is the response rate of 4%, which is very low. Clinical survey response rates have demonstrated a decline in the past two decades and in 2002 averaged 68% in one study conducted by the American Academy of Pediatrics.[15] While the results of this survey reflect only a small percentage of Kansas physicians and findings are not generalizable to larger populations, it is a first step in gauging the awareness and beliefs for healthcare interaction for DMST victims. Further, the study may have been affected by response

bias, as physicians who are aware of the issues may have been more likely to respond than those unaware and uninterested in DMST. Future research should explore attitudes and knowledge of all disciplines of healthcare professionals in Kansas and nationwide as well as the impact of screening and recognition training for DMST.

Conclusions

Domestic minor sex trafficking has made local headline news as a problem in Kansas. In this study, a few Kansas physicians reported having treated victims of DMST in their clinical practice. Further, other physicians reported possibly treating DMST, but were uncertain. Respondents were interested in the topic yet were lacking factual knowledge. This lack of knowledge and self-reported low confidence in recognition suggested a need for clinical training in DMST. Survey respondents, while representing a small percentage of Kansas physicians, agreed this is a problem and advocate training for recognition, interaction, and reporting. With healthcare workers in such a prime position to identify and report victims, it is important they have the knowledge and skills to do so.

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