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Human Trafficking in Healthcare and the Efforts to Identify and Rescue

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"So, what happened?" the emergency physician inquires. He senses tension in the room glancing between his patient – an African American female adolescent – and the accompanying older woman standing to the side. The older woman begins to speak on the patient's behalf as the young disheveled girl sits in her chair, fidgeting apprehensively. After a short while, the physician and his scribe leave the encounter and return to their workspace. He turns to the scribe and says, "please include in the note: 'Considered suspicion that patient may be a victim of human trafficking'".

INTRODUCTION

Human trafficking (HT) is a transnational issue that deeply infringes upon human rights and public health. This form of modern slavery is estimated by the International Labor Organization to generate $150 billion in illegal profits per year. [1] It is increasingly recognized as a problem permeating the healthcare realm. In the period of being trafficked, many victims of exploitation step foot into healthcare settings and go undetected with their medical needs unmet. Under the Protocol to Prevent, Suppress and Punish Trafficking in Persons, human trafficking encompasses both sexual and labor exploitation of individuals through any type of coercion, deception, or abduction regardless of consent or age.[2] A 2017 report estimates that 40.3 million people globally at any time are victims of human trafficking and modern slavery. [3] Statistics from the Polaris Project and the National Human Trafficking Hotline estimates that in the U.S. alone more than 10,000 individuals were identified in 2017 and the number of calls to the hotline increases each year. [4]

Human trafficking includes sexual and labor exploitation, which has both a significant physical and psychological impact on the health of the victims. Thus, one point in safely intervening and removing victims from their situation is in healthcare settings such as emergency departments, urgent care clinics, women's health clinics, Planned Parenthood offices, or other neighborhood clinics. According to one study, about 88% of HT victims had encountered a medical provider for treatment

while they are trafficked, but few had been asked in detail about their situations by a healthcare staff or provider.[5] Furthermore, various studies had suggested that healthcare providers are generally ill-equipped to identify, respond to, and refer potential HT victims when they present to the clinical setting.

Given the covert nature of HT, there exists little compelling evidence of its full extent in healthcare. Nonetheless, there is growing development in research, training, and interventions to improve the knowledge and skills of healthcare providers. To apply this in the clinical setting, researchers must demonstrate, for clinicians likely to encounter HT victims, how the knowledge and confidence levels to identify and respond to HT victims compare before and after a training session.

CURRENT UNDERSTANDING OF HUMAN TRAFFICKING IN HEALTHCARE

Understanding medical providers' current knowledge and perception of HT is important to determine why many clinicians are ill-equipped to identify and respond to potential HT victims. A study in 2015 surveying 168 providers showed that there were gaps in their knowledge and awareness of HT, which corresponded with a lack of prior training and confidence levels in identification. For instance, the study found that 10% of providers incorrectly labeled young HT victims as prostitutes and also failed to identify pediatric victims unless coercion was evident. In contrast, those who received prior training were more likely to express confidence and awareness in responding to HT victims.[6]

Misconceptions of HT can even transcend borders as another 2015 study revealed in regions of the Middle East, the Caribbean, and Central America. Many of the participants were uncertain of the characteristics of trafficked victims. Providers from these areas falsely believed that trafficking had to cross international borders, did not include exploitation of youths in domestic work, and affected only people with little education. Participants were also uncertain as to whether contacting the police was the appropriate step of action or not.[7]

Though HT in healthcare remains an enigma for many health providers to recognize and tackle, research efforts are in place to better identify and understand the scope of its obscurity. A 2019 mixed-methods study attempted to illuminate the issue of undetected HT victims by collecting electronic health record (EHR) data and gathering provider perspectives on the issue in their workplace. The EHR data pull on potential characteristics of HT victim encounters – such as fake identification, sexual abuse, controlling companion – did not yield productive results, suggesting that little empirical data on HT encounters are documented and victims' trafficked status go undetected. The second part of the study, which consisted of interviews with medical providers, assessed the standpoints on HT as a public health issue, structure of information and healthcare delivery, and data sharing for victims' continuity of care. Of the 972 physicians and nurses, only 12.2% reported awareness of warning signs of a trafficked victim, 12.8% reported confidence in providing trauma-informed care, and >85% of providers had little knowledge of appropriate referral services. Despite this, respondents conveyed great interest in learning more about identifying, responding, and providing continuity of care to HT victims. [8]

General gaps of knowledge in the understanding of HT in healthcare are compounded by the lack of training to respond to such situations, which hinders the delivery of proper care for the victims. Nevertheless, providers generally have a strong desire to be better informed of the issue.

CURRENT SCREENING & TRAINING IMPLEMENTATIONS IN NON-CLINICAL SETTINGS

What training programs or screening tests have currently been implemented to identify and meet the needs of HT victims? Presently, well-established screening tools for identifying sexual exploitation have been carried out in non-clinical settings, such as law enforcement or child protective services. Reviewing these tools and results may provide a model for screening in a healthcare environment. For instance, 211 participants varying from non-governmental organization representatives to law enforcement officials and prosecutors in five different U.S. cities partook in a

three-day training session for understanding the definition and scope of sexual exploitation and promoting classification of exploited children as victims rather than criminals. Those who underwent the training modules had a substantial increase in knowledge, skills, attitudes, and motivation to learn more. This training would enable, for example, law enforcement agencies to collaborate with other organizations to assist victims in seeking rehabilitative services, report other abuse, and prosecute the perpetrators.[9]

A follow-up quasi-experimental study in 2013 assessed a training implementation for Child Protective Services (CPS) employees. This evaluated whether initial beliefs, knowledge, and referrals to specialized services improved with training. A 90-minute webinar was given to 123 participants who were assigned to either the treatment group or control group. As a result of the web-based training, CPS personnel's knowledge and beliefs on child exploitation, and the ability to identify the risk factors were enhanced. Awareness of local laws and services, and increased willingness to refer victims to appropriate specialized services also improved.[10]

Next, a mixed-method study in 2019 was done to assess the differences between a standard psychosocial assessment tool and a human trafficking-specific assessment tool in identifying HT among homeless youths. The HT screening tool for risk factors queried details such as race, gender, sexual orientation, education, past truancies, family relationships, shelter use or history of running away, labor or sex exploitation, abuse (financial, emotional, physical or sexual), past arrests, history of drug use or binge drinking, and any attempts to seek aid. Youths had reported more risk factors through the screening tool rather than the standard psychosocial review of systems assessments – Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety (HEEADSSS). [11]

Training and screening tools already used in non-clinical settings such as law enforcement, CPS, and homeless shelters may provide a basis to develop or refine current tools implemented in the clinical setting to better identify, understand, and provide better services to HT victims.

CURRENT SCREENING & TRAINING TOOLS IMPLEMENTED IN CLINICAL SETTINGS

Some screening and training tools have been applied to the clinical settings to aid clinicians in recognizing and managing HT encounters, which begs the question: how does knowledge and confidence level compare before and after a training intervention in terms of identifying and responding to HT victims? A 2012 cross-sectional study aimed to assess the knowledge and comfort levels of emergency department (ED) providers in identifying and treating HT victims before and after exposure to an educational workshop. The workshop covered identification, clinical presentation, and treatment of human trafficking victims. Before the training session, 79.8% reported feeling hesitant or not confident in their ability to define human trafficking. After the training session, 90.3% reported being confident or very confident.[12]

Similarly, a 2014 study evaluated ED providers' recognition of HT victims and awareness of resources to manage these cases after receiving an educational presentation. A single standardized session about HT background, relevance to healthcare, clinical signs, and referral options was administered to a total of 258 participants spanning 20 of the largest San Francisco Bay Area EDs. Knowledge of who to call when encountering a potential victim increased more in the intervention group (from 24% to 100%) than the delayed intervention group. Suspicion for a potential HT victim also doubled from 17% to 38%, compared to the delayed intervention group, which remained at 10%. The study's results show that a short, single presentation statistically and significantly increased knowledge of HT and steps to respond to a potential victim. Importantly, this short intervention also sensitized providers to signs and symptoms of possible victims and produced a statistically significant shift in their

practice. The study took place in Northern California with possibly greater awareness of the HT issue due to high levels of immigration and HT incidence.[13]

Another study in 2017 done at a level two trauma center in Pennsylvania tested a screening tool and treatment algorithm to improve identification and response to HT victims in the ED and also evaluated provider competence level. Initially, no HT victims had been identified in the ED. However, after implementation, 38 potential victims were identified, 5 accepted help, and one who was rescued was indeed a victim of trafficking. Of the participants in the study, 97% stated they were committed to changing their practice as a result. Most perceived that the educational session improved their competency and 75% planned to use alternative communication strategies to identify victims in the future.[14]

In a more extensive investigation, Greenbaum et al in 2018 performed two different studies to determine whether there were differences in screening for sexually exploited children among other high-risk non-trafficked adolescent populations such as acute sexual abuse patients.[15, 16] The first study – assessing English-speaking youths ages 11-17 who were deemed at risk of HT and who presented to the ED, child advocacy centers, and adolescent clinics – found differences and classified 90 out of 810 participants as HT victims.[15] A subsequent cross-sectional study created and used a 6-item screening tool that highlighted 16 demographic, behavioral, physical, and historical factors that differentiated between victims of trafficking versus victims of sexual abuse. These studies provided important quantitative evidence and had a sensitivity of 92%, specificity of 73%, positive predictive value (PPV) of 51%, and negative predictive value of 97%. Although the PPV is low, the tool would prompt the provider to ask additional questions in a trauma-informed manner that may lead to greater chances of proper HT identification. [16]

Given that many institutions have implemented their own screening and training tools, would a standardized protocol for HT in healthcare be more effective for providers across the nation to follow? A

2016 mixed-method study featured interviews with experts in HT education, which reviewed a variety of HT education materials that currently exist. These materials shared common themes such as global estimates of prevalence, risk factors, victim and trafficker characteristics, signs and symptoms, and recommended initial steps to such encounters. Furthermore, the common themes correlated with a general request by clinicians for standardized training and more evidence-based studies into the resulting impact on clinical practice. For instance, one impact is the number of provider calls to the National Human Trafficking Resource Center (NHTRC) hotline to report potential cases of trafficking. The study's results showed a gradual uptick in calls since 2008, suggesting that health providers are becoming more aware of HT, and further training could prompt a level of change in behavior and practice.[17]

Clinicians would be better equipped to identify and react appropriately to encounters of possible HT victims with training geared specifically for such situations. Across the board, confidence level increased after training than before. However, perhaps to be more effective in identifying and caring for this population, standardization of HT protocols may need to be instituted.

BARRIERS TO IMPLEMENTING TRAINING & IDENTIFYING VICTIMS

What are the potential barriers to identifying trafficked victims? Researchers in a 2017 study asked several healthcare professionals about their views and personal experiences of HT victims as well as possible barriers of identification. Examples of obstacles cited were language barriers, difficulty separating the victim from the accompanying trafficker, concerns of violating patient confidentiality, time constraints and competing priorities on the providers' part. Moreover, the victims' fear of retaliation by their trafficker was another key obstacle in identifying and intervening.[19] From the perspective of healthcare providers, these are common barriers to successfully recognizing and rescuing their patients in trafficking situations.

Conversely, additional barriers to identification from the victims' point of view were explored through anecdotal accounts in a 2011 study. This qualitative study highlighted common barriers to disclosure, such as traffickers taking over all aspects of the clinical encounter including completing paperwork and speaking with staff and providers on the victim's behalf. Victims also cited trust issues with the staff and providers who to the victims were absolute strangers. And feelings of shame and embarrassment are common emotions held by victims during their clinical encounters, thus, further complicating disclosure of their situations. One victim feared she would be judged by the clinicians and staff and another felt shame over the possibility that her family would discover her situation. Many informants mentioned cases in which the trafficker appeared to have a personal relationship, such as being a relative, with the clinician; therefore, minimizing opportune moments for victim disclosure to a provider. Even if such relationships were not the case, victims had felt that the providers were not working on their behalf. [20] There are many potential obstacles on both the provider's and victim's end and it is critical to be tactful of these situations that could hinder HT victim identification and rescue.

WHY HUMAN TRAFFICKING MATTERS IN HEALTHCARE

Though human trafficking is a national and global crisis, why is this important in healthcare practice and what impact does it have on victims who are patients? Healthcare providers must be aware of HT because it affects the care that they provide to potential victims that present to their settings. One qualitative study in 2013 held interviews of medical providers treating women who were victims of sexual exploitation to reveal the traumatic nature and psychological consequences. For example, providers cited themes of rape, abusive environments, running away from home, and subsequent recruitment by a pimp, which victims experienced before and leading up to victimization and trafficking. These carry significant physical and mental weight on a victim's health considering many had experienced traumatic injuries (beatings, stabbings, gunshot wounds), sexually transmitted diseases,

and gynecological issues. Even in the aftermath of trauma, victims are plagued with long-lasting problems including depression, sleep disorders, nightmares, self-harm, posttraumatic stress disorder (PTSD), eating disorders, and substance addiction for coping. Providers must recognize the complexity of care and need for continuous management for this vulnerable patient group. Though informative, this study only offers a perspective from the medical providers who treated these victims.[18]

Researchers in a 2014 mixed-method study delved into greater detail of the many health consequences faced by victims of sex trafficking: physical, psychological, reproductive, violence, humiliation, and substance abuse. This study utilized qualitative data gathered from survivors' interviews along with quantitative analysis of their responses. Almost all survivors (99.1%) endured physical health problems such as injuries to the head and face and dental problems as a result of trafficking. Other health issues included cardiovascular/respiratory (68.5%), gastrointestinal (62.05%), and neurological (91.7%). Dietary health was impacted as well and survivors had endured malnutrition, eating disorders, and severe weight loss.[5] These rampant physical health problems are important to recognize when approaching treatment of HT victims.

By far, psychological trauma may be the worst of the health issues affecting HT victims. Respondents reporting at least one psychological problem during trafficking did not see much improvement after trafficking. Indeed, depression (88.7%), PTSD (54.7%), and poor self-esteem (81.1%) are just some of the mental health issues ravaging HT victims. Personality disorders are also included, such as bipolar (30.2%), depersonalization (19.8%), multiple personality (13.2%), and borderline personality (13.2%) disorders.[5]

Reproductive issues are yet another health problem experienced by survivors of sexual exploitation. More than two-thirds had contracted a sexually transmitted infection and more than half reported at least one gynecological symptom such as dyspareunia, urinary tract infections, and abnormal vaginal discharge. Sex trafficking victims are at greater risk of acquiring these problems as

they may be used by buyers for sex on average 13 times per day and some with as many as 30 to 50 buyers a day. Other reproductive issues include unwanted pregnancies, miscarriages, abortions (elective or forced) during their time trafficked. Of the 66 respondents, 47 had reported at least one pregnancy (71.2%) and 14 of these reported five or more pregnancies. Frequently forced abortions are also an alarming trend with more than half of the respondents reporting one or more forced abortions while trafficked.[5]

In this study, nearly all survivors (92.2%) had reported some form of violence, abuse, and humiliation. Survivors reported being strangled, burned, kicked, punched, raped, or penetrated with a foreign object. One woman said she had been whipped and had bleach poured on her. Many victims had been subjected to offensive names and starved of basic physical and emotional human needs. Lastly, many survivors (84.3%) suffered from substance abuse (alcohol, drugs, or both) either as a way to cope with the intense abuse or forced by their traffickers to use as a means of control.[5] The inhumane level of treatment that these victims underwent is unacceptable, and providers should be aware of the degrees of suffering inflicted to better understand the resultant health problems.

A new question that arises is how and if the matter of HT in healthcare should be integrated into the teaching curriculum of professional schools such as nursing, physician assistant studies, and medical schools. Curricula can vary across the nation and the degree of HT education likely differ from one curriculum to the next. Nonetheless, all healthcare personnel should be trained and informed one way or another through their educational institutions or employment.

CONCLUSION

Human trafficking is a pervasive infringement upon human rights and a public health issue across the world. Clinicians are obligated to provide the best care possible to all patients but this is not achievable unless clinicians can reach out to patients of the most vulnerable populations. Even though

the underground nature of HT keeps healthcare providers from realizing the full scope of this crime, research exists and new studies continue to broaden the understanding of signs, symptoms, misconceptions, screening and training tools, referral services, victim experiences, and barriers to HT identification. Current studies unanimously show that there is an improvement in the knowledge and confidence level of clinicians after receiving training to identify and respond to HT victims. Further studies are needed though to assess the results of applying the new knowledge and skill. Additionally, more research is needed to determine if more providers are calling the NHTRC hotline or referring HT victims to specialty services. Perhaps further discussion should take place on whether there is a pressing need for standardization of HT guidelines and protocols for providers to follow.

These findings are relevant to how it will impact clinical practice. For instance, there are few studies – if any – that discuss how HT in healthcare relates to the roles and practices of physician assistants. Just as having a broad differential diagnosis allows PAs to consider other potential problems, awareness of HT and knowing the next steps and guidelines to respond appropriately will help aid those still lost in the shadows of human trafficking.

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