Human Trafficking Victim Identification and Response Within the United States Healthcare System

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INTRODUCTION

Human trafficking is a complex worldwide problem affecting many aspects of society. This problem transcends national borders and affects all countries, all types of victims, and healthcare systems worldwide. Human trafficking is considered a form of modern slavery involving the commercial exchange and exploitation of humans for the purpose of receiving benefits or monetary gain (UNOCD, 2003). Most human trafficking victims interact with the healthcare system while being trafficked; therefore, health care systems have an important role in identifying and responding to trafficked persons (Leslie, 2018). Understanding the role of the health care system, the best methods to identify trafficked individuals, and respond to their needs is key to addressing this problem. Safety professionals can play an important role in supporting and advising the healthcare system as they develop and implement policies related to human trafficking.

Definition of Human Trafficking

The United Nations Office of Drugs and Crime defines human trafficking as the "recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (UNOCD, 2003). Exploitation can include the "exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs" (UNODC, 2003). The United States defines sex trafficking and labor trafficking separately. Sex trafficking is defined as the, "recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age" (United States, 2000) Whereas labor trafficking is the, "recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery, (Trafficking Victims Protection Act (TVPA) 22 USC § 7102)." (United States, 2000).

Prevalence of Human Trafficking

Estimating the prevalence of human trafficking in the United States is extremely difficult. The methods used to derive estimates of human trafficking are rarely described in the literature or government reports. Human trafficking estimates are most often derived from incomplete criminal justice data or data from human trafficking service agencies or hotlines, both of which likely underestimate the scope of the problem. According to the Women's Center, every year between 18,000 and 20,000 human trafficking victims are brought into the United States (USDOJ, 2015). Since 2017, there have been 56,504 cases of human trafficking reported to the National Human Trafficking Hotline (Polaris, 2018). In 2015, the US Department of Homeland Security and the US Department of Justice opened 2,847 investigations of suspected human trafficking cases and prosecuted 377 defendants for human trafficking crimes (US Department of State, 2016). Also, in 2015, federally funded victim service agencies in the United States reported 3,889

open client cases (Nichols, 2015). These estimates are thought to represent a small fraction of all human trafficking cases in the United States. Recent attempts to quantify the number of human trafficking victims in the United States include innovative sampling methodologies and analytic strategies to better estimate the prevalence of human trafficking in hard-to-reach and vulnerable populations (White, 2019). A study including child welfare, legal services, and law enforcement data in and around Ohio from 2014 through 2016 found over 1,000 human trafficking victims in that state alone (Anderson, 2019). Garnering credible prevalence estimates of human trafficking, calculating the number of new cases (incidence) per year, and estimating the proportion of the population experiencing victimization is of the highest priorities in understanding this public health problem and in enacting policies and programs that are effective.

Characteristics of Trafficked Persons

The characteristics of trafficking victims can vary widely. Trafficking victims can span all races, genders, ages, and sexual orientations. Data from more than 23,000 trafficking survivors interacting with the National Human Trafficking Hotline in 2018 provide a snapshot of victim characteristics (Polaris, 2018). According to this data, the three predominant types of trafficking cases encountered were (1) sex trafficking such as escort services and pornography; (2) labor trafficking such as domestic labor, agricultural, and travelling sales; and sex and labor trafficking combined such as massage, health and beauty; bars, strip clubs and cantinas, and (3) other illicit activities. Of the victims the National Hotline interviewed, 47% were adults, 21% were minors, and one-third of victims did not disclose their age. Most trafficking victims interacting with the National Hotline were female (65%) or of unknown gender (22%). Approximately 13% of trafficking victims interacting with the National Hotline were male. While most victims of human trafficking who were served by the National Hotline did not disclose their race/ethnicity, those that did were more likely to be an ethnic or racial minority: 37% were Latino, 28% were Asian, 18% were African American and 15% were White (Polaris, 2018).

Risk Factors

According to the 2018 Human Trafficking National Hotline, the major risk factors for human trafficking were: recent migration or relocation; substance abuse; unstable housing; being a runaway or homeless youth; or having a mental health concern (Polaris, 2018). The predominant methods used by perpetrators of human trafficking included isolation and confinement, economic abuse, threats, emotional abuse, and physical abuse. While the Human Trafficking National Hotline data provide some preliminary profiles of the characteristics and risk factors of those who are victims of human trafficking, these statistics should be viewed with caution given that victims interacting with these services may not represent all victims as they are predominantly self-selected (Polaris, 2018).

The imprecise estimates of prevalence and poor understanding of risk factors should not prevent the implementation of meaningful screening and prevention programs to identify and assist victims who have been trafficked. It has been estimated that 80 to 90 percent of human trafficking victims are seen by a healthcare provider while still being trafficked, making healthcare organizations an ideal place to recognize, identify, assist, and refer

victims (Leslie, 2018). This paper reviews the evidence associated with identification methods for healthcare professionals and issues associated with responding to trafficking victims.

HEALTHCARE AND HUMAN TRAFFICKING

Health Burdens

Trafficking is associated with significant health burdens for victims (Ottisova, 2016; Ottisova, 2018; Kiss, 2015). Human trafficking victims have an increased risk for physical injuries such as fractures, lacerations, chronic pain, headaches, skin conditions, malnutrition, infectious diseases, reproductive health problems, dental problems, and persistent mental health problems such as post-traumatic stress disorders, depression, anxiety, and suicidality (Oram, 2012: Ottisova, 2016; Ottisova, 2018; Kiss, 2015; WHO, 2012). Substance use and abuse is prevalent among victims of human trafficking. Substance use is a risk factor for being trafficked, is used as a way to control victims, and is used as a means of coping with physical and psychological abuse both during and after trafficking (Goldberg, 2017; Goldberg, 2018; Salami, 2018; Le, 2018). One study of 107 survivors of human trafficking reported that 84.3% of those trafficked used alcohol or drugs while a victim and nearly one-third of victims were forced to use alcohol or drugs as a control mechanism (Lederer, 2014). Given the increased risk of health problems related to trafficking, victims often encounter the healthcare system through primary care, emergency departments, and community health clinics.

Interaction with the Healthcare System

While many studies show that over 80% of victims have interacted with the healthcare system while being trafficked, these victims often go unnoticed (Baldwin, 2011; Chisolm-Straker, 2016; Chisolm-Straker, 2018; Ijadi-Maghsoodi, 2018; Ravi, 2017). In one survey, almost a third of victims indicated they came in contact with healthcare providers while being trafficked but were not recognized as being victims (Family Violence Prevention Fund, 2005). Another survey indicated that 85% of trafficking victims had received treatment for an illness or injury directly related to their work or exploitation (Polaris, 2020). Evidence shows that most victims (63%) receive care through emergency departments (Lederer,2014). The healthcare setting may be the first nonfamily point of contact for victims of abuse. Despite these opportunities to assist human trafficking victims, surveys of healthcare professionals indicate that only 6 percent of providers reported ever treating a human trafficking victim and the majority (57%) of victims of trafficking report never being asked trafficking or abuse-related questions during their healthcare visits (Polaris, 2018).

There are, however, clear signs that the healthcare industry is taking human trafficking seriously. More than 14 medical societies including the American Hospital Association have created policies on human trafficking, and many states have mandated training and education for healthcare providers. Another major step in understanding human trafficking and how healthcare can respond to this crisis is the creation of new disease classification codes to recognize and classify human trafficking victims and to differentiate human trafficking victims from other abuse victims. The first trafficking-specific codes were

approved for the *International Classification of Diseases, 10th Revision, Clinical Modification* (*ICD-10-CM*). These codes are expected to strengthen data collection on the incidence and risk factors for trafficking, the burden of comorbid illness and injury, and the resources needed to effectively care for trafficked persons. The 2019 Addenda for the ICD-10-CM List of Diseases and Injuries are in Table 1.

Table 1: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for Human Trafficking

Under *Adult and child abuse, neglect and other maltreatment, confirmed*	T74.5 - Forced sexual exploitation, confirmed
	T74.51 - Adult forced sexual exploitation, confirmed
	T74.52 - Child sexual exploitation, confirmed
	T74.6 - Forced labor exploitation, confirmed
	T74.61 - Adult forced labor exploitation, confirmed
	T74.62 - Child forced labor exploitation, confirmed
Under *Adult and child abuse, neglect and other maltreatment, suspected*	T76.5 - Forced sexual exploitation, suspected
	T76.51 - Adult forced sexual exploitation, suspected
	T76.52 - Child sexual exploitation, suspected
	T76.6 - Forced labor exploitation, suspected
	T76.61 - Adult forced labor exploitation, suspected
	T76.62 - Child forced labor exploitation, suspected
Under *Encounter for examination and observation for other reasons*	Z04.81 - Encounter for examination and observation of victim following forced sexual exploitation
	Z04.82 - Encounter for examination and observation of victim following forced labor exploitation
Under *Problems related to upbringing: Personal history of abuse in childhood*	Z62.813 - Personal history of forced labor or sexual exploitation in childhood
Under *Personal risk factors, not elsewhere classified: Personal history of psychological trauma, not elsewhere classified*	Z91.42 - Personal history of forced labor or sexual exploitation

Healthcare Provider Training and Education

Training of health care providers in the identification of trafficked persons is severely lacking. One study that surveyed 168 health care professionals in Wisconsin, found that 63% of the respondents had never received such training. Of those surveyed that had received training, 68% worked in an urban setting (Beck, 2015). Educational programs to train healthcare providers have expanded greatly in the last several decades. Although many training programs and resources are available, most lack any evidence of effectiveness, have not been published in the peer-reviewed literature, and very few have examined behavior changes as a result of training and education (AHN, 2013). Many organizations offer continuing education credits for completion of their programs, but many of these offer credit for simply reading or reviewing trafficking-related resource material and completing post-test assessments. Some educational resources use pre-test and post-test assessments to evaluate the impact of the trainings on the provider's knowledge and self-efficacy in handling suspected trafficking incidents. However, most

studies lack rigorous evaluation designs and only a few have examined whether these education materials and trainings are effective in enhancing clinical practices or improving identification, treatment and referral of victims in the long term. One study randomized 20 of the largest emergency departments in the San Francisco Bay area into an intervention consisting of a standardized presentation of human trafficking or a delayed intervention comparison group. Findings indicate that educational interventions can increase provider knowledge of human trafficking and the identification of who to call when encountering a human trafficking victim. This study also demonstrated that those receiving education on human trafficking were more likely to suspect their patients were victims of human trafficking than those in the delayed intervention group (Grace, 2014).

Researchers indicate that human trafficking education is highly variable and there is a need to build a body of evidence-based programs for health professionals (Powell, 2017). Moreover, a greater understanding of how best to introduce training, establish the format for trainings, and tailor training for various healthcare audiences is needed. Additional rigorous evaluations of existing educational resources are needed including an assessment of content validity and effectiveness in impacting clinical outcomes. These training programs and educational resources are critical to changing the way healthcare providers identify, assess, and refer trafficking victims. Training in and of itself, however, is not sufficient for healthcare organizations to have an impact. Healthcare organizations must also develop supportive policies and procedures that are tailored to their context and environment.

Screening

Although many screening instruments and protocols exist, few have been validated. A review of the literature revealed only six studies published in the peer-reviewed literature that examined the feasibility or validity of human trafficking identification within a healthcare setting between 2010 and 2019. Table 2 shows the population, type of trafficking, and medical setting that the six articles evaluated. Validity is measured using sensitivity and specificity. Sensitivity or the true positive rate measures the proportion of those screening positive for human trafficking and are actual human tracking victims. Specificity or true negative rate measures the proportion of those screening negative for human trafficking and are not human tracking victims.

Table 2: Human Trafficking Studies Evaluating Feasibility and Validity

Author, Year, and Title	**Population (adult, youth, or both)**	**Type of Trafficking (labor, sexual, or both)**	**Medical setting**
Egyud (2017) Implementation of Human Trafficking Education and Treatment Algorithm in the Emergency Department	Both	Both	Emergency department

Author, Year, and Title	Population (adult, youth, or both)	Type of Trafficking (labor, sexual, or both)	Medical setting
Greenbaum (2018a) A Short Screening Tool to Identify Victims of Child Sex Trafficking in the Health Care Setting	Youth	Sexual	Pediatric emergency department and child protection clinic
Greenbaum (2018b) Evaluation of a Tool to Identify Child Sex Trafficking Victims in Multiple Healthcare Settings	Youth	Sexual	Emergency departments, child advocacy centers, and teen clinics
Mumma (2017) Screening for Victims of Sex Trafficking in the Emergency Department: A Pilot Program	Adult	Sexual	Emergency department
Kaltiso (2018) Evaluation of a Screening Tool for Child Sex Trafficking Among Patients With High-Risk Chief Complaints in a Pediatric Emergency Department	Youth	Sexual	Pediatric emergency department
Raj (2019) Incorporating Clinical Associations of Domestic Minor Sex Trafficking Into Universal Screening of Adolescents	Youth	Sexual	Primary care clinic

Table 3 displays the items used in the various studies. The number of items in most human trafficking screening questionnaires varies from seven to 17. One study used the Department of Health and Human Services Screening Tool for Human Trafficking to identify both labor and sex trafficking (Egyud, 2017). Another study used similar items, to screen for sex trafficking. The remainder of the surveys included questions that were specific to sex trafficking. The following section describes each of these studies (Mumma, 2017).

Table 3: Human Trafficking Screening Questions

Study	Question Items
Egyud, 2017	1. Can you leave your job or situation if you want? 2. Can you come and go as you please? 3. Have you been threatened if you try to leave? 4. Have you been physically harmed in any way? 5. Describe your working or living conditions. 6. Where do you sleep and eat?

	7. Do you sleep in a bed, on a cot, or on the floor? 8. Have you ever been deprived of food, water, sleep, or medical care? 9. Do you have to ask permission to eat, sleep, or go to the bathroom? 10. Are there locks on your doors and windows so you cannot get out? 11. Has anyone threatened your family? 12. Has your identification or documentation been taken from you? 13. Is anyone forcing you to do anything that you do not want to do?
Kalitso, 2018	1. Have you ever broken any bones, had any cuts that required stitches, or been knocked unconscious? 2. Some kids have a hard time living at home and feel that they need to run away. Have you ever run away from home? 3. Kids often use drugs or drink alcohol, and different kids use different drugs. Have you used drugs or alcohol in the past 12 months? 4. Sometimes kids have been involved with the police. Maybe for running away, for breaking curfew, for shoplifting. There can be lots of different reasons. 5. Have you ever had any problems with the police? 6. Added question for transition into sexual history: Have you ever had sex of any type? (penis in vagina or penis/finger in “butt” or mouth on penis or mouth on vagina) 7. How many sexual partners have you had? 8. Have you ever had a STI, like herpes or gonorrhea or chlamydia or trichomonas?
Greenbaum, 2018a	1. Have you been to see a nurse, doctor or other health provider in the last year? 2. Have you ever broken any bones or had any cuts that needed stitches? 3. Have you ever been knocked unconscious (“knocked out”)? 4. Have you ever run away from home or been ‘kicked out’ of your home? 5. Have you used drugs or alcohol in the last 12 months? 6. If yes, do you remember how old you were when you first tried alcohol or drugs? 7. Have you ever had any problems with the police? 8. Has a boyfriend or girlfriend in a dating or serious relationship ever physically hurt you or threatened to hurt you (hit, pushed, kicked, choked, burned or something else)? 9. Have you ever had sex of any type? 10. If yes, when you had sex, what did it involve (vaginal, anal, oral) 11. Since the first time you had sex, how many partners have you had? 12. Which of the following best describes you? (Heterosexual (straight), Homosexual (Gay or Lesbian), Bisexual, Transgender, Not sure 13. Have you ever had any sexually transmitted infections, like herpes, gonorrhea, chlamydia or trichomonas? 14. Have you ever traded sex for money, drugs, a place to stay, a cell phone, or something else?

	15. Has a boyfriend, a girlfriend or anyone else ever asked you, or forced you to have sex with ANOTHER person? (If asked, did you have to actually do it?) 16. Has anyone ever asked or forced you to do some sexual act in public, like dance at a bar or a strip club? (If asked, did you have to actually do it?) 17. Has anyone ever asked you to pose in a sexy way for a photo or a video? (If asked, did you have to actually do it?)
Greenbaum, 2018b	1. Is there a previous history of drug and/or alcohol use? 2. Has the youth ever run away from home? 3. Has the youth ever been involved with law enforcement? 4. Has the youth ever broken a bone, had traumatic loss of 5. consciousness, or sustained a significant wound? 6. Has the youth ever had a sexually transmitted infection? 7. Does the youth have a history of sexual activity with more than 5 partners?
Mumma, 2017	1. Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor? 2. Were you (or anyone you work with) ever beaten, hit, yelled at, raped, threatened or made to feel physical pain for working slowly or for trying to leave? 3. Has anyone threatened your family? 4. Is anyone forcing you to do anything that you do not want to do? 5. Do you owe your employer money? 6. Does anyone force you to have sexual intercourse for your work? 7. Is someone else in control of your money? 8. Are you forced to work in your current job? 9. Does someone else control whether you can leave your house or not? 10. Are you kept from contacting your friends and/or family whenever you would like? 11. Is someone else in control of your identification documents, passports, birth certificate, and other personal papers? 12. Was someone else in control of arrangements for your travel to this country and your identification documents? 13. Do you owe money to someone for travel to this country?
Raj, 2019	1. History of childhood maltreatment 2. History of running away or truancy 3. History of child welfare (i.e., child protective services [CPS]) involvement 4. History of sexually transmitted infection (STI) 5. History of recurrent STIs (i.e., ≥2 times) 6. History of substance use 7. History of self-harm 8. History of suicidal ideation 9. History of psychiatric diagnosis

	10. Public or private insurance

A 2017 study by Egyud and colleagues tested a multi-pronged approach to identify human trafficking victims in a level two trauma center in a southwestern Pennsylvania community hospital (Egyud, 2017). First, they initiated screening at the registration desk, where staff looked for signs of human trafficking (no insurance, offer to pay cash, no personal identification, no guardianship documentation, or a patient who is with a person who does all of the talking). If registration staff identified these signs or a patient answered yes to existing questions on a domestic violence survey, the emergency nurse completed the Department of Health and Human Services Screening Tool for Human Trafficking (Egyud, 2017).

In addition, a silent notification system was implemented by placing signs in the bathroom and asking potential victims to place a blue dot on their specimen cup. The blue dot would alert staff to ensure that the patient was in a safe area when answering the screening questionnaire. Screening could also be triggered if emergency nurses or physicians noticed common physical health symptoms such as urinary tract infection, pelvic or abdominal pain, suicide attempt, or psychogenic nonepileptic seizures during the health assessment (Egyud, 2017).

The implementation of this multi-pronged screening approach was measured for five months. Study findings indicated that the screening protocols were adhered to with a 100% compliance. The process yielded a total of 38 potential trafficking victims. Medical red flags identified 20 patients, and the silent notification process identified 18 patients. Intervention and rescue were offered to all patients identified as possible victims. Four (11%) of the adults accepted help, and one minor received mandatory intervention because of child abuse laws. Three of the five victims who accepted interventions were identified by nurses or physicians through their physical examination. One victim was identified through the blue dot identification process. There were 17 other patients who placed blue dots on their urine specimen and were assumed to be victims but changed their minds once they were questioned by a health care provider. The validity of the screening questionnaire was not measured (Egyud, 2017).

Mumma and colleagues assessed the validity and feasibility of a 14-item survey and an independent physician's personal assessment among 143 females aged 18-40 years visiting the emergency department. A positive screen was defined as having a "yes" answer to any question on the survey or having physician concerned about trafficking. Of those enrolled, 27% screened positive including 10 females who were ultimately identified as a sex trafficking victim. The survey's sensitivity was 100% compared to the physician's assessment of 40%. Conversely, the physician's assessment had greater specificity (91%) than the screening survey (78%). All of those who were determined to be trafficking victims answered yes to at least one question on the screening survey (Mumma, 2017).

Kalitso and colleagues assessed sex human trafficking screening methods among a convenience sample of adolescents (10-18 years old) visiting a pediatric emergency department for complaints related to high-risk social or sexual behaviors in an urban area

(Kalitso, 2019). The study evaluated the sensitivity and specificity a six-item screening questionnaire. A positive screen was defined as answering "yes to at least two items on the questionnaire. An adolescent was classified as a true trafficking victim if any information during the visit confirmed that their circumstances met the federal definition of child sex trafficking. The study enrolled 203 adolescents, and 49% screened positive on the questionnaire. The total number of adolescents who met the federal definition of child sex trafficking was 11 (5.4%). The study found a sensitivity of 90.9% and a specificity of 53.1% for adolescents who answered "yes" to at least two items of the screening questionnaire. They also found that among those who screened positive for child sex trafficking, 10% were determined to meet the definition of sex trafficking by federal standards (Kalitso, 2019).

Greenbaum and colleagues tested the validity of screening items of a child sex trafficking and exploitation screening instrument among adolescents aged 12 to 18 years, who visited three metropolitan pediatric emergency departments or a child protection clinic (Greenbaum, 2018a). Adolescents were classified as suspected child sex trafficking victims if information obtained by the medical provider indicated a high likelihood that the youth had been a victim of sex trafficking based on the definitions of the United Nations and the Institute of Medicine (UNODC, 2004; Diaz, 2014). This information came from a variety of sources (e.g., law enforcement, medical records, parents, other informants, or the youths themselves). Greenbaum and colleagues examined the sensitivity of various cutoff scores for the six-item screen among 108 participants: 25 were classified as victims of human trafficking and 83 as victims of acute sexual abuse, but not victims of child sex trafficking. The authors found that a cut-off score of two positive answers from the screening instrument yielded a sensitivity of 92%, and a specificity of 73%. They reported that half (51%) of adolescents who indicated a "yes" on at least two items on the screening instrument, were classified as having a high likelihood of child sex trafficking (Greenbaum, 2018a).

In another recent study, Greenbaum and colleagues tested the validity of a 10-item screening instrument among 810 adolescents aged 11 to 17 years old visiting one of 16 healthcare settings that included five pediatric department, six child advocacy centers, and five teen clinics (Greenbaum, 2018b). Criteria included being between 11 and 17 years of age, speaking English and, in the emergency department sites only, presenting with a chief complaint sexual abuse, abuse, or child sexual trafficking. Exclusion criteria included refusing to answer questions.

An adolescent was classified as being a victim of child sex trafficking based on the healthcare provider's opinion. Overall 11.1% (n=90) were classified as victims of child sex trafficking based on the healthcare provider's opinion. This classification varied by type of healthcare facility and included 13.2% of patients visiting emergency departments, 6.3% at child advocacy clinics, and 16.4% at teen clinics. A positive screen was defined as answering "yes" to two or more items on the screening survey. Overall, authors reported a sensitivity of 84.44% and specificity of 57.50% among the overall sample. One in five adolescents who screened positive on the survey were classified as child sex trafficking victims based on the healthcare provider's opinion. While the sensitivity of this

screening instrument did not vary significantly by the type of setting, the specificity and positive predictive value varied by setting type. The specificity for the emergency departments, child advocacy clinics, and teens clinics were 49.4%, 61.4%, and 64.6%, respectively. The number of adolescents screening positive out of those who were classified as being sex trafficking victims (positive predictive value) was 20.0%, 12.8%, and 26.8% from the emergency departments, child advocacy clinics, and teens clinics, respectively (Greenbaum, 2018b).

The most recent study identified was a 2019 study conducted by Raj and colleagues (Raj, 2019). They compared 36 female patients who were confirmed to be involved in domestic minor sex trafficking with 148 female patients with no domestic minor sex trafficking involvement. Classification of confirmed cases was based on self-disclosure or law enforcement evidence. The females in both groups ranged in age from 11 to 18 years of age, with an average age of 15.6 years of age. The two groups of patients were assessed and compared using a set of screening items taken from medical records. The individual items were assessed for sensitivity, specificity, and likelihood ratio. The sensitivity of the items ranged from 28% (for recurrent sexually transmitted infections) to 89% (for substance abuse). Other variables that had high sensitivity were evidence of runaway or truancy (83%), history of child maltreatment (83%), and a history of psychiatric diagnosis (78%). The specificity of the items ranged from 62% to 95%. Most variables exhibited a specificity of greater than 80% (substance use, runaway or truancy, self-harm, history and recurrence of sexually transmitted infections, child protective services involvement, and suicidal ideation). History of a psychiatric diagnosis exhibited a specificity 62%. The likelihood ratios of the items ranged from 2.1 to 7.3. They found that the items with the highest likelihood ratios were substance use (7.3), runaway or truancy history (6.2), history of self-harm (5.6), and history of sexually transmitted infection (5.4) (Raj, 2019)

HUMAN TRAFFICKING: HEALTHCARE RESPONSE

Trafficked persons in need of medical attention provide an opportunity to engage with the victim, provide needed medical care and refer the victims to authorities and organizations that might be able to help them. There are several considerations that healthcare providers should be aware of when responding to human trafficking victims, including understanding the risks of disclosure, using trauma-informed approaches, and identifying resources.

Disclosure and Legal Liability

The goal of healthcare personnel in the identification of trafficking victims should be the well-being of the victim and not necessarily an aggressive pursuit of disclosure. A victim's decision to disclose is influenced by many complex factors that include guilt, shame, fear of being judged, fear of retaliation against family and others, fear of deportation, fear of imprisonment, threats of physical and emotional harm, and fear of being reported. (Macias-Konstantopoulos, 2016). In fact, disclosure could cause more harm to the patient if it is not handled carefully. Providers should focus on building trust and rapport with patients suspected of being trafficked instead of immediately trying to obtain a disclosure.

Once a patient discloses that they are a victim of human trafficking, the legal and ethical reporting requirements are less clear. In 2008, the Trafficking Victims Protection Reauthorization Act (TVPRA of 2008) stipulated that civil lawsuits may be filed against anyone who "knew or should have known" that sex trafficking occurred and financially benefited (United States, 2008) (Strauss, 2009). This law may place providers and healthcare organizations in legal jeopardy. There are also two types of laws that can put healthcare providers and organizations at risk for failing to identify victims: state mandatory reporting laws and conspiracy law. Mandatory reporting laws as they relate to human trafficking, often fall under child abuse reporting laws. Each state has different mandatory reporting laws that generally require a provider to report any minor that is suspected of being a victim of trafficking, or otherwise be in violation of the law. Security professionals and healthcare staff should be aware of the mandatory reporting laws in their respected state and understand how they relate to human trafficking identification and response. Conspiracy laws can also make healthcare providers and hospitals liable. Courts have stated that businesses that have knowingly witnessed or financially benefitted from a crime can be liable. There is little precedent for how these statutes may apply in a healthcare setting (English, 2017).

A Trauma-Informed Approach

Researchers in the area of human trafficking strongly recommend that providers should have training in a trauma-informed approach to care. This type of care recognizes the effect that trauma has had on the victim and acknowledges the vulnerabilities and triggers associated with being a survivor. Trauma-informed approaches seeks to create safety and security, minimize re-traumatization, and foster a physical, psychological, and emotional environment that promotes health and well-being (Macias-Konstantopoulos, 2016). A trauma-informed approach can also assist healthcare providers in managing their own emotions when traumatized patients exhibit negative behaviors. Healthcare providers who are trained in trauma-informed approaches are more likely to build trust and show compassion and respect for the patient. (Macias-Konstantopoulos, 2016).

The Critical Role of Safety & Security in Addressing Human Trafficking

While hospital safety and security professionals have a critical role to play in addressing human trafficking in a healthcare setting, little has been published about their role specific to human trafficking. In fact, few law enforcement professionals have been trained to understand the signs and symptoms of human trafficking, and nothing is known on training for security professionals. National studies show that most local law enforcement officials perceive that human trafficking is not a problem in their community, and fewer than 20% of law enforcement professionals have received training (Grubbs, 2012; Mapp, 2016). One study reported that only one-third of law enforcement officials from the state of Georgia were aware of the definition of human trafficking, one-third were familiar with human trafficking laws, and only 11.2% has received formal training on human trafficking (Grubbs, 2012). Most human trafficking victims are hiding in plain sight, and, therefore, it is important for security professionals to have the tools, resources, and vocabulary to be able to identify victims.

Security professionals should be aware that human trafficking victims themselves often do not want to be identified for reasons that include fear of arrest, threats of bodily harm, threats of financial harm, threats to harm family members, or psychological ties to their trafficker. Trafficking victims may also be illegally in this country and fear deportation (Mapp, 2016). Security professionals are in a unique position to identify signs of human trafficking that healthcare providers may not observe. In addition to screening questionnaires used by healthcare professionals, security officials may be in a unique position to observe evidence of controlling or dominating relationships exhibited in waiting rooms. Signs of a controlling relationship include not being left alone, not being able to speak for themselves, avoidance of eye contact with authority figures such as those in uniform, or adherence to scripted or rehearsed responses in social interactions.

After being trained, security professionals can be more fully integrated into the healthcare team to actively work with clinical staff and patients to address human trafficking. In addition to observing signs of human trafficking that the healthcare team may not observe, it is important for security professionals to assess what situations could lead to violence so they can mitigate these threats before they escalate. Most human trafficking protocols in healthcare settings attempt to separate potential victims from their traffickers so health histories and human screening can be conducted. Perpetrators of human trafficking may become anxious or even violent if they are separated from their victim. Security professionals should be fully trained in crisis intervention and in interacting with patients who have been traumatized. Victims, themselves, may be at higher risk of being violent because they are more likely to abuse substances and be fearful (Hickle, 2016).

Security professionals should be trained to understand and recognize the impact of trauma on survivors of human trafficking. This type of training, called trauma-informed care, emphasizes identifying potential triggers that may retraumatize victims and may also lead to behavioral issues such as aggression, anxiety, appearing adversarial, and being uncooperative. Individuals who have been traumatized may appear hostile, hypervigilant, or in a constant state of arousal especially when they feel threatened. Creating an environment of safety and support is critical when dealing with trauma victims. De-escalation techniques such as being calm, genuine and respectful and building rapport can assist with creating a safe environment and prevent violence (Hickle, 2016).

Security and safety professionals should be involved in the development of guidelines and policies regarding human trafficking identification and referral as well as on-going monitoring of the effectiveness of policies and programs. Policies should clearly articulate the role security professionals have in identification and reporting. The healthcare security industry can play a major role in reducing human trafficking by advocating for the development and implementation of human trafficking policies in healthcare settings that include the role of security. The healthcare and security communities should be on the forefront of developing programs to train safety professionals in human trafficking, trauma-informed care, and crisis management. Finally, programs and policies should be evaluated, and best practices should be disseminated.

Resources

Healthcare organizations must have the appropriate resources to respond to the needs of trafficking victims. Trafficked persons have a high prevalence of complex health needs, but they may not have access to insurance or resources. It is important for the organization to have established clear policies, guidelines, and protocols on how to respond to human trafficking. Having clear guidelines and policies provides a sense of safety and confidence to intervene in these situations. Clear policies can prevent situations that may place the patient or provider in potentially harmful situations.

In addition, organizations must identify personal resources that can adequately address this issue, as well as resources for referral and further treatment. Personal resources in the healthcare setting may include security, law enforcement, social work staff, patient advocates, and educational and development staff. Healthcare organizations should be aware of local organizations that assist victims as well as the services provided by the National Human Trafficking Resource Center. Macias has suggested a framework for healthcare preparedness that includes: development of human trafficking response protocols, identification of a multidisciplinary team to guide protocol development and implementation, adoption of a trauma-focused approach to care, implementation of evidence-based practices, understanding of mandatory reporting laws, development of internal and external resource guides and services available to victims, establishment of algorithms for responding to various scenarios, development of communication channels for knowledge dissemination, and implementation of monitoring and evaluation of the impact and effectiveness of these activities (Macias-Konstantopoulos, 2016.)

CONCLUSION

Human trafficking, a modern form of slavery, is a complex problem affecting virtually every aspect of society including the healthcare system. The healthcare industry and medical societies have made great strides in addressing human trafficking. While medical societies and healthcare organizations have created policy statements or guidelines regarding identification and treatment of victims, there are still large gaps.

Major challenges exist in identifying which patients are really victims of human trafficking. While questionnaires and screening instruments exist, little research has been conducted to determine the feasibility and validity of these instruments. Without valid screening instruments to identify victims, it is impossible to fully understand the prevalence of human trafficking in healthcare settings. As demonstrated by all reviewed studies, screening instruments can have a high probability of identifying patients who are truly victims of human trafficking. However, these instruments also have false positive rates that range from 20 to 50 percent of those screened. The high false positive rates make screening programs in healthcare settings more expensive, since as many as half of those who screened positive would have unnecessary follow-ups by social workers or law enforcement.

It was found that human trafficking education for healthcare providers is highly variable and virtually nonexistent for safety and security professionals working in the healthcare system. There is a need to build a body of evidence-based programs for healthcare

providers and security professionals working in healthcare settings (Powell, 2017). Training programs and educational resources are critical to changing the way healthcare identifies, assesses, and refers trafficking victims. It is likely, though, that training in and of itself is not sufficient for healthcare organizations to have an impact. Healthcare organizations must develop supportive policies and procedures that are tailored to their context and environment. Safety and security professionals should be an integral partners in the development of these policies.

Healthcare organizations must have the appropriate resources to respond to the needs of trafficking victims. Trafficked persons have a high prevalence of complex health needs, but they may not have access to insurance or resources. It is important for the organization to have established clear policies, guidelines, and protocols on how to respond to human trafficking. Clear policies can prevent situations that may place the patient or provider in potentially harmful situations. Healthcare organizations can play a critical role in advancing the goal of reducing human trafficking and ending the suffering of victims.

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