

*Original Paper*

# Human Trafficking Readiness for Clinicians: Content Validation of a Survivor Co-Led Education Program

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## **Abstract**

*Purpose.* This project validates knowledge and confidence in nurses/clinicians who could encounter human trafficking (HT). *Background.* HT, a worldwide problem, is the exploitation of human beings. There are up to 40 million victims globally and 18,000-20,000 in the US. Many victims encounter healthcare professionals who often lack HT training. *Methods.* Clinicians/HT survivors led trainings at two Northern California hospitals. Ability to identify/treat HT patients was measured before and after training. *Results.* 254 professionals, (73.9% nurses) participated. Despite 66.1% indicating HT could affect their patients, most lacked HT identification/treatment training. At baseline, 26.3% of participants felt comfortable/very comfortable identifying and treating potential victims of human trafficking, compared to 93.2% ( $p < .001$ ) and 90.4% ( $p < .001$ ), respectively, at posttest. *Implications.* The training improved red-flag identification and documentation and expanded the trauma-informed care approach. Prioritizing departments likely to serve trafficked patients, this program was implemented across our three-state hospital system.

## **Keywords**

human trafficking, survivor, education, advocacy

## 1. Introduction

Human Trafficking (HT) is a complex, global problem that impacts people in numerous contexts (sexual, labor, other), across all types of geography, and all populations. At its core, it is exploitation, generating some actual or perceived benefit for the trafficker from another human being who does not have the ability to terminate that relationship at will. More formally defined by the United Nations in 2019 as “recruitment, transportation, transfer, 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” (United Nations Office on Drugs & Crime, 2021). Due to the illicit nature of HT, there is limited data available to define the scope with certainty; however, there is ample evidence to verify that HT occurs worldwide and harms large numbers of individuals. It has been estimated that there are 40 million victims globally, and documented reports within all 50 United States (Anthony et al., 2017; Bepalova et al., 2016; Global Slavery Index, 2019; Polaris, 2019; United States Department of State, 2019). While difficult to accurately quantify, over 11,500 victims of HT were identified in the United States in 2019 according to the organization Polaris and the human trafficking hotline (Polaris, 2019).

HT victims come from all backgrounds, but there are certain populations that are at higher risk due to vulnerability that can be leveraged by traffickers. Higher risk populations include foreign nationals, particularly those without legal status or sufficient understanding of immigration processes and the rights of migrants; people with debt or other financial insecurity; people who are homeless; those with addictions; and people who are working in the commercial sex industry. Despite being a specially protected population, children constitute 26% of all victims (Anthony et al., 2017; Bepalova, 2016; United States Department of State, 2019). Children have increasing vulnerability when the aforementioned factors are present, but anyone who is susceptible to the three defining elements of force, fraud, or coercion can be vulnerable to HT victimization (ILO, 2017).

Common misconceptions about HT lead to the assumption that only cisgender women and girls are victims; however, 45% of labor trafficking victims are men and boys. Homeless and runaway boys, particularly within the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community are at risk for sex and labor trafficking. These persons are trafficked using similar mechanisms of force, fraud, and coercion as those employed against cisgender women and girls. There are several forces that perpetuate and drive HT, ranging from political, such as child soldiers in Uganda, to social, such as child brides in India, to sexual exploitation and trafficking that happens worldwide, but particularly in parts of Southeast Asia. Financially driven HT like migrant agricultural labor, exploited factory workers, and other forms of manual labor amounts collectively to \$150 billion a year (Anthony et al., 2017; Bepalova, 2016; United States Department of State, 2019).

HT is gaining attention in the popular press, but remains widely unrecognized, and may not be recognized by those who are experiencing the exploitation. <sup>7</sup> This holds true for health care workers as

well as the general public. In a 2017 study, 64% of labor and sex trafficking survivors reported having seen a clinician during their time as a victim, and of these individuals who had seen a health care provider, 97% stated they did not receive information about HT from their clinicians. <sup>8</sup> One explanation for the lack of information is that clinicians may be underprepared to identify and treat victims and survivors of HT. There is opportunity for the health care team to be instrumental in the identification of victims, and, potentially, in breaking the cycle of exploitation. Several recent publications describe studies that show anywhere between 30-88% of HT victims encounter a clinician during their time of being exploited (Chaffee & English, 2015; Curtis et al., 2008; Hornor & Sherfield, 2018; Greenbaum et al., 2015; Lederer & Wetzel, 2014; Lumpkin & Taboada, 2017; Peters, 2015). Raising awareness among health care staff may be a critical step in reducing this inhumane crime.

HT victims/survivors are reporting interactions with the health care system, yet clinicians have not been routinely trained on how to identify HT and how to safely and effectively intervene (Chisolm-Straker et al., 2012; Chisolm-Straker et al., 2016; United States Department of Labor, 2009). The Coalition to Abolish Slavery and Trafficking's survey of HT victims/survivors found that the perception of the respondents was that health care workers did not recognize their status of being trafficked; only 3.3% (one respondent) said that they had a health care interaction where they were screened and identified as a victim of HT (United States Department of Labor, 2009). The combination of common presentation in health care settings and low rates of screening and identification presents an opportunity to the health care community to create and test a standardized education program.

### *1.1 Education Program*

A large not-for-profit health care provider in California is implementing a universal education approach to screening and intervention in emergency and obstetric clinics and departments, which are the hospital areas most likely to see HT victims/survivors (Brown, 2014; Chisolm-Straker et al., 2012; PBS News Hour, 2014). The goal is to provide hospital staff (nurses, physicians, residents, spiritual and social services departments) the necessary tools to raise awareness and initiate safe interventions. This training program was designed and co-led by a survivor of HT. This effort spans venues of practice (hospitals and clinics), includes facilities in three states (Arizona, California, and Nevada), and has a broad diversity of population density including urban, rural, and agricultural communities. The program is based in victim-centered, trauma-informed care as a means of identifying without retraumatizing the victim and intervening in ways that are responsive to and supportive of the individual person's needs and wishes. The trauma informed approach is a method used keeping the trauma at the center of the persons care and recognizing the impact of that trauma in all aspects of the care continuum (U.S. Department of Health and Human Services, 2014). The unique nature of this program, puts it at a position to meet these goals, being effective, without causing additional harm.

The director of human trafficking response at the health system led an interdisciplinary human trafficking steering committee, with members representing all system regions. Having a HT survivors on the steering committee was key to a successful design and course implementation, because the

expertise of this individual ensured that materials were helpful and informative while maintaining compassion and empathy. Several committee members were experienced clinicians including physicians, nurses, social workers, chaplains, and others—many with extensive experience encountering HT victims in the clinical settings. Given that the steering committee is interdisciplinary, the steering committee was in a distinct position to design training curriculum to train clinicians and non-clinicians who regularly encounter/observe patients including admitting clerks, security guards, housekeepers, and others. This curriculum was administered to numerous clinicians around the corporation for education, evaluation, validation, and improvement over several iterations. The final version of the course titled “Human Trafficking 101—Dispelling the Myths” is used in several organizations and is publicly available online to any interested party at the Dignity Health website (Dignity Health, 2019).

The HT education team scheduled training sessions for ED and obstetric staff from across the organization. This curriculum is offered as an in-person education throughout the three-state health system. Interested staff members enrolled in the courses as did outside parties such as first responders and law enforcement. When administered in person, the final course takes approximately one to two hours to deliver, depending on time constraints and requests. The module takes approximately one hour to deliver, and additional time can be allotted for a survivor’s testimony, Q&A, and time for short presentations by local agencies/service providers.

These components were added and expanded to the 4-hour training session discussed in this study. This session began with a one-hour testimonial of a HT survivor who encountered the health care system while being trafficked, which was followed by time for Q&A and group interaction. This part of the training was very emotional and appeared to inspire the class participants. The second portion consisted of the Human Trafficking 101 module. The third portion consisted of a panel of community experts discussing resources for victims/survivors of HT and other types of violence. Panel members represented local shelters, medical and dental resources, interpretative services, addiction treatment, mental health, legal, and other community resources that are important to survivors as they heal and recover. The final session included Q&A and/or case debriefings. The emotional aspects of the training, as well as some of the debriefings were anticipated and mitigated by the experienced and diverse interdisciplinary education team, who led the course design and implementation.

## **2. Method**

This project received approval from the Institutional Review Board (IRB), and the research team developed a pre-and post-course survey design study to evaluate the efficacy of a survivor co-led HT training program. The surveys were based on a similar study of emergency department clinicians in New York; permission to use the instrument was generously granted by the study author (see Figure 1).  
16 For efficiency our team utilized a proven survey instrument found in the literature and unfortunately no validity and reliability information related to the instrument was available at the time of our project.

Course participants were mostly nurses, other caregivers, social workers, etc., currently working at a large California-based health system that were recruited to take part in the training, as well as the pre and post training surveys.

At the beginning of each training session, we briefed participants, providing an overview of the course, and offered participants the opportunity to complete the pre-course survey on a voluntary basis. At the end of each training session, the participants were again asked to voluntarily complete a post-course survey. The voluntary surveys were administered and collected in a large envelope to assure privacy by members of the nursing research team; these individuals were not course presenters. The surveys and training materials were co-designed and co-implemented by a diverse interdisciplinary team, which was important, especially given the compelling information provided. When designing materials for such courses, it is important that all impacted parties are involved from start to finish, and in this case, the HT survivor was a co-leader of the project, therefore, this perspective was largely considered.

### 3. Result

Nurses constituted the majority of the 254 professionals who participated in this training and nearly 2/3 of the participants had six or more years of clinical experience. The majority (66.1%) indicated that they believed that human trafficking affects their patient population.

We gathered data on prior familiarity with HT: 97.6% reported that they were familiar with human trafficking prior to the intervention, 26.0% reported that they had treated a potential victim of human trafficking, 25.2% reported that they had received prior training on identifying human trafficking victims, and 18.9% reported that they had received training on how to treat and care for trafficked persons.

We conducted a chi-square analysis to assess each participant's ability to identify and treat victims of human trafficking using a 4-point Likert scale instrument (1 = Not confident, 2 = Hesitant, 3 = Comfortable, 4 = Very comfortable). Chi-square analysis revealed that at baseline, only 26.3% of the participants reported feeling either comfortable or very comfortable in identifying victims of human trafficking, however, post-training, 93.2% indicated that they were comfortable or very comfortable ( $p < .001$ ), constituting a statistically significant increase of 254.4%.

At baseline, 23.6% of the participants reported feeling either comfortable or very comfortable treating victims of human trafficking, whereas, at the posttest, 90.4% indicated that they were comfortable or very comfortable ( $p < .001$ ), a statistically significant increase of 283.1%.

Further analysis of the Likert scale scores pertaining to confidence in identifying HT victims produced a pretest mean of 2.13 (.742) and a posttest mean of 3.12 (.492); scores for confidence in treating trafficked persons had a pretest mean of 2.00 (.805) and a posttest mean of 3.12 (.548). Initially, we considered comparing the deidentified (non-matched) pre- and posttest means using the traditional t test, however, the data failed to meet the essential assumptions of normality and homogeneity of variance, hence, we opted for the Mann-Whitney U test, the nonparametric equivalent of the t test. The

results revealed statistically significant differences between the pretest and posttest scores for both variables ( $p < .001$ ).

In terms of participant's evaluation of the in-service, 96% indicated that it was useful, 85% felt it was motivating, 80% stated that the presentation was well-organized, 74% rated it as thorough, and 57% indicated that it was interesting.

**Table 1. Participant Professions**

Profession	Percentage
RN	73.9%
Other	13.0%
MSW	7.9%
Chaplain	4.3%
Resident	.4%
NP	.4%

**Table 2. Participants Professional Experience**

Duration	Percentage
Less than 1 year	6.3%
1 – 3 years	22.5%
4 – 5 years	7.9%
6 – 10 years	18.6%
10 or more years	44.5%

#### 4. Discussion

In addition to the significant quantitative findings, we observed and noted qualitative aspects of how participants reacted to these trainings. These sessions were well attended and appeared to be successful. The participants appeared to be genuinely engaged in the training and had in-depth dialogue with the presenters. Several of the course participants appeared to become emotional when describing encounters, they had had with potential victims of HT. It is the opinion of the authors that the content of the course, which had been co-created with survivors and clinicians, was appropriate and applicable to the participants.

The community resource panel provided valuable information to the clinicians who may be encountering HT victims/survivors in the clinical setting, enabling them to provide essential referrals. Participants reported finding this portion of the in-service to be particularly useful, enabling them to go from detection to intervention. The course participants were able to directly connect with human trafficking survivors as part of this training and view the issues from a unique perspective. Of note, we

had little to no physician participation in this course as they have a specific course targeted to the needs of physicians and advanced practice providers.

Lessons learned in the development of a system-wide HT response program, co-designed and co-led by survivors, and in the delivery of the associated training were chronicled in a comprehensive white paper titled Human Trafficking Response Program Shared Learnings Manual. This manual is guiding human trafficking response nation-wide and is publicly available at the Dignity Health website (Dignity Health, 2017).

There has been substantial evolution and expansion of the HT training and intervention programs since their inception. Based on numerous trainings with interdisciplinary teams and discussions with course participants, providers and HT survivors, the HT education team was determined to build even more inclusive educational offerings. Under the guidance of the steering committee, the trauma-informed approach arising from this HT program has been expanded to include all victims/survivors of trauma, not just those arising from HT. Thus, as the HT response training program was implemented, the steering committee concurrently embarked on developing the “PEARR” tool in partnership with Health, Education, Advocacy, Linkage (HEAL) Trafficking and Pacific Survivor Center. The PEARR Tool describes a trauma informed approach to victim assistance of any kind in the health care setting using the following steps: 1) Provide privacy; 2) Educate; 3) Ask; 4) Respect and Respond. The PEARR tool is publicly available at the Dignity Health website (Dignity Health, 2018).

This content validation of an HT training program has numerous limitations including survey options that were too similar and potential confusing, choice to examine data that was aggregate and not paired, and truly limited to a simple pre and post course evaluation. This study examined perceptions of voluntary participants immediately following an emotionally compelling presentation. While the results are impressive in that they show a large and significant increase in perceived self-knowledge and confidence, it is unclear if that improvement is sustained over time, or if that improved self-perception results in desirable clinical outcomes. Further research is needed to determine if this type of training results in more effective identification of HT victims/survivors, and if that improvement exists, if it is sustained. Similarly, additional research is needed to fully understand if this self-perception, potential identification, and subsequent interventions are effective in reducing the incidence of HT or reducing the duration of exploitation for those experiencing this form of human exploitation.

## **5. Conclusion**

HT is abundant across the United States and victims of this tragic crime are, knowingly or unknowingly by health care workers, encountering health care workers regularly. A large California-based health system has made HT response part of its overall mission to provide comprehensive care to all members of the communities it serves. With no known standard training curriculum for clinician at the time, the health system’s Human Trafficking Response Team mindfully worked with expert providers and HT survivors to develop the program.

Comparing the pre- and post-course evaluations, there appeared to be a significant improvement in the confidence to identify and treat HT victims/survivors. Based on the initial training success, the California-based health system plans to expand its educational offerings in HT and trauma-informed care to further promote its mission and values.

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Dignity Health Human Trafficking Response Steering Committee

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