IDENTIFICATION OF HUMAN TRAFFICKING VICTIMS IN THE HEALTH CARE SETTING: AN INTEGRATIVE REVIEW

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

By

Jami Leigh Castellucci

Liberty University

Lynchburg, VA

July, 2020

IDENTIFICATION OF HUMAN TRAFFICKING VICTIMS IN THE HEALTH CARE SETTING: AN INTEGRATIVE REVIEW

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

By

Jami Leigh Castellucci

Liberty University

Lynchburg, VA

July, 2020

Scholarly Project Chair Approval:

Dorothy Murphy, DNP, FNP-BC, A.A.C.C. Date

ABSTRACT

Most victims who have escaped trafficking report that during their captivity they were taken to health care facilities. Though health care–based trafficking reporting has increased over the last few years, studies show that private practices and most hospitals within the country do not have a human trafficking protocol, policy, nor educational intervention for their frontline staff to be able to identify and refer victims for short- and long-term support. The United States health care system is poised to play a large role in the fight against human trafficking. This integrative review describes the current status of human trafficking victim identification in the health care setting and common themes surrounding victim identification. Gaps in the literature and areas for further research are presented with implications for health care practice and policy. Without purposeful and targeted human trafficking identification interventions in the health care setting, victims will continue to go unrecognized.

Keywords: health care, sex trafficking, human trafficking, labor trafficking, identify, detect

Acknowledgments

Everything I have accomplished I could not have done without the grace of God, the support of my husband and family, and the encouragement of my peers and professors. To the Lord who is my constant strength and my rock. To my husband, my support system, my best friend, and love who took on many roles so that I could focus on my studies and the completion of my scholarly project. To my daughters, I love hearing your dreams and ambitions and I hope I was able to show you that you can accomplish them with hard work and determination. To my family and friends, thank you for cheering me on, for listening when I was overwhelmed, and for encouraging me along the way. To my cohort, we did it! I have enjoyed working with you and getting to know you through the last three years. To my professors and my scholarly project chair, thank you for pouring into my life and helping me reach my goals.

Table of Contents

List of Abbreviations

American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Obstetricians and Gynecologists (ACOG)

Committee on Child Abuse and Neglect (CCAN)

Emergency Department (ED)

Human Trafficking (HT)

The Joint Commission (JCHO)

National Human Trafficking Resource Center (NHTRC)

National Human Trafficking Hotline (NHTH)

Section on International Child Health (SICH)

Sexually Transmitted Infection (STI)

Introduction

Human trafficking (HT) is a worldwide issue occurring in both foreign countries and in all 50 states of the United States. In the U.S., HT represents a $32 billion crime industry, and approximately only one percent of the victims is ever identified (Donahue et al., 2018; Egyud et al., 2017; Shandro et al., 2016). Most health care facilities in the country are ill equipped to recognize an HT victim or know what to do once one is identified. Studies show that out of 6,000 U.S. hospitals, around 60 have a human trafficking policy and plan in place (Donahue et al., 2018). Approximately 87% of identified victims report that they had received medical care at least one time during their captivity (Donahue et al., 2018; Egyud et al., 2017; Shandro et al., 2016). One study found that 96.7% of victims who were cared for in a medical facility did not receive any information or resources on HT, nor were they questioned about it during their stay (Donahue et al., 2018). Despite many human trafficking victims reportedly receiving medical care while in captivity, they continue to go unrecognized in the health care setting. The purpose of this integrative review is to identify the current status of HT victim identification in the health care setting. A review of literature and common themes surrounding victim identification will be presented. Gaps in the literature and areas where further research is needed will be discussed. Finally, implications for health care practice and policy will be addressed.

Background

HT victims are defined as anyone who is recruited, harbored, or transported through force, fraud, or coercion for the purpose of sex trafficking and/or labor trafficking (National Human Trafficking Hotline [NHTH], 2018b; Victims of Trafficking and Violence Protection Act of 2000, 2000). Trafficking affects all genders and ages; victims are most often part of a vulnerable population that includes homeless, runaways, foster children, migrant workers, legal

and illegal immigrants, those having low income, and minorities (Greenbaum et al., 2018; The Joint Commission [JCHO], 2018; Shandro et al., 2016). Since 2007, there have been 51,919 reports of human trafficking within the US to the NHTH (NHTH, 2018a). Of the reported victims, 7,126 were female, 1,137 were male, 5,070 were over 18 years old, and 2,378 were 17 years old or younger (NHTH, 2018a). In 2018, there were 1,499 identified trafficking victims that identified as U.S. citizens and 1,237 who identified as being foreign born (NHTH, 2018a). The true prevalence of HT is unknown as it is grossly underreported, but it is estimated that between 14,500 and 17,500 foreign nationals alone are trafficked into the US every year, and 75% to 83% of all trafficked victims in the country are US citizens (Ernewein & Nieves, 2015; Hachey & Phillipi, 2017; Lamb-Susca & Clements, 2018; NHTH, 2018b; Shandro et al., 2016). The four states that have the highest reports of trafficking are areas of high travel in and out of the country: California (1,656), Texas (1,000), Florida (767), and New York (492; NHTH, 2018a). Rural areas are increasingly being targeted for trafficking as smaller police forces and a misconception that trafficking only occurs in cities makes it easier for traffickers to not be discovered (McCarthy & Marshall, 2018).

Encounters with Health Care Systems

Testimonies from identified HT victims reveal that approximately 50% to 87.8% of victims had received medical care at least one time during their captivity, with 63 percent of identified victims stating that they had sought medical care within an emergency department (ED) at least once before being freed (Breuer & Daiber, 2018; Byrne et al., 2019; Donahue et al., 2018; Egyud et al., 2017; Hachey & Phillipi, 2017; Macias-Konstantopoulos, 2016; Shandro et al., 2016). Interactions with health care have been found to increase with pregnancy (Lamb-Susca & Clements, 2018). Eighty percent of victims reported being seen in a medical facility

within a year of being identified as a trafficking victim, and 35% were seen at an outpatient health care site (Greenbaum, 2017). Within a group of identified victims, 96.7% reported they were cared for in a medical facility but did not receive any information or resources on HT, nor were they questioned about it during their stay (Donahue et al., 2018). Another study found that 40% of survivors indicated that a provider they came into contact with during captivity could have helped them while they were being seen (Bauer et al., 2019). In a study of 105 subjects who identified themselves as being trafficked, 56% reported that the provider who identified them did not offer them any HT interventions (Chisolm-Straker et al., 2016). HT survivors in the Polaris Project report stated that victims may not disclose their trafficking victimization the first, second, or third time they are asked by a medical professional, but just like with smoking cessation questioning, they implore medical staff to keep asking because one day they will feel safe enough to ask for help (Anthony et al., 2018).

Vulnerable Populations, Red Flags, and Indicators of Trafficking

It is often difficult to identify human trafficking victims as they can be threatened, in debt bondage, psychologically entrapped, or in isolation, relying only on their captor (Ernewein & Nieves, 2015; Hachey & Phillippi, 2017). For these reasons, victims are often reluctant to talk to medical personnel and identify themselves as victims. Vulnerable populations are composed of both males and females, adults and children, U.S. citizens and internationals citizens (Ernewein & Nieves, 2015; Greenbaum, 2016; Hachey & Phillippi, 2017; Mumma et al., 2017). They are made up of "runaways, homeless, kidnapped, or foster care children," (Ernewein & Nieves, 2015, p. 798) and those who have been abused, are in poverty, are minorities, are parts of gangs, or have a history of behavioral issues (Greenbaum, 2016; Greenbaum, Dodd, & McCracken, 2018; Hachey & Phillippi, 2017).

Medical issues that often bring this population in for treatment include urinary tract infections, pelvic and abdominal pain, sexually transmitted infections, pregnancy complaints, abortion, migraines, mental health complaints, and the presence of pseudo seizures (Byrne et al., 2019; Egyud et al., 2017; Greenbaum, 2016; Hachey & Phillippi, 2017; Kaltiso et al., 2018; Lamb-Susca & Clements, 2018; Mumma et al., 2017). Mental health complaints include anxiety, depression, suicidal ideation, bipolar episodes, addiction, and post-traumatic stress symptoms (Byrne et al., 2019; Ernewein & Nieves, 2015; Hachey & Phillippi, 2017; Lamb-Susca & Clements, 2018). Victims are at risk for multiple medical problems including mental health issues, physical assault, sexual trauma, human immunodeficiency virus, sexually transmitted diseases, hepatitis B and C, and issues stemming from a lack of preventative care such as vaccines (Ernewein & Nieves, 2015; Greenbaum, 2016; Hachey & Phillippi, 2017; Kaltiso et al., 2018; Lamb-Susca & Clements, 2018; Shandro et al., 2016).

Common red flags include a visitor who refuses to leave the room or leave the patient alone, multiple pregnancies especially at a young age, presence of sexual trauma, discrepancy between given age and behavioral age, frequent treatment of sexually transmitted diseases, evidence of branding including with tattoos, allowing a visitor to do all communication, and malnourishment (Byrne et al., 2019; Ernewein & Nieves, 2015; Fang et al., 2018; Greenbaum, 2016; Greenbaum, Dodd, & McCracken, 2018; Hachey & Phillippi, 2017; Lamb-Susca & Clements, 2018; Mumma et al., 2017). Red flags to identify during patient registration include lack of personal identification documents, not having insurance, and paying their bill with cash (Egyud et al., 2017; Hachey & Phillippi, 2017).

Current National Recommendations

In 2018, JCHO published recommendations for health care organizations on preparing their facility and staff to identify and care for this patient population. Facilities should have professional interpreters available during the care and interviewing process (JCHO, 2018). Screening questions need to address patient social, work, and home histories as well as assess for domestic violence. These screening questions should be routinely asked during triage. Staff should be educated on when to call for the organization's security or local police officers (JCHO, 2018). Frontline staff, who are most likely to encounter potential victims, need to be trained in how to "identify, refer and report human trafficking victims," (JCHO, 2018, p. 3) and how to refer patients to and connect them with short- and long-term support programs and services. Staff need to be educated on local and state resources, the effect of the Health Insurance Portability and Accountability Act of 1996 on confidentiality and reporting of potential trafficking victims to law enforcement and the National Human Trafficking Resource Center (NHTRC), and on what mandatory reporting entails (JCHO, 2018). Local, state, and federal resource information should be made available to staff to facilitate patient management and referrals.

In 2018, the Emergency Nurses Association, in a joint publication with the International Association of Forensic Nurses, listed seven joint position statements pertaining to HT in the ED setting. They identified that both ED and forensic nurses are important stakeholders in the identification of human trafficking victims and should work in collaboration with each other and community partners to provide treatment and service referrals (Breuer & Daiber, 2018). Forensic nurses should aid in the examination of all potential HT victims regardless if there is biological or trace evidence (Breuer & Daiber, 2018). The statement also called for a proactive approach in health care to implementing education and training for hospital staff to bring awareness to the

potential presence of this patient population within those they care for and treat (Breuer & Daiber, 2018). The training should be trauma-informed and include cultural awareness and should equip staff to be able to identify and report HT when applicable (Breuer & Daiber, 2018). Policies for identification of and interventions for HT victims should be developed with the help of ED and forensic nurse leadership.

The American Academy of Pediatrics (AAP) released an HT policy statement in 2017 that discussed recommendations for policies and the education of medical professionals, current research, and the need for collaboration with the community stakeholders and medical professionals (Greenbaum et al., 2017). The AAP recommended improving upon and developing policies to aid in the identification of HT victims amongst illegal immigrants, introducing legislation and support current legislation that works toward preventing child trafficking efforts, and advocating for HT victims under 18 years old to not be prosecuted for crimes a trafficker forced them to commit (Greenbaum et al., 2017). They called for the training and education of health care staff on HT identification, indicators, physical and visual assessment, interventions, and referral for short- and long-term services. The training of pediatricians should begin while they are still in residency, as trafficking victims can present in any primary, specialty, or hospital practice location. There is also a need for training in "trauma-informed, culturally sensitive, rights-based" (Greenbaum et al., 2017, p. 7) care within the academic and continuing education settings. Future researchers should complete empirical, high-level studies that inform on child trafficking risk-factors, the experience of child victims, longitudinal effects of HT on minors, and the effectiveness of interventions (Greenbaum et al., 2017). The AAP recommends collaboration between community services, health care professionals, law enforcement, and the legal community in multidisciplinary teams in order to identify and treat the short- and long-term

needs of child victims and increase publish awareness of trafficking. Protocols and processes of identification and response need to be developed and put into place to aid in the recognition of HT victims (Greenbaum et al., 2017).

The American Academy of Family Physicians (AAFP) released a policy statement on HT in 2016. It acknowledged the affect trafficking has on human health and its potential long-term consequences. The policy discusses the lack of education and training of clinicians as adding to the difficulty in identifying potential victims and supports the training of family practice providers at the "pre-doctoral, residency, and CME levels" (AAFP, 2016, para 7). The AAFP supports the training and use of "holistic, trauma-informed, and compassionate care" (AAFP, 2016, para. 6) of HT victims and encourages providers to work in collaboration with local organizations and law enforcement in identifying, intervening, and preventing HT in their communities.

In 2019, the American College of Obstetricians and Gynecologists (ACOG) Committee on Health Care for Underserved Women updated their committee opinion on HT. The committee recommended obstetricians and gynecologists educate themselves on the indications and medical concerns that HT victims present with for treatment, as well as equip themselves with screening questions to identify potential victims (ACOG, 2019). Providers should create an inviting and safe environment that utilizes effective communication methods. They need to become aware of local and federal laws surrounding HT and mandatory reporting. Resources should be made available to identified victims and survivors of HT (ACOG, 2019).

Current State of Identification in the United States

More than law enforcement, nurses and medical professionals have the unique role of being able to gain a victim's trust so that they may self-identify as a victim; yet only 60 hospitals

within the United States out of 6,000 have a policy, procedure, or employee education initiative in place to identify and potentially rescue HT victims (Donahue et al., 2018; McCarthy & Marshall, 2018). Despite this statistic, there has been evidence of progress toward increased reporting of potential victims by health care professional between the years of 2007 and 2017. The NHTN reported a 71.29% increase in calls by health care professionals to the hotline regarding potential victims between 2012 and 2014 (Anthony et al., 2018). The nonprofit anti-human trafficking organization Polaris found a 171% increase in health care reporting of potential trafficking victims between 2007 and 2017 (Anthony et al., 2018). Training resources for health professionals from the NHTN went from being viewed online 340 times in 2014 to 15,838 views in 2017 (Anthony et al., 2018). Easier access to training became available in 2014 with the creation of the U.S. Department of Health and Human Service's (2019) online SOAR to Health and Wellness training module. Nationally, "14 medical societies have created policies on trafficking and a number of states have mandated education and training for health professionals" (Anthony et al., 2018, p. 19). Only two state nursing boards require HT education as a part of licensure requirements. The Florida Board of Nursing requires nurses at every level of practice to complete HT training every two years (Lawrence & Bauer, 2020). The Michigan Board of Nursing requires a one-time HT course for their nurses (Lawrence & Bauer, 2020).

Rationale

HT victims are being treated within the health care setting and yet are going unidentified by health care providers and frontline medical staff. There has been an increase in literature surrounding victim identification with the publication of policy statements from prominent health care organizations such as the Emergency Nurses Association, ACOG, AAP, and the AAFP that inform and admonish the medical community to increase their efforts to recognize

this unseen patient population. The NHTN has shown an increase in health care workers accessing their website for training resources, and other online formats for HT education have been developed. With the increase in available educational resources and knowledge on the presentation of HT victims, there is a need to determine where disparity between literature and victim identification in health care exists.

Purpose

The purpose of this integrative review is to identify the current status of HT victim identification in the health care setting and to discover what is impeding the health care community from identifying potential victims.

Review Questions

This integrative review focused on the following questions:

1. Where are HT victims going for health care needs?
2. How are HT victims currently being identified in the health care setting?
3. What are the barriers to identifying HT victims in health care?

Methodology

The Whittemore and Knafl's methodology for integrative reviews was used as the framework for this study. CINAHL Plus with Full Text, Health Source: Nursing/Academic Edition, Medline, and Nursing & Allied Health Database were reviewed for studies pertaining to the keywords of "healthcare," "health care," "hospital," "health services," "health facilities," "sex traffick*," "human traffick*," "labor traffick*," "identify," "recognize," "detect," "United States," America," U.S.," and "USA." Studies were excluded if they were not written in English, peer reviewed, full text articles, published within the last five years, or focused on the identification of human trafficking victims in health care settings within the US. The population

demographics and locations of health care service were not defined in order to capture the full scope of potential victims and the health care settings where identification can occur.

A preliminary keyword search of the databases identified 11,322 articles. After exclusion criteria were applied, it yielded 208 articles. Of these articles, 12 articles were excluded as duplicates. A further 121 articles were excluded based on titles. After reading their abstracts, 17 articles were excluded as they did not pertain to identifying victims. Another 28 articles were excluded after a full text read. Two articles were excluded as they did not add new information for the study. Seven additional studies were utilized that were referenced in multiple articles' literature reviews. In total, 35 articles were identified for this study. See Appendix A.

Quality Appraisal

Melnyk's Table of Evidence was used to appraise the literature for quality and content. According to Melnyk's Table of Evidence, one article was a Level 2 study (Grace et al., 2014), seven were Level 4 studies (Berishaj et al., 2019; Chisolm-Straker et al., 2016; Donahue et al., 2018; Greenbaum, Dodd, & McCracken, 2018; Greenbaum, Livings, et al., 2018; Kaltiso et al., 2018; Mumma et al., 2017), six were Level 5 studies (Ernewein & Nieves, 2015; Fang et al., 2018; Greenbaum, 2016; Hachey & Phillippi, 2017; Lamb-Susca & Clements, 2018; Shandro et al., 2016), 16 were Level 6 studies (Bauer et al., 2019; Byrne et al., 2019; Chaffee & English, 2015; Dols et al., 2019; Egyud et al., 2017; Greenbaum, 2017; Greenbaum & Crawford-Jakubiak, 2015; Lawrence & Bauer, 2020; Long & Dowdell, 2018; Macias-Konstantopoulos, 2016; McCarthy & Marshall, 2018; Nazer & Greenbaum, 2020; Nguyen et al., 2018; Nierengarten & Goldberg, 2018; Ravi et al., 2017; Stoklosa et al., 2017), and five were Level 7 studies (Breuer & Daiber, 2019; Greenbaum et al., 2017; Leslie, 2018; Normandin, 2017; Tiller & Reynolds, 2020). See Appendix B for full the literature appraisals.

Analysis of Literature

The articles were analyzed for common themes pertaining to the identification of HT victims within the health care setting. A broad focus was taken so multiple aspects of victim identification could be encompassed. Three themes were formed: common health care settings where victims seek medical care, current identification practices, and challenges in their identification within medical facilities.

Common Locations HT Victims are Seen in Health Care

HT victims are treated for medical complaints in EDs, child advocacy centers, dental offices, reproductive clinics, obstetricians' and gynecologists' offices, teen clinics, urgent care facilities, primary care offices, pediatricians' offices, alternative healing facilities, and other outpatient health care sites (Breuer & Daiber, 2018; Byrne et al., 2019; Chisolm-Straker et al., 2016; Donahue et al., 2018; Egyud et al., 2017; Greenbaum, 2017; Greenbaum & Crawford-Jakubiak, 2015; Greenbaum, Livings, et al., 2018; Hachey & Phillipi, 2017; Macias-Konstantopoulos, 2016; Mumma et al., 2017; Nierengarten & Goldberg, 2018; Shandro et al., 2016). In a study by Macias-Konstantopoulos (2016), survivors reported that they continued to live at their home, go to their school, and still had appointments with their primary care providers while being trafficked. Inpatient hospital staff and mental health facilities should be aware that victims present in inpatient settings due to more serious injuries, illnesses, or mental health concerns that need longer medical or psychological management (Bauer et al., 2019; Byrne et al., 2019; Nierengarten & Goldberg, 2018). A descriptive study that interviewed female prisoners discovered that the women who were trafficked in sex rings most commonly reported receiving medical care in "EDs, jails, women's health clinics such as Planned Parenthood and free or

Department of Health clinics" (Ravi et al., 2017, p. 410). Those who were not trafficked in sex rings reported going to primary care and gynecology locations (Ravi et al., 2017).

Identifying Human Trafficking Victims in Health Care

At-Risk Populations

Understanding why victims are targeted aids health care professionals in recognizing at-risk populations while obtaining answers to medical and social screening questions so that they can then begin asking more targeted HT screening questions. Most victims are brought into HT between 12 and 17 years of age (Greenbaum, 2016; Greenbaum & Crawford-Jakubiak, 2015; Hachey & Phillippi, 2017). Children are at high risk for victimization, as they are easier to manipulate and they have an "immature prefrontal cortex" (Greenbaum & Crawford-Jakubiak, 2015, p. 567) which affects their impulse control, critical thinking skills, and ability to discern the risks versus benefits of behavior (Greenbaum, 2017). Children and adolescents who are homeless, runaways, throwaways, and immigrants are highly vulnerable to trafficking victimization as a means of survival (Ernewein & Nieves, 2015; Greenbaum, 2016; Greenbaum, 2017; Greenbaum & Crawford-Jakubiak, 2015; Greenbaum, Livings, et al., 2018; Nazer & Greenbaum, 2020). A third of adolescents who end up on the streets are "lured into prostitution within 48 hours of leaving home" (Nierengarten & Goldberg, 2018, p. 9). Greenbaum, Livings, et al. (2018) reported that suspicion should be increased if an adolescent meet risk factors that include "running away from home, prior involvement with law enforcement, history of STIs, [greater than] 5 sex partners, and/or drug/alcohol use" (p. 750), as these attributes were found in 40% to 88% of the 90 identified sex trafficking victims within a study of 810 participants. Practitioners who care for pediatric patients that are seen for sexual assault should consider if their patient could be a trafficking victim, as this medical presentation makes them part of a

higher risk population for HT (Greenbaum, Livings, et al., 2018). Other at-risk groups include those who have caregivers who are involved with substance abuse or crime, are members of gangs, have a history of physical or sexual abuse, are neglected, have low self-esteem, are members of minority groups, live in poverty, have behavioral issues, are refugees or immigrants, have disabilities; or are in foster care (Ernewein & Nieves, 2015; Greenbaum, 2016; Greenbaum, 2017; Hachey & Phillippi, 2017).

Encouraging Self-Identification

Bilingual posters, flyers, and brochures are available from government and nongovernment organizations and should be posted in public locations including bathrooms to encourage potential victims to self-identify (Bauer et al., 2019; Breuer & Daiber, 2019; Donahue et al., 2018; Egyud et al., 2017). Egyud et al. (2017) began a silent notification initiative where blue dot stickers were placed in bathrooms with signage informing potential victims to place a blue dot on the bottom of their urine specimen if they were not in a safe situation. The study found that it was an effective and nonconfrontational way to promote self-identification, with 18 out of the 38 identified potential victims in the study coming from this method.

Screening Questions

Screening questions can be used by staff who suspect that their patient is a victim of human trafficking (Lamb-Susca & Clements, 2018). Potential victims should be interviewed and screened in private, away from those who brought them, in order to increase the chances of disclosure (Byrne et al., 2019; Lamb-Susca & Clements, 2018; Macias-Konstantopoulos, 2016). They should be asked where they sleep, work, and live (Ernewein & Nieves, 2015; Nazer & Greenbaum, 2020). It is important to discover if they feel safe where they are and if they can come and go on their own without having to gain permission. They should be asked if they must

get permission to have basic physical necessities (Ernewein & Nieves, 2015). More poignant questions should be asked once trust is developed. These include if they are forced to have sex or do labor without pay or made to do something because they are indebted to another individual (Ernewein & Nieves, 2015; Greenbaum, 2016; Kaltiso et al., 2018). Multiple studies reported the importance of separating the victim from their captor during the interview process, which can be accomplished by telling the visitor that the patient needs to go for an x-ray but interviewing them in a safe place within radiology instead (Egyud et al., 2017; Greenbaum, 2016; Greenbaum, Livings, et al., 2018; Lamb-Susca & Clements, 2018; Tiller & Reynolds, 2020).

Mental Health Patients

All mental health patients should be routinely screened for HT regardless of their age, gender, ethnicity, appearance, or level of education (Nguyen et al., 2018). Even though a validated screening tool does not exist, screening still needs to occur using an available tool or set of questions so that HT patients do not go unrecognized and can receive needed resources. It is important to rescreen mental health patients as they begin to mentally stabilize and gain trust with medical staff, as they are more likely to disclose HT victimization further into their treatment (Nguyen et al., 2018).

Child Trafficking Victims

As child victims seldom self-identify, medical personnel need to make themselves aware of indicators and red flags of trafficking in children (Nazer & Greenbaum, 2020; Normandin, 2017). Their behavior should match their age, and the story of the presenting complaint should match the injury or illness (Ernewein & Nieves, 2015; Normandin, 2017). Patients should be observed for how they interact with the adult or other children in the room (Normandin, 2017). Providers should perform an across the room visual assessment to see if the minor appears gaunt,

malnourished, disheveled, to be wearing inappropriate clothing for the weather, nervous, scared, or to be avoiding people (Bauer et al., 2019; Ernewein & Nieves, 2015; Normandin, 2017). During the head-to-toe assessment, providers should look for strange markings, tattoos, or physical signs of maltreatment or sexual trauma (Ernewein & Nieves, 2015; Normandin, 2017). An adolescent or school aged child should know where they live and be able to give their address (Normandin, 2017). Health care workers must inform minors of their confidentiality rights and the reporting required of medical personnel (Nazer & Greenbaum, 2020; Tiller & Reynolds, 2020).

Trauma-Informed and Victim-Centered Care

Clinicians and health care workers need to evaluate patients using a trauma-informed and victim-centered approach to build rapport with the patient and increase the chance for disclosure of trafficking (Breuer & Daiber, 2019; Greenbaum, 2017; Greenbaum et al., 2017; Greenbaum & Crawford-Jakubiak, 2015; Leslie, 2018; Nazer & Greenbaum, 2020; Nierengarten & Goldberg, 2018; Tiller & Reynolds, 2020). Trauma-informed care teaches health care personnel to "recognize the effects of violence and victimization on an individual's health, behavior, and development" and to focus on the "needs and safety" of the patient (Hachey & Phillippi, 2017, p. 40). It is important to use certified medical interpreters to ensure that the person in the room that came with the patient does not inhibit conversations and to give the patient a voice (Lamb-Susca & Clements, 2018; Leslie, 2018; Tiller & Reynolds, 2020). Patients can be made to feel more comfortable and in control when providers allow them to make decisions such as the gender of the provider who sees them (Leslie, 2018; Nierengarten & Goldberg, 2018).

Policy and Protocol Development

Policies and protocols need to be developed and put in place within medical organizations to inform and guide medical professionals in identifying HT victims (Bauer et al., 2019; Berishaj et al., 2019; Byrne et al., 2019; Dols et al., 2019; Ernewein & Nieves, 2015; Greenbaum et al., 2017; Macias-Konstantopoulos, 2016; Tiller & Reynolds, 2020). The HEAL Trafficking Protocol toolkit and the NHTRC aid organizations in implementing trafficking identification and intervention policies and protocols (Leslie, 2018; Nierengarten & Goldberg, 2018; Tiller & Reynolds, 2020). Community stakeholders and multidisciplinary teams should be involved in the development and implementation process (Breuer & Daiber, 2019; Tiller & Reynolds, 2020). Police and victim advocates should be invited to developmental and educational sessions to provide information on local trafficking issues and statistics that will aid providers in identifying the type of victims that are found in the area the health organization serves (Tiller & Reynolds, 2020).

Identification Challenges

There are many barriers that make identifying HT victims challenging in the health care setting. Many of the medical complaints, indicators, and red flags associated with trafficking are also found among other patient populations. Victims do not frequently self-identify as trafficked, as a portion of them do not realize that they are victims of HT or have been trained or threatened by their trafficker to deny that they are being exploited or harmed (Byrne et al., 2019; Chaffee & English, 2015; Dols et al., 2019; Greenbaum, Livings, et al., 2018). There is often little time for medical professionals to gain rapport and trust in order to ask the potential victim screening questions in a trauma-informed way that would make them feel comfortable in disclosing their situation (Greenbaum, 2017). Victims may not know who to trust and often have been threatened

harm by the trafficker if they reveal their situation to medical staff (Macias-Konstantopoulos, 2016). Health care costs, not being allowed to seek treatment by their trafficker, language barriers, fear of being reported to law enforcement and deported or sent to jail, fear of discrimination by medical staff, and not knowing what resources are available to them are just a few of the barriers victims face in even getting in front of a provider (Byrne et al., 2019; Greenbaum & Crawford-Jakubiak, 2015; Leslie, 2018; Macias-Konstantopoulos, 2016; Nazer & Greenbaum, 2020).

Child Victims

Children and adolescents are less likely than adults to identify themselves as being trafficked due to having fewer resources and not being able to defend themselves or stand up to their trafficker (Greenbaum, 2017). The psychological manipulation they often endure makes it difficult for minors to identify themselves even when directly questioned by a provider or medical professional (Greenbaum, 2017). They may not understand that they are being manipulated and will more readily believe a trafficker's negative claims about themselves or that it is their fault they are being hurt. They may feel an attachment to the trafficker and think that they are dating or consenting to acts. Young children may not know how to or are not able to verbalize what is happening to them (Greenbaum, 2017).

Perceptions of Health Care Staff

Health care professionals cannot begin to identify potential victims if they believe they do not exist within their health care setting or if they have misconceptions of who could be a trafficking victim and how they would present. The number of HT victims is increasing in rural communities, yet many community members and medical professionals are unaware of this trend and continue to believe that trafficking is something that occurs in more urban settings

(McCarthy & Marshall, 2018). ED nurses working in one location known to have a high rate of human trafficking reported that none of them had knowingly treated or screened for an HT victim (Long & Dowdell, 2018). Participants in the study felt that an HT victim would present to the ED similarly to a victim of interpersonal violence, but they still felt unsure of how to screen or connect an HT victim with needed resources (Long & Dowdell, 2018). They reported that they believed trafficking victims are mainly "young, female, and foreign born" and would present to the ED looking "very traumatized [and] scared" (Long & Dowdell, 2018, p. 378). They felt that the visitor presenting with the patient would be an "overbearing man," but research shows that they are often "charismatic, well-mannered 'boyfriends' or 'family' friends," a female, or a family member (Long & Dowdell, 2018, p. 378). This group also did not feel that prostitutes were being trafficked but were willing participants in the sex industry (Long & Dowdell, 2018).

Lack of Educational Training of Medical Staff

In order to identify and rescue HT victims, providers and frontline health care workers must be able to identify a potential victim, especially children, who are even less likely than adults to report that they are being trafficked without targeted questioning (Greenbaum, 2017). A common theme found in the literature review was the lack of previous training of medical staff in identifying human trafficking victims which leads to missed opportunities (Bauer et al., 2019; Breuer & Daiber, 2018; Byrne et al., 2019; Chaffee & English, 2015; Donahue et al., 2018; Egyud et al., 2017; Grace et al., 2014; Greenbaum et al., 2017; Hachey & Phillippi, 2017; Lawrence & Bauer, 2020; Macias-Konstantopoulos, 2016; Mumma et al., 2017; Shandro et al., 2016; Stoklosa et al., 2017). Educational interventions for medical staff on human trafficking victim identification were found to increase confidence levels and provide a comprehensive

understanding of management and identification (Bauer et al., 2019; Donahue et al., 2018; Egyud et al., 2017; Grace et al., 2014; Lawrence & Bauer, 2020; Stoklosa et al., 2017). Effective educational interventions include in-person training during meetings, huddles, and conferences, as well as the use of simulation and online methods with proof-of-training-completed documents obtained (Bauer et al., 2019; Berishaj et al., 2019; Egyud et al., 2017; Grace et al., 2014; Lawrence & Bauer, 2020; Stoklosa et al., 2017). Training should also involve ancillary staff such as registration personnel, as they could identify those who do not have personal identification documents, which is a common red flag (Egyud et al., 2017).

Medical staff participating in a study reported the need for a tool that would guide their steps of patient care and contain samples of screening questions to increase their levels of confidence (Donahue et al., 2018). Tools that were helpful for identification included prewritten screening questions and algorithms for staff to follow (Egyud et al., 2017). The Department of Health and Human Services recommends that medical professionals be educated on human trafficking, have regular competencies to maintain comprehension, and have dedicated resources for staff and victims (Ernewein & Nieves, 2015).

Lack of a Validated Screening Tool

Currently, there is not a validated screening tool that can be used in health care settings (Bauer et al., 2019; Chaffee & English, 2015; Dols et al., 2019; Greenbaum & Crawford-Jakubiak, 2015; Lamb-Susca & Clements, 2018; Macias-Konstantopoulos, 2016; Nazer & Green, 2020; Nguyen et al., 2018; Shandro et al., 2016; Tiller & Reynolds, 2020). A sex trafficking screening tool was validated for use in EDs, teen clinics, and child advocacy centers in Asian youth populations in California, and a second screening tool for sex trafficked youth was validated in EDs, teen clinics, and child advocacy centers within the U.S. but requires

further study for generalizability (Nazer & Greenbaum, 2020). As of 2019, eight screening tools for health care have been developed with many found to be useful for screenings, but they have not undergone the rigor of research testing to confirm that they will consistently identify potential victims or minimize gaps in the identification of victims (Dols et al., 2019). Several of these screening tools are lengthy and/or require specific training in order administer them, which hinders the ability of frontline staff to screen patients in an effective and timely manner (Dols et al., 2019). The NHTRC developed a flow chart for the identification of red flags and indicator aids that are free for anyone to modify for their facility, and the U.S. Department of Health and Human Services created a screening toolkit to aid health care organizations in the implementation of identification policies and procedures; neither has been validated (Dols et al., 2019).

Discussion & Limitations

The purpose of this review was to discover the current state of HT identification in the US and to identify needed practice and policy changes as well as gaps in literature where further research is needed. At-risk populations are clearly defined and consistently reported in literature findings, with evidence showing that victims go to a variety of types of sites for care and inpatient services. Educational interventions have been shown to increase the confidence level of staff in their ability to identify and interview HT victims and demonstrate positive outcomes of increased potential victim identification. Yet, one of the most frequently reported identification challenges in health care is the lack of informed medical staff, who report never receiving training in HT recognition. Due to the lack of education, health care staff's preconceived perceptions of what an HT victim looks like or how one would present in a health care setting creates bias that leads to missed opportunities for victim identification. Trauma-informed and

victim-centered care with the aid of a certified interpreter mitigates barriers to victim identification through the building of rapport and trust between patient and medical staff members, but this too requires training that research has shown is not frequently provided to frontline staff. Screening tools have been developed but not validated, further studies are needed to increase their generalizability and test their usability to ensure that victims are not being missed when using the tool. Assessing and screening mental health patients and children as potential victims requires special considerations a one-size-fits-all approach cannot be taken when developing screening tools.

As victims can present at any practice setting, there needs to be a national push for training of medical personnel on HT identification and trauma-informed care within degree programs and in health care work settings as part of annual competencies. State medical and nursing licensure boards should follow the example given by Florida and Michigan in requiring HT identification and intervention training as a requirement of licensure renewal (Lawrence & Bauer, 2020). Hospitals and outpatient settings can utilize tools found in organizations such as NHTRC and HEAL Trafficking to develop policies and procedures for their facilities to implement HT identification and management. Screening for HT victims needs to become routine occurring with every patient, at every appointment, during triage in an ED, and when the patient is admitted to inpatient floors.

Future research needs to work toward the validation of screening tools, best identification methods, and policy implementation in health care facilities. There is a need more high-level studies, but descriptive studies interviewing survivors would allow researchers to learn more about reducing the barriers to victim identification. Research should also be conducted to determine effective prevention methods, such as education for parents and children during all

well child checks and school-based HT awareness programs. This review also found that much of the literature surrounds identifying HT victims in the ED, possibly because the literature currently shows the ED as the most likely location they will present. More studies need to focus on identifying patients in other outpatient facilities and inpatient settings to close this gap in the literature and improve upon screening tools for those locations. Research needs to be conducted to understand the gap between knowledge and implementation of policies in hospitals and health care communities to support their staff in HT victim identification and intervention efforts. Only two state nursing licensure boards require HT education, and only one percent of hospitals have policies and procedures in place to facilitate and guide HT identification and intervention management (Donahue et al., 2018; Lawrence & Bauer, 2020).

There were several limitations identified for this study. There was a risk of introducing bias during the article identification phase of this review and during the completion of the thematic analysis of the final 35 articles. Only full articles found in electronic databases online were used for this study. Studies that required purchase were not chosen. This excluded several studies, as well as articles only found in print form. A record of how many articles were excluded due to these criteria was kept in order to understand the significance of leaving these articles out of the study. Bias could also have been introduced during the selection of articles based on title, then abstract, and the reading of the full article. This author tried to minimize this bias by only excluding titles and abstracts that did not pertain to health care, HT, or HT identification occurring within the US. The themes chosen for analysis most commonly appeared within the 35 articles. A matrix was created for each article to extract the data in an organized format, but it is possible that important ideas and information from the articles regarding HT patient identification in health care were missed.

Conclusion

There is a consensus among the literature in this review that health care settings are places in which victims are brought out of hiding for care in large numbers. Unlike law enforcement HT identification and recovery efforts where victims must be sought out and searched for, HT captives are presenting themselves to health care facilities and being overlooked. Their interaction with the health care community may be the only opportunity they have to be rescued from a life of slavery in sex or labor trafficking. There is a growing body of literature that supports the identification of HT victims within the US, but the medical community is lagging in evidence-based implementation efforts that incorporate recognition policies, protocols, screening tools, and education of medical professionals.

References

The American Academy of Family Physicians. (2016). *Human trafficking.* https://www.aafp.org/about/policies/all/human-trafficking.html

The American College of Obstetricians and Gynecologists. (2019). Human trafficking: ACOG committee opinion no. 787. *Obstetrics & Gynecology, 134*(3), e90–e95. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/09/human-trafficking.pdf

Anthony, B., Amatullah, A., Anderson, J., Arias, E. F. P., Crisp, J. D., Crosson, L., D'Souza, H., Fasthorse, H., Hollis, J., John, D., Johnson, N., Liles, T., Lipenga, F., Lundstrom, M., Marty, R., McCarty, T., Morrissey, M. A., Placides, R. P., Pugh-Roberts, C., Rosseland, J., Smillie, E., Street, T., Thompson, V., Vaden, S., Wendell, C., Woworuntu, S., Crowe, S., Benjamin, C., Couture, T., McCartin, E., Gerrior, E., Agbeyegbe, L., Kosciusko, M. K., Leeburg, L., & Stoklosa, H. (2018). *On-ramps, intersections, and exit routes: A roadmap for systems and industries to prevent and disrupt human trafficking*. https://polarisproject.org/wp-content/uploads/2018/08/A-Roadmap-for-Systems-and-Industries-to-Prevent-and-Disrupt-Human-Trafficking.pdf

Bauer, R., Brown, S., Cannon, E., & Southard, E. (2019). What health providers should know about human sex trafficking. *Medsurg Nursing, 28*(6), 347–351.

Berishaj, K., Buch, C., & Glembocki, M. M. (2019). The impact of an educational intervention on the knowledge and beliefs of registered nurses regarding human trafficking. *The Journal of Continuing Education in Nursing, 50*(6), 269–274. https://doi.org/10.3928/00220124-20190516-07

Breuer, G. J., & Daiber, D. (2018). *ENA joint position statement: Human trafficking awareness in the emergency care setting*. https://doi.org//10.1016/j.jen.2018.11.011

Byrne, M., Parsh, S., & Parsh, B. (2019). Human trafficking: Impact, identification, and intervention. *Nursing Management, 50*(8), 18–24. https://doi.org/10.1097/01.NUMA.0000575304.15432.07

Chaffee, T., & English, A. (2015). Sex trafficking of adolescents and young adults in the United States: Healthcare provider's role. *Current Opinion in Obstetrics & Gynecology*, *27*(5), 339–344. https://doi.org/10.1097/GCO.0000000000000198

Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P. N., & Richardson, L. D. (2016). Health care and human trafficking: We are seeing the unseen. *Journal of Health Care for the Poor & Underserved*, *27*(3), 1220–1233. https://doi.org/10.1353/hpu.2016.0131

Dols, J. D., Beckmann-Mendez, D., McDow, J., Walker, K., & Moon, M. D. (2019). Human trafficking victim identification, assessment, and intervention strategies in south Texas emergency departments. *Journal of Emergency Nursing, 45*(6), 622–633. https://doi.org//10.1016/j.jen.2019.07.002

Donahue, S., Schwien, M., & LaVallee, D. (2018). Educating emergency department staff on the identification and treatment of human trafficking victims. *Journal of Emergency Nursing, 45*(1), 16–23. https://doi.org/10.1016/j.jen.2018.03.021

Egyud, A., Stephens, K., Swanson-Bierman, B., DiCuccio, M., & Whiteman, K. (2017). Implementation of human trafficking education and treatment algorithm in the emergency department. *Journal of Emergency Nursing, 43*(6), 526–531. https://doi.org/10.1016/j.jen.2017.01.008

Ernewein, C., & Nieves, R. (2015). Human sex trafficking: Recognition, treatment, and referral of pediatric victims. *The Journal for Nurse Practitioners, 11*(8), 797–803. https://doi.org/10.1016/j.nurpra.2015.06.005

Fang, S., Coverdale, J., Nguyen, P., & Gordon, M. (2018). Tattoo recognition in screening for victims of human trafficking. *The Journal of Nervous and Mental Disease, 206*(10), 824–827. https://doi.org/10.1097/NMD.0000000000000881

Grace, A. M., Lippert, S., Collins, K., Pineda, N., Tolani, A., Walker, R., Jeong, M., Trounce, M. B., Graham-Lamberts, C., Bersamin, M., Martinez, J., Dotzler, J., Vanek, J., Storfer-Isser, A., Chamberlain, L. J., & Horwitz, S. M. (2014). Educating health care professionals on human trafficking. *Pediatric Emergency Care, 30*(12), 856–861. https://doi.org/10.1097/PEC.0000000000000287

Greenbaum, J. (2016). Identifying victims of human trafficking in the emergency department. *Clinical Pediatric Emergency Medicine, 17*(4), 241–248. https://doi.org/10.1016/j.cpem.2016.09.006

Greenbaum, V. J. (2017). Child sex trafficking in the United States: Challenges for the healthcare provider. *PLOS Medicine*, *14*(11), Article e1002439. https://doi.org/10.1371/journal.pmed.1002439

Greenbaum, J., Bodrick, N., Committee on Child Abuse and Neglect, & Section on International Child Health. (2017). Global human trafficking and child victimization. *Pediatrics, 140*(6), Article e20173138. https://doi.org/10.1542/peds.2017-3138

Greenbaum, J., & Crawford-Jakubiak, J. E. (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics*, *135*(3), 566–574. https://doi.org/10.1542/peds.2014-4138

Greenbaum, V. J., Dodd, M., & McCracken, C. (2018). A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatric Emergency Care, 34*(1), 33–37. https://doi.org/10.1097/PEC.0000000000000602

Greenbaum, V. J., Livings, M. S., Lai, B. S., Edinburgh, L., Baikie, P., Grant, S. R., Kondis, J., Petska, H. W., Bowman, M. J., Legano, J., Kas-Osoka, O., & Self-Brown, S. (2018). Evaluation of a tool to identify child sex trafficking victims in multiple healthcare settings. *Journal of Adolescent Health, 63*(6), 745–752. https://doi.org/10.1016/j.jadohealth.2018.06.032

Hachey, L. M., & Phillippi, J. C. (2017). Identification and management of human trafficking victims in the emergency department. *Advanced Emergency Nursing Journal, 39*(1), 31–51. https://doi.org/10.1097/TME.0000000000000138

The Joint Commission. (2018). Identifying human trafficking victims. *Quick Safety.* https://www.jointcommission.org/-/media/tjc/newsletters/qs_41_human_trafficking_6_12_18_final1pdf.pdf?db=web&hash=3DCCB6D913AEE7163280AD4DE164E999

Kaltiso, S. O., Greenbaum, V. J., Agarwal, M., McCracken, C., Zmitrovich, A., Harper, E., & Simon, H. K. (2018). Evaluation of a screening tool for child sex trafficking among patients with high-risk chief complaints in a pediatric emergency department. *Academic Emergency Medicine, 25*(11), 1193–1203. https://doi.org/10.1111/acem.13497

Lamb-Susca, L., & Clements, P. T. (2018). Intersection of human trafficking and the emergency department. *Journal of Emergency Nursing, 44*(6), 563–569. https://doi.org/10.1016/j.jen.2018.06.001

Lawrence, M., & Bauer, P. (2020). Knowledge base of nurses before and after a human trafficking continuing education course. *The Journal of Continuing Education in Nursing, 51*(7), 316–321. https://doi.org/10.3928/00220124-20200611-07

Leslie, J. (2018). Human trafficking: Clinical assessment guideline. *Journal of Trauma Nursing, 25*(5), 282–289. https://doi.org/10.1097/JTN.0000000000000389

Long, E., & Dowdell, E. B. (2018). Nurses' perceptions of victims of human trafficking in an urban emergency department: A qualitative study. *Journal of Emergency Nursing, 44*(4), 375–383. https://doi.org/10.1016/j.jen.2017.11.004

Macias-Konstantopoulos, W. (2016). Human trafficking: The role of medicine in interrupting the cycle of abuse and violence. *Annals of Internal Medicine, 165*(8), 582–588. https://doi.org/10.7326/M16-0094

McCarthy, C., & Marshall, J. (2018). The role of the nurse leader in battling human trafficking in rural hospitals in Texas. *Nurse Leader*, *16*(6), 375–378. https://doi.org/10.1016/j.mnl.2018.07.013

Mumma, B. E., Scofield, M. E., Mendoza, L. P., Toofan, Y., Youngyunpipatkul, J., & Hernandez, B. (2017). Screening for victims of sex trafficking in the emergency department: A pilot program. *The Western Journal of Emergency Medicine, 18*(4), 616–620. https://doi.org/10.5811/westjem.2017.2.31924

National Human Trafficking Hotline. (2018a). *2018 statistics from the National Human Trafficking Hotline.* https://humantraffickinghotline.org/sites/default/files/Polaris_National_Hotline_2018_Statistics_Fact_Sheet.pdf

National Human Trafficking Hotline. (2018b). *What is human trafficking?* https://humantraffickinghotline.org/what-human-trafficking

Nazer, D., & Greenbaum, J. (2020). Human trafficking of children. *Pediatric Annals, 49*(5), e209–e214. https://doi.org/10.3928/19382359-20200417-01

Nguyen, P. T., Lamkin, J., Coverdale, J. H., Scott, S., Li, K., & Gordon, M. R. (2018). Identifying human trafficking victims on a psychiatry inpatient service: A case series. *The Psychiatric Quarterly*, *89*(2), 341–348. https://doi.org/10.1007/s11126-017-9538-3

Nierengarten, M. B., & Goldberg, A. P. (2018). Identify, screen, treat, and advocate for child victims of sex trafficking/COMMENTARY. *Contemporary Pediatrics, 35*(12), 8–10.

Normandin, P. A. (2017). Child human trafficking: See, pull, cut the threads of abuse. *Journal of Emergency Nursing*, *43*(6), 588–590. https://doi.org/10.1016/j.jen.2017.07.014

Ravi, A., Pfeiffer, M., Rosner, Z., Shea, J., Pfeiffer, M. R., & Shea, J. A. (2017). Identifying health experiences of domestically sex-trafficked women in the USA: A qualitative study in Rikers Island jail. *Journal of Urban Health*, *94*(3), 408–416. https://doi.org/10.1007/s11524-016-0128-8

Shandro, J., Chisolm-Straker, M., Duber, H. C., Findlay, S. L., Munoz, J., Schmitz, G., Stanzer, M., Stoklosa, H., Wiener, D. E., & Wingkun, N. (2016). Human trafficking: A guide to identification and approach for the emergency physician. *Annals of Emergency Medicine*, *68*(4), 501–508. https://doi.org/10.1016/j.annemergmed.2016.03.049

Stoklosa, H., Lyman, M., Bohnert, C., & Mittel, O. (2017). Medical education and human trafficking: Using simulation. *Medical Education Online, 22*(1), Article 1412746. https://doi.org/10.1080/10872981.2017.1412746

Tiller, J., & Reynolds, S. (2020). Human trafficking in the emergency department: Improving our response to a vulnerable population. *The Western Journal of Emergency Medicine, 21*(3). https://doi.org/10.5811/westjem.2020.1.41690

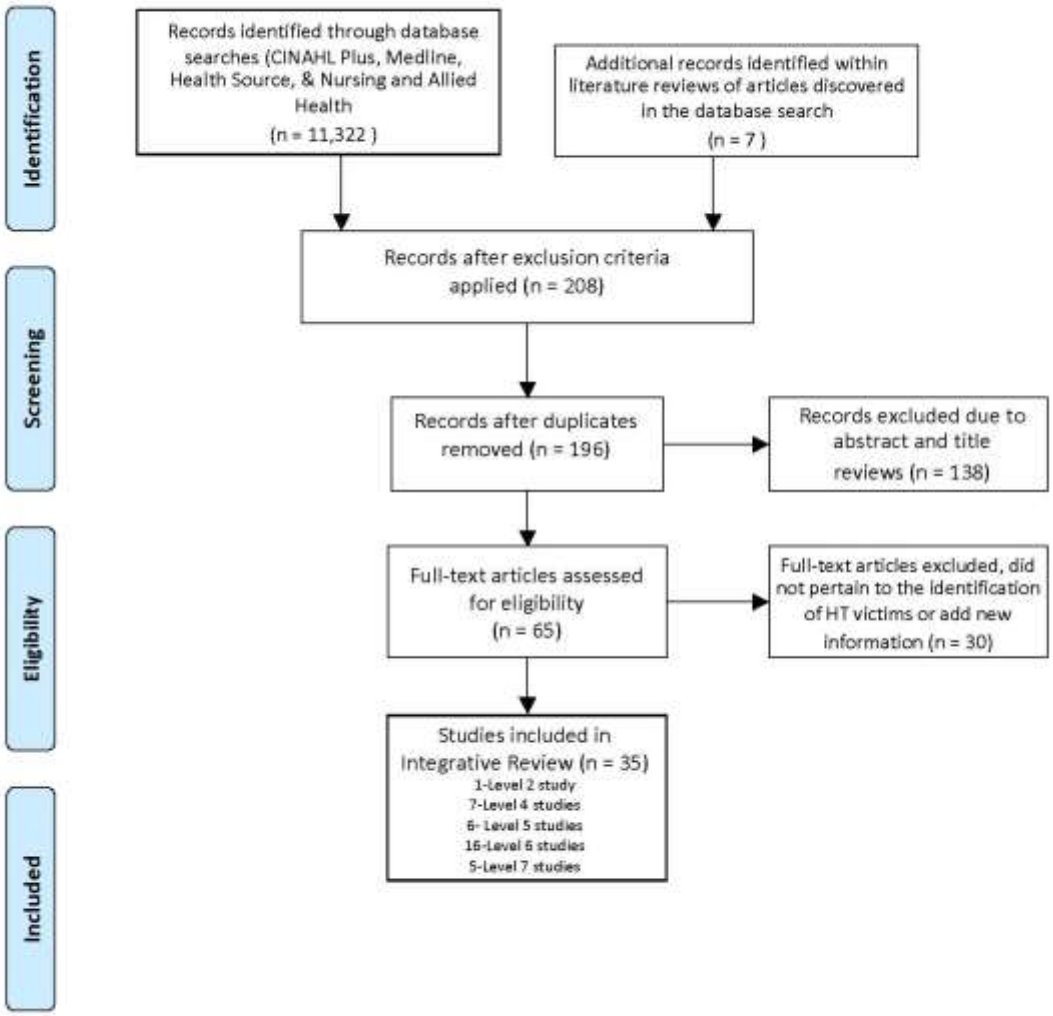
U.S. Department of Health & Human Services. (2019). *Training: SOAR online.* https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training/soar-online

Victims of Trafficking and Violence Protection Act of 2000, Pub. L. No 106-386 (2000). https://www.govinfo.gov/content/pkg/PLAW-106publ386/pdf/PLAW-106publ386.pdf

Appendix A

Figure 1

PRISMA Breakdown of Article Search



Appendix B

Evidence Table

Name: Identification of Human Trafficking Victims in the Healthcare Setting

Clinical Question: Where are HT victims going for healthcare needs?

Clinical Question: How are HT victims currently being identified in the healthcare setting?

Clinical Question: What are the barriers to identifying HT victims in healthcare?

Article Title, Author, etc.	Study Purpose	Sample	Methods	Study Results	Melnyk's Level of Evidence	Study Limitations
Bauer, R., Brown, S., Cannon, E., & Southard, E. (2019). What health providers should know about human sex trafficking. *Meds urg Nursing, 28*(6), 347–351.	*The purpose of this article was to inform medical-surgical nurses on human trafficking, identification of potential victims, and reporting/referring as appropriate.	*The subjects are human trafficking victims that could be seen in the US healthcare system; particularly by Med-Surg nurses.	*This is a descriptive study utilizing evidence in literature to inform Med-Surg nurses on the topic of human trafficking, what drives the industry, legal implications, how to report a suspected case, nursing implications, and common indicators.	*Human trafficking victims can be found in the inpatient setting due to more serious injuries and illnesses that need longer management (p. 349). *A screening tool is not available and is needed (p. 349). There are many versions of screening tools but none that are validated to be used in healthcare (p. 349). *Only 1% of the nearly 6,000 hospitals within the US have a policy on human trafficking	Level 6 Descriptive Study	*Limitations -No limitations were given by the authors.

				treatment requirements in place (p. 349). *Only Michigan and Florida mandate human trafficking education for medical staff (p. 349). *Article describes one health care organization that decided nurses, providers, registration staff, and ED technicians should know how to identify and report potential trafficking (p. 349). They developed online education that included two case studies and treatment guidelines (p. 349). Pre- and post-survey scores showed an increase in confidence level for identifying and treating potential victims (p. 349). *Posters and signs that promote self-identifying and reporting should be placed in public areas of healthcare facilities (p. 349).		

				*Page 350 Table 2 lists sex trafficking indicators, including the presence of branding/tattoos, inappropriate clothing for the weather/season, history of high-risk behaviors, reported age not consistent with appearance, behavior not consistent with age, history of multiple abortions, and history of sexually transmitted infections. * "40% of human trafficking survivors have reported there was something their providers could have done to assist them when they were seeking medical attention" (p. 350).		
Berishaj, K., Buch, C., & Glembocki, M. M. (2019). The impact of an educational intervention on the knowledge and beliefs of registered nurses regarding human	The purpose of this study "was to determine the effect of an educational intervention on nurses' self-reported knowledge and beliefs regarding human	*93 nurses who attended a human trafficking educational conference held in the Midwest (p. 271).	*A pilot study utilizing a quasi-experimental, pre- and post-test design to determine if education given during a conference was effective in educating nurses	*Providing education through a conference format was found to be effective in increasing the nurses' "knowledge and beliefs" on human trafficking (p. 272). *The self-reported improvement through the surveys showed increased	Level 4: quasi-experimental cohort study with convenience sampling	*Limitations -Small sample size (p. 272) -All but one participant was female (p. 272) -Although results showed an increase in knowledge, it does

trafficking. *The Journal of Continuing Education in Nursing, 50*(6), 269–274. https://doi.org/10.3928/00220124-20190516-07	trafficking" (p. 269).		on human trafficking (p. 269). *Intervention: 4-hour conference entitled, "Human Trafficking 101: A Practical Conference on Understanding the Issues and Responding to the Epidemic" was given by field experts working in nursing, law and criminal justice (p. 271). PowerPoints were used by the speakers. *The pre- and post-surveys had 19 questions with a Likert scale response (p. 271).	understanding about what human trafficking is, the vulnerable populations who are at risk, what the laws in their state say about trafficking, knowledge of available resources, and increased belief that they could identify and intervene in potential human trafficking cases (p. 272). *Recommendations for practice: -Standardized education and protocols for identifying and intervening in potential human trafficking cases (p. 272). *First develop the policy and identification methods before educating staff (p. 272). *Gather resources for staff and victims in an easy to access format (p. 272). *Continuously monitor and evaluate the effectiveness of the strategy (p. 272).		not necessarily mean that the nurses will change their practice or that any changes will be lasting (p. 272).

				*Multidisciplinary identification approach with education for all staff who have patient contact		
Breuer, G. J., & Daiber, D. (2018). ENA joint position statement: Human trafficking awareness in the emergency care setting. *Journal of Emergency Nursing, 45*(1), 67. https://doi.org//10.1016/j.jen.2018.11.011	*The purpose of this article was to state the position of the Emergency Nurses Association (ENA) and the International Association of Forensic Nurses (IAFN) on human trafficking and healthcare.	*Human trafficked victims seen by ED and forensic nurses in healthcare settings.	*Descriptive review of human trafficking based on literature which informed the position statements made by the IAFN and the ENA as expert opinions.	*Position Statements: 1. The ED and forensic nurse have an important role in identifying human trafficking victims (p. 2). 2. Collaboration with community partners is necessary to provide treatment and refer victims to needed services (p. 2). 3. Collaboration with partners in the community will be used to educate healthcare workers and members of the community on "human trafficking trends, vulnerabilities to victimization, signs of victimization, and barriers to disclosure" (p. 2). 4. ED and forensic nurses will aid in the development of human trafficking policies in	Level 7: Expert Opinions	*Limitations -No limitations were given by the author

				their workplaces and within legislature of the local, state, and federal government (p. 2). 5. Forensic nurses will work with the ED nurse in evaluating and examining victims regardless if there is biological or trace evidence (p. 2). 6. It is the job of the hospital to raise public awareness through signage in restrooms and other means to increase public awareness (p. 2). The hospital will also create safety procedures for victims and staff to protect them from harm when a victim comes for interventional help to escape trafficking (p. 2). 7. Healthcare systems will provide "culturally sensitive, trauma-informed education and in-service training to all staff" to raise awareness of trafficking, how to		

				identify a victim, and how to report it (p. 7). * "Lack of guidance for healthcare providers will likely impede identification of victims of trafficking as they will not be asking patients the necessary questions" (p. 5).		
Byrne, M., Parsh, S., & Parsh, B. (2019). Human trafficking: Impact, identification, and intervention. *Nursing Management*, *50*(8), 18–24. https://doi.org/10.1097/01.NUMA.0000575304.15432.07	*The purpose of the study is to inform the reader on human trafficking background, impact, the role of the nurse, how to recognize and assess victims, interventions, the role of the nurse manager, and to provide a list of educational resources on the topic.	*The subjects of the article were human trafficking victims and the healthcare workers who will come into contact with them.	*A descriptive review of human trafficking impact, identification, and interventions (p. 19).	*Human trafficking is a growing criminal enterprise that impacts 12 to 30 million victims worldwide and between 800,000 and 1 million people in the US (p. 19-20). *Not all victims know they are being trafficked, some believe their situation is normal, and others are afraid to disclose their circumstance due to fears of prosecution, shame, or retaliation (p. 20). *Due to the nature of human trafficking and the difficulty in identifying victims, it is important for nursing leaders to educate frontline staff on victim	*Level 6 Descriptive Review Study	*Limitations -The authors do not list any limitations.

				identification, reporting, and referrals to long term solutions (p. 20). *Average age that individuals enter trafficking is 12 to 14 years (p. 20). *Multiple risk factors are mentioned, including "history of abuse and neglect, involvement with child protective services or juvenile justice system, and identifying as lesbian/gay/bisexual/transgender/queer, […and] who've run away or are homeless" (p. 20). *Estimated that between 50% and 80% of human trafficking victims are seen by a healthcare provider while in captivity (p. 20). *Common reasons to be seen are due to "an illness that prevents the ability to work, recurring sexually transmitted infections (STIs), positive		

				pregnancy tests, or abortions" (p. 20). *Page 20 and 21 describe in length recognition of victims based on common complaints and presentations to healthcare facilities such as mental health disorders, substance abuse disorders, behavioral concerns, physical signs of abuse or sexual abuse, or common urgent care complaints like strains, headaches, backpain, and STIs (p. 20-21). Victims can also appear with "unusual tattoos or branding marks" that are placed by the traffickers to identify that an individual is theirs (p. 21). *Assess a potential victim alone, separated from the alleged trafficker or handler (p. 21). *Gain trust and build a rapport. Utilize a license interpreter when English is not		

				their first language (p. 21). *Patient may not have money or identification (p. 21). *Pages 21 and 22 lists questions that can be asked of potential victims to learn if they are being trafficked. *Short- and long-term interventions utilizing a multidisciplinary approach are needed (p. 22). Utilize resources such as the National Human Trafficking Hotline and have a list of local resources available (p. 22). *The nurse manager can be the advocate and facilitator for education of frontline nursing staff on identifying, managing care of, and referring potential victims of trafficking (p. 22). They can also build/create policies and procedures to implement within their facility (p. 22). *A list of educational resources is on page 23.		

Chaffee, T., & English, A. (2015). Sex trafficking of adolescents and young adults in the United States: Healthcare provider's role. *Current Opinion in Obstetrics & Gynecology*, *27*(5), 339–344. https://doi.org/10 .1097/GCO.0000 000000000198	*The purpose of this review article is to provide "an overview of the definitions of sex trafficking and commercial sexual exploitation, contributing factors, health consequences, recruitment of victims, and identification and response by healthcare providers" (p. 339).	*The subject/sample group this article is about are adolescents and young adults who are victims of sex trafficking within the United States (p. 339).	*The method was a literature review to develop a descriptive study of human trafficking of adolescents and youth within the United States: defining HT; describing recruitment of victims; health consequences of trafficking; identification of victims; and how to report, assess, and respond.	Identification: *37% to 50% of victims have had contact with healthcare professionals at least once while in captivity (p. 341). *Victims are often not recognized due to minimal or no education or training on recognizing and identifying potential victims, absence of protocols or policies in healthcare systems, or barriers due to language, distrust, or the feeling of shame (p. 341). *Not all victims perceive themselves as victims or they have been trained by traffickers to lie about their situation to avoid detection (p. 341). *Trafficking also poses a risk to public health (p. 341). *There are screening tools for identifying victims, but they need to be evaluated (p. 341)	Level 6: Descriptive review study	Limitations: *No limitations were given by the authors.

				*Can present with an individual who answers all the questions or does not leave the patient alone (p. 341). *The victim's story may not be consistent with the injury or they could be poor historians (p. 341). *May present without identification documents (p. 341). *Numerous medical conditions and red flags are presented on pages 341 and 342. *Healthcare workers are mandated reporters of child abuse (p. 342). *Needs to utilize trauma-informed care practices (p. 343).		
Chisolm-Straker, M., Baldwin, S., Gaïgbé-Togbé, B., Ndukwe, N., Johnson, P. N., & Richardson, L. D. (2016). Health care and human trafficking: We are seeing the unseen. *Journal*	*The purpose of the study was "to build the evidence base around human trafficking (HT) and health in the U.S. by employing a quantitative approach to exploring the notion that health	*173 survivors of U.S. human trafficking (p. 1220). *There were no restrictions on gender or age.	*Anonymous retrospective study (p. 1222) *Utilized a survey in English, Haitian Creole, and Spanish in paper and online format (p. 12222). *Over 24 organizations	*Out of the 173 participant surveys: 75 surveys were done on paper and mailed in; 10 were completed in Spanish (p. 1223). * "The mean age of escape for participants who completed paper surveys was 31 years compared with 26 for	*Level 4 retrospectiv e cohort study	Limitations: *Small sample size *Had instances where webpages for online surveys were not working correctly and wrong contact information on others that did not

of Health Care for the Poor & Underserved, 27 (3), 1220–1233. https://doi.org/10.1353/hpu.2016.0131	care providers encounter this population" as well as to discuss what health care settings victims are most likely to be seen (p. 1220).		were contacted to participate in recruiting survivors and 9 agreed (p. 1222). These 9 organizations sent paper surveys while the online survey was placed on their websites, advertisements, blogs, and Facebook (p. 1222). *No record of survivors who were approached but declined were kept. *Participants were chosen if they answered affirmatively to the question, "Are you a survivor of slavery, or were you made to work or made to do sexual acts?" (p. 1222). * "Questionnaire content included basic demographics,	online respondents" (p. 1223). *It was found that those who responded online were "more likely to be male, more educated, and non-U.S. born" but it did not show to have a bearing on their use of health care services, the chance they would have disclosed that they were trafficked, or if they were offered assistance all while still being trafficked (p. 1223). *More females than males were citizens of the U.S. and reported being trafficked as minors (68% vs 18%; 44% vs 10%) (p. 1223). *Mean age for being trafficked: US born- 16.5 years, Non-US born- 23.3 years (p. 1224). *117 (or 68%) participants reported being seen "by a health care provider while being trafficked" (p. 1220, p. 1228).		get corrected because those institutions did not respond to the authors' reaching out to them. This can cause missed opportunities. *Only 9 out of almost 24 organizations participated *Many survivors may not understand that they were trafficked, or they were not in connection with survivorship groups that would have reached out to them to participate in this study which limits the generalizability (p. 1230). If they were poorly literate or illiterate and did not have an advocate to help them with the survey, they would not be able to give their

			items about type of exploitation experienced while being trafficked, medical ailments survivors suffered, and whether health care was desired and/or received" (p. 1222). *Participants were asked if they had received treatment from a health care provider while in captivity, what type of provider and location it was, and if they were screened for possible trafficking or offered help while there (p. 1222). *Survey questions were created based on data from a qualitative study conducted with 12 survivors and their experiences in captivity with health care, and then updated to	*US born findings (p. 1225): -Wanted to see a doctor (67.9%) -Able to see the doctor (62.8%) -Talked to doctor about being trafficked (14.1%) *Non-US born findings (p. 1225): -Wanted to see a doctor (81.8%) -Able to see a doctor (72.7%) -Talked to doctor about being trafficked (44.3%) *56% of participants reported being trafficked for sexual purposes (p. 1225). *12% were trafficked for labor/outdoor work (p. 1227). *Health care locations they were in while trafficked (p. 1227): -26.5% Dentist -55.6% ED/Urgent care -25.6% OB/GYN -44.4% Primary Care -3.4% Pediatrician		responses which also affects generalizability (p. 1230). *Only Spanish and English speaking surveys were received which limits the generalizability to others who speak different languages.

			include insights from professionals who work with survivors and to follow the U.S. Department of Health and Human Services recommendations (p. 1222).	-8.5% Alternative Healer -0.9% Don't Know -5.1% other *Page 1228 has a table that lists the questions that were asked by health care workers when they were being trafficked and whether the participant was identified when they were asked. *105 of the participants reported being asked at least one screening question that has been nationally recommended by experts to be asked to identify potential victims But 56% reported that after being recognized as potentially trafficked, they were not offered interventions (p. 1229).		
Dols, J. D., Beckmann-Mendez, D., McDow, J., Walker, K., & Moon, M. D. (2019). Human trafficking	*The purpose of this study was to "identify whether a standard protocol is currently used to identify, assess, and intervene for	*Twenty-seven ED leaders in south Texas were surveyed on their strategies for identifying human	*Descriptive study which used a survey to collect information from ED leaders on their current human trafficking	*Screening tools have been developed but "health care still lacks a standardized, validated human trafficking tool" (p. 624). *Study found that only a few of the EDs had	*Level 6 Descriptive study	*Limitations -Had a regional focus design - "The convenience sample, low response rate, and data collection

victim identification, assessment, and intervention strategies in south Texas emergency departments. *Journal of Emergency Nursing, 45*(6), 622–633. https://doi.org//10.1016/j.jen.2019.07.002	human-trafficking victims [within EDs] in 47 south Texas counties" (p. 622).	trafficking victims (p. 622). *EDs located near the Mexico/US boarder were included.	identification practices (p. 624). *The survey consisted of 23 questions developed through a literature review (p. 624). *Question topics included "type of emergency department, providers, and clinical staff; methods used to screen adult and child human-trafficking victims; and results, including number of positive screens, characteristics of individuals with positive screens, strategies helpful to identify human trafficking victims, and the actions taken following identification" (p. 624). *99 EDs were sent surveys, with 27 of them	identified human trafficking victims 2017, despite their location and data showing that the hospitals were located in high trafficking areas (p. 628). *There was a lack of standardization and screenings differed based on "individuals performing the screenings, the location and timing of the screenings, education of clinical staff, patient education provided, and assessments performed" (p. 628). *Self-identification by victims as trafficked was rare (p. 628). *40.7% of the EDs "specifically screened adults," and often the screening was using safety questions; sometimes just one safety question (p. 628). *Some EDs only reported screening children for trafficking (p. 628).		that relied on 1 ED leader at each site having comprehensive information" (p. 631) -Technical issues with online data collection slowed down the process; as did the turnover of leadership in some of the facilities (p. 631). -Did not address victim demographics or if an interpreter was needed and used (p. 631).

			responding (p. 624).	*A forensic nurse in one ED that participated in the study identified 10 trafficked children (p. 628). This individual was trained to identify trafficking signs and symptoms (p. 628). *Pages 629 to 631 in Table 5 lists 16 human-trafficking screening tools, what they screen, the setting they are intended for, if they require training, and the number of questions they contain. *Implications for practice: validation is needed of currently available screening tools; ED nurses need to be trained to identify and intervene in potential human trafficking cases; and healthcare workers need to understand reporting mandates (p. 631-632).		
Donahue, S., Schwien, M., & LaVallee, D. (2018). Educating	*The purpose of this study was to "educate ED personnel on the issue of human	*The study sample consisted of emergency department	*This study utilized pre-and post-surveys with a Likert scale after an educational	*89% of participants reported never being trained in human	Level 4: Cohort Study	*Limitations *75 employees participated in the pre-test with only

emergency department staff on the identification and treatment of human trafficking victims. *Journal of Emergency Nursing, 45*(1), 16–23. https://doi.org/10.1016/j.jen.2018.03.021	trafficking, to increase staff confidence in recognizing and treating possible human trafficking victims, and to develop and implement a screening tool with guidelines of care for anyone who is identified as a possible victim" (p. 17).	(ED) staff from two hospitals located in the suburbs of a major city consisting of nurses, physicians, NP/PAs, registration, and technicians (p. 18). *75 staff members had completed the pre-survey and 56 staff members had completed the post-survey (p. 18).	intervention and implementation of a screening tool. *Education was given online with a PowerPoint presentation, two case studies, and guidelines to inform identifying and managing the care of a human trafficking victim (p. 18). *Participants began by learning from the PowerPoint presentation the "definition of human trafficking, general statistics, stages of entrapment, a discussion of at-risk populations, potential red flags to identify victims, screening questions, and typical health implications" (p. 18). A flowchart guideline was introduced during the education	trafficking identification (p. 18) *Under half the subjects reported an understanding of human trafficking prior to the education (p. 18) *There was a 93% increase in reported comprehensive understanding after education was given (p. 18) *The average confidence level in identifying a victim of human trafficking increased from 4/10 to 7/10; average confidence in understanding treatment of victims from 4/10 to 8/10 (p. 18). *96% of subjects reported that they felt the education would be helpful for their job (p. 18). *Having an assessment tool with questions that are used in all patient assessments increased confidence level of staff (p. 20).		56 employees taking the post-survey causing a 25% attrition rate (p. 20) *Subject to reporting bias by the staff (p. 20) *Post- surveys subject to participant bias and could be skewed rating of their actual ability (p. 20)

			which combined two well-known protocols for identification (p. 18). *Once that was completed, they completed two case studies on human trafficking (p. 18). *Participants learned to call the Human Trafficking National Hotline anytime they identified a potential victim (p. 18).	*Study identified the need for written materials within the EDs studied to increase human trafficking awareness in the department seen by patients, such as posted on bathroom walls, with hotline phone numbers for them to seek help (p. 20). *Bilingual posters and the phone number for the national hotline were added to the department after the study in the bathrooms, lobby, and hallways (p. 20).		
Egyud, A., Stephens, K., Swanson-Bierman, B., DiCuccio, M., & Whiteman, K. (2017). Implementation of human trafficking education and treatment algorithm in the emergency department. *Jour nal of*	* The purpose of the study was to "implement a screening system and treatment algorithm in the emergency department to improve the identification and rescue of victims of human trafficking" (p. 526)	*Conducted at a level 2 trauma center ED in Pennsylvania located near major highways *Participants were the medical staff, registration, ancillary staff, and security guards for the ED with 102 staff members	*Non-experimental descriptive study utilizing post-education surveys of increased competency level after educational intervention was implemented after a gap analysis was completed showing a need (p.	*Created an interprofessional team of ED nurses, administration, security, radiology, social services, patient registration, physicians, and community experts to discover the gaps in evidence-based practice versus their current practice (p. 527). *Utilized the Johns Hopkins Nursing Evidence-based	Level 6: Descriptive study	*Limitations -The study could not determine if all the identified victims that were screened as positive were also offered rescue options due to the fact that there was no way to know if those who identified themselves by a blue dot were all

Emergency Nursing, 43(6), 526–531. https://doi.org/10.1016/j.jen.2017.01.008		completing a post-education survey (not the entire number who received the education) (p. 527, 529)	*An identification and treatment algorithm were used for the study which assessed "(1) medical red flags created by a risk-assessment tool embedded in the electronic health record and (2) a silent notification process" (p. 526). *Data was collected on the outcomes of the implemented treatment algorithm, but the main outcome was the educational result.	Practice Model and the Everett M. Rogers Change Model to develop the plan (p. 527). *Deduced that education, screening, and rescue plans needed to be developed (p. 527). *Mandatory education was developed and completed by "ED staff including nursing, physicians, laboratory, social services, radiology, registration, security, and transport" (p. 527). *Live training through meetings and huddles along with an informational binder was implemented (p. 527). *Video and a treatment algorithm were uploaded to the hospital intranet for referencing (p. 527). *Education included "screening tools, medical red flags of human trafficking, resources for rescue,		charted upon because the screening tool was not filled out to include verification that rescue was offered (p. 530).

				and plans for notification of appropriate agencies" (p. 527). *Red flags were split into two parts: a social screening with registration staff and a health screening with ED nurses and physicians (p. 527). *Registration red flags included not having an ID, paying in cash, not having insurance, and the explanation of who the guardian was with the patient not making sense (p. 528). *ED staff medical signs of trafficking included "urinary tract infection, pelvic or abdominal pain, suicide attempt, and psychological nonepileptic seizures (p. 528). *Triage questions were added into the EHR from the Department of Health and Human Services Screening Tool for Human Trafficking that would be asked by the triage		

				nurse if trafficking was suspected (p. 528). *Signs were placed in the bathrooms indicating to place a blue dot sticker on the urine cup if they were not in a safe situation (p. 528). *Interventions included a safe space in radiology to talk to the patient away from the abuser as it appears normal for a patient to go to x-ray alone (p. 529). *An anonymous survey of those who participate in the education program was given to measure perceived gained knowledge (p. 529). *Data was gathered from the electronic health record for five months from the start of the interventions and education to survey for compliance with documentation changes, and to gather information on the number of possible		

				victims that were identified with the implemented tools (p. 529). *97% of the 102 individuals who completed the post-education survey reported that they were committed to continuing with the changes made; 3 reported being somewhat committed (p. 529). *74% believed the education improved their competence level and 75% planned to use the communication strategies they had learned (p. 529). *Medical record showed 100% compliance after 5 months with 38 patients identified as potential trafficking victims; 20 potential victims were identified through medical red flags and 18 potential victims through the blue dots on urine cups (p. 529).		

				*Four adult victims accepted help and one minor victim had mandatory interventions due to mandatory reporting laws (p. 529). *The medical red flags that identified three of the victims were a suicide attempt, a pseudo-seizure, and a domestic abuse case. The fourth was through the blue dot (p. 529). *One of the 5 victims who accepted help was rescued from trafficking (p. 530).		
Ernewein, C., & Nieves, R. (2015). Human sex trafficking: Recognition, treatment, and referral of pediatric victims. *The Journal for Nurse Practitioners, 11*(8), 797–803. https://doi.org/10.1016/j.nurpra.2015.06.005	* Purpose is to educate the nurse practitioner on recognition, treatment, and referral options of pediatric human sex trafficking victims.	*Pediatric sex trafficking victims in the United States.	*This is a review of studies and their findings to educate nurse practitioners on specific clinical presentations, health risks, red flag indicators or trafficking, screening questions, management, the nurse practitioner's role in the process, and resources for	*Common precursor to becoming a sex trafficker as an adult is a history of previous physical and/or sexual abuse as a child (p. 798). *Identifying victims is often hard because they are isolated, threatened, in debt bondage, or in physical bondage (p. 798). *Vulnerable children include runaways, homeless, kidnapped,	Level 5: Review of Descriptive Studies	*Limitations -The author did not list any limitations.

			reporting (p.798-801).	or in foster care children (p. 798) *Health risks of trafficked children: mental health issues, physical and sexual assault trauma; HIV/AIDs and STI/STDs, and lack of preventative care (p. 798). *69% of pediatric sex trafficking victims are homeless with increased rates of hepatitis B, HCV, and HIV, and risk of pregnancy and physical violence (p. 798). *Red flags (p.798): "1. Discrepancies in behavior and reported age 2. Evidence of sexual trauma 3. Multiple or frequent sexually transmitted infections 4. Excessively large number of pregnancies 5. Tattoos or other types of branding		

				6. Use of slang relating to involvement in prostitution 7. Evidence of controlling or dominant relationship 8. Malnourishment or generally poor health" *There is an increased risk of HIV in women who were trafficked when they were 14 years old and younger compared to those who were trafficked at 18 years and older (p. 799). *A study showed that educating providers on prevention resources, psychological support, and how to help victims exit the sex industry reduces the risk of harm in victims and helped prevent them entering the sex trade (p. 799). *Psychological issues seen in this patient population are "depression, anxiety, suicidal ideation, posttraumatic stress		

				disorder, and addiction" (p. 799). *Identifiable risk factors of mental disorders in trafficking include "education status, socioeconomic status, emotional abuse in childhood, physical and sexual abuse, and duration of the trafficking situation" (p. 799). *Screening Questions for Minors: "1. Where do you sleep? 2. What are your working/living conditions like? 3. Are you able to come and go as you please? 4. Has anyone ever physically harmed or threatened you? 5. Are you required to ask permission for physical necessities? 6. Have you/are you forced to have sex or perform sex acts?" (p. 799)		

				*Management includes identifying victims, treating physical and emotional problems due to the trafficking, and refer to appropriate services for help (p. 800). *Discusses US Department of Health and Human Services training recommendations that include the education and training of nurse practitioners; mandated annual training for competency; and the development of dedicated resources for the training of staff and as a reference (p. 800).		
Fang, S., Coverdale, J., Nguyen, P., & Gordon, M. (2018). Tattoo recognition in screening for victims of human trafficking. *The Journal of Nervous and Mental Disease, 206*(10)	The purpose of this article was to identify "objective physical features [that] can be useful in clinical settings" to identify human trafficking victims (p. 824)	Samples were articles and online pictures and descriptions of tattoos and physical markings associated with human trafficking	*Sample was scholarly medical literature on "identifying human trafficking victims through external stigmata" using key words of "human," "trafficking," and "tattoo" (p. 824) *Search of non-academic "gray" literature on	*Approximately 25% of the United States between 18 and 50 years has at least one tattoo (p. 825). *Few articles link tattoos to human trafficking and many resources used to "help healthcare providers identify victims neither mentioned the presence of tattoos nor elaborated on any	Level 5 review of descriptive studies	*Limitations -Not enough scholarly literature to determine the effectiveness of using tattoos as an identification tool. The five articles that were found only had one with a picture in it. -Articles found discussed

, 824–827. https://doi.org/10.1097/NMD.0000000000000881			Google using the same keywords; and a social media photo album of tattoos that were covered up by tattoo artists with their permission (p. 824)	distinguishing characteristic of trafficking tattoos" (p. 825). *One article mentioned tattoos, but it was in relation to postmortem identification (p. 825). *5 articles discussed tattoos in the context of human trafficking: tattoos of names and explicit content on children can be indicators of trafficking; male names, barcodes, or gang symbols especially on neck, inner thigh, or around genitals were highly indicative of human trafficking; one study had a pediatric patient with expletives and nonspecific symptoms tattooed on her body discovered during surgery; tattoos more common in commercially sexually exploited kids (48%) verses other sexual abuse victims (5%) (p. 825).		branding and other means than tattoos of physical signs but did not go into detail to help someone know what to look for. -Did not talk to former trafficked victims to gather evidence for this as a tool.

				*Poor quality tattoos can be an indicator because they are most likely not done by a professional and therefore could have been done as a branding (p. 825). *Several common features of tattoos found when analyzing photos from the tattoo transformation organization: symbols of wealth (gold bars, diamonds, ATM, crowns, barcodes, money bags); names bearing the alias of the trafficker to show ownership, especially when in a possessive form); profanity; small hearts with a name or an initial (p. 825). *Locations of tattoos varied: arm, face, hand, back of neck, under arm, genitals, eyelids, gums, breasts (p. 825). *Identification through tattoos is not able to be used as a soul identifier but can alert the provider to get the		

				patient alone to ask more questions (p. 826)		
Grace, A. M., Lippert, S., Collins, K., Pineda, N., Tolani, A., Walker, R., Jeong, M., Trounce, M. B., Graham-Lamberts, C., Bersamin, M., Martinez, J., Dotzler, J., Vanek, J., Storfer-Isser, A., Chamberlain, L. J., & Horwitz, S. M. (2014). Educating health care professionals on human trafficking. *Pedi atric Emergency Care*, *30*(12), 856–861. https://doi.org/10.1097/PEC.0000000000000287	The purpose of the study was to "determine whether an educational presentation increased emergency department (ED) providers' recognition of human trafficking (HT) victims and knowledge of resource to manage cases of HT" (p. 856).	*"20 largest San Francisco Bay area EDs randomized into interventions (10 of the EDs) or delayed intervention comparison groups (10 EDs) who had standardized educational presentation" (p. 856). *"258 study participants from 14 EDs; 141 from 8 EDs in the intervention group and 117 from 7 EDs in the delayed intervention comparison group" (p. 856) *Included physicians, nurses, and social workers	*Group randomized controlled trial *Anonymous survey was used to assess "changes in the participants attitude, knowledge, and recognition of HT victims[s]" as a pilot to assess the questions. Tested on 77 random subjects before it was revised (p. 858). *Finalized survey was given to participants prior to and then after the educational intervention with data collected (p. 858)	*Intervention group had a higher increased in self-rated knowledge more than in the control group (p. 858) *Increased knowledge of who to contact in intervention group from 24% to 100%. Delayed comparison control group increased from 20% to 35% (p. 859) *The intervention group doubled their suspicions of HT victims based on learned identification tools. Delayed intervention group did not improve but stayed at 10% (p. 859). *Study also looked to see if a shorter (25-minute) versus longer (60-minute) educational intervention affected results. Was found to not affect results (p. 859)	Level 2 randomized control trial	*Limitations -Was not completely blind randomization as the administrators of the hospital knew what group their hospital was placed in (p. 860) -Subject to reporting bias with pre- and post-tests -The IRB would not allow identifying information to be gathered on the delayed intervention group, so they were not able to be contacted for a second pre-test that was just for the control group (p.860). -The time between the delayed group having the intervention was longer than the intervention group

						having the pre- and post-test which made it possible for those in the control group hospital to have had exposure to HT information, but the effect was decided to be not affecting the results (p. 860).
Greenbaum, J. (2016). Identifying victims of human trafficking in the emergency department. *Clinical Pediatric Emergency Medicine*, *17*(4), 241–248. https://doi.org/10.1016/j.cpem.2016.09.006	*The purpose of this article was to provide an "overview of child sex and labor trafficking, describe risk factors for exploitation, and review the adverse physical and emotional effects associated with human trafficking" (p. 241).	*The subject was identified as those who were identified as human trafficking victims in the ED.	*Review of studies and compilation of the results to form guidance for providers.	*Reports that most studies have found that victims are between 12 and 17 years of age when they were first brought into trafficking (p. 242). *84% of victims are US citizens and 94% were female (p. 242) *Increased vulnerability in those with "prior history of abuse or neglect, caregiver substance use or criminality, exposure to intimate partner violence, gang affiliation, sexual minority status, poverty, substance use, behavioral problems, school truancy, and/or	Level 5: review of descriptive studies	*Limitations - This is not an exhausted list of interventions and identification technique. -Does not discuss which methods have been shown most effective.

				runaway behavior" (p. 242-243). *Article lays out a table with physical and emotional effects listed to alert providers and healthcare workers to potential victims (p. 242). * Table of potential indicators of human trafficking listed on page 243 *Reminds providers that the victim may be a parent bringing in a child for an exam (p. 243) *Contains the Vera Institute screening for human trafficking questions: 3 for sexual exploitation and 4 questions for labor exploitation (p. 244) *Table that lists important interviewing points (p. 244) includes taking time to establish trust, letting the patient know that they are not required to answer questions, and avoiding making promises you cannot keep.		

				*Describes the medical interview process and reminds the provider that the victims may be harsh, protective, and aloof at first as defense mechanisms (p. 244) *Look for verbal and nonverbal cues. Can utilize the World Health Organization's interviewing recommendations (p. 244) *Separate the victim from the one who came with them through taking them to radiology (p. 244) *One study showed only 50% of victims reported condoms were used often or always; 45% had an STI when being assessed; and 31% reported being pregnant at least once (p. 245) *One study reported high rates of substance abuse with 100% in boys and 46% in girls (p. 245) *Table listing components of medical		

				evaluation on p. 245 listing tests to order, assessments to do, and discussing forensic nursing involvement *Article lists reporting and referral numbers and contacts. Discusses that victims will need help after their ED visit with food, shelter, education, job skill training, and other concerns (p. 245-246)		
Greenbaum, V. J. (2017). Child sex trafficking in the United States: Challenges for the healthcare provider. *PLOS Medicine*, *14*(11), Article e1002439. https://doi.org/10.1371/journal.pmed.1002439	*The purpose of this article was to report on the challenges healthcare providers face in identifying child sex trafficking victims, and to recommend ways to address these issues.	*The article was written for health care providers with the subject of caring for and identifying victims of child sex trafficking.	*Descriptive article that uses known studies to define child trafficking and give the scope of the issue. It describes healthcare's role and the challenges providers and healthcare professionals face in identifying victims.	*The article defines child sex trafficking and includes examples such as "using a minor to produce child sexual exploitation materials, using a child in a sex-oriented business, soliciting a child for commercial sex, and having a child perform a sex act with another person(s)" (p. 2). *84% of sexually trafficked individuals within the US are citizens of the country; 94% are females (p. 2). *Writer suggests that the demographic information may be	Level 6: Descriptive study	Limitations: *The author did not describe any limitations to their study. *The study is limited in that it does not study the effectiveness of a specific identification strategy, but it does describe what is the issue and ways evidence in literature reports it can be solved.

				skewed by cultural conceptions that influence investigator bias (p. 2). This could cause other victims to go unrecognized. "There is evidence that males and transgender youth" are victims of sex trafficking (p. 2). *Growing evidence showing US child sex trafficking victims are seeing medical professionals while in captivity and high percentages (p. 2). The medical care is occurring in multiple healthcare sites, not just urgent cares or EDs (p. 2). *80% were seen in a medical facility within a year of being identified as a trafficking victim (p. 2). *63% reported being seen in an ED (p. 2) *35% were seen in an outpatient healthcare site (p. 2). *Common medical complaints: STIs,		

				HIV/AIDS, pregnancy, assault injuries; PTSD, depression, suicidal ideation, and behavioral complaints (p. 2). *47% of the female youth had an STI when evaluated during a study (p. 2) *32% reported at least one pregnancy in another study (p. 2). *47% reported at least one attempted suicide with 78% meeting criteria for PTSD in a study (p. 2) *Youth are less likely than adults to identify themselves as being trafficked due to "fewer resources" and being "less able to protect themselves" from their trafficker (p. 2). *Children may not understand that they are being manipulated and will more readily believe a trafficker negative claims about themselves or that it is all their fault (p. 2). They also may feel an		

				attachment to the trafficker thinking that they are dating or consenting to acts (p. 2). “Many children have dep unmet needs that are exploited by a trafficker- the need for love, attention, a father figure etc.” (p. 2). The psychological manipulation makes it difficult for a minor to identify themselves to a provider or medical worker. *Natural child development stages mean their cognitive development “render adolescents prone to risk-taking and seeding immediate gratification” instead of identifying potential risky behaviors and decisions (p. 2). *The very young are either unable to verbalize what is happening to themselves or they do not understand what is occurring in order to tell someone and ask for help (p. 2). “There		

				symptoms of stress may be nonspecific and misinterpreted by others (tantrums, anxiety, sleep problems)" (p. 2). *In order to identify and rescue children from trafficking, providers and frontline healthcare workers must be able to identify a victim; especially since children are unlikely to report they are being trafficked without questioning (p. 2). *A table on p. 3 lists risk factors for child trafficking that are useful in educating frontline staff. *Challenges faced by healthcare workers in identifying potential victims: little time to gain rapport; it takes time to ask the potential victim screening questions "in a sensitive, trauma-informed, victim-centered" way (p. 3).		

				*With child trafficking, the parents of the child may "be 1) victims of human trafficking, themselves, (2) the persons trafficking the child, (3) not the actual parents" (p. 3). *The article cites a study where 63% of providers report not having previous training in identifying potential victims (p. 3). *The article's author suggests educating providers on risk factors and common identifiers of trafficking will help increase identification of youth who are at risk of trafficking while asking their normal medical and social histories (p. 3). *Resources for interventions discussed by article: National Human Trafficking Resource Center; U.S. Department of Health and Human Services SOAR to Health and Wellness training; HEAL Trafficking; the		

				American Academy of Pediatrics guidelines for recognizing and responding to human trafficking (p. 3). *Trauma-Informed care: -It is not enough to know common risk factors and indicators of trafficking; providers need to learn how to assess potential victims in a "trauma-informed, culturally sensitive, victim-centered manner" (p. 3). -Providers are taught to assume that patients are answering questions to the best of their ability, with all honesty, and are there to gain help from them, but this cannot be an assumption when working with child trafficking victims (p. 3). -Trauma-informed care must be taught so that providers learn how to "build trust, assume a nonjudgmental attitude,		

				convey respect for the patient, ensure a sense of safety, and empower" the child/youth to be a part of their care and decisions (p. 3 &4). -The trauma the trafficking victim goes through effects their whole person, outlook, view of others and self which is why trauma-informed and victim-centered approach is necessary in questioning them (p. 4). -Victims can act out, refuse to speak, or be aggressive due to what they have been through (p. 4). This can make it more difficult to interview them which training in trauma-informed care can help (p. 4). -Resources on trauma-informed care (p.4): National Child Traumatic Stress Network; Children's Healthcare of Atlanta; Polaris; National Health Collaborative on Violence and		

				Abuse; Christian Medical and Dental Associations *Though resources exist for both trauma-informed care and human trafficking victim identification, literature shows that there needs to be a nation-wide dissemination of these resources (p. 4). *Healthcare workers are not needed to ask probing questions, but just need to be able to identify a victim and know what medical care they may need and where/how to refer them to the proper resources. *Interview potential victims using open-ended questions that are not suggestive or leading (p. 4). * "Time is arguably one of the greatest barriers to HCP intervention in human trafficking" (p. 4). Make time to do the assessment and		

				interview right just like you would make time for a trauma patient or assault case. *It can help if the healthcare agency/department has a "designated, trauma-trained professional" to conduct the interview and make referrals (p.4). This can be a nurse or a social worker and not necessarily a provider. *There are self-administered screening sheets the victim can fill out as well but it needs to be given where they are safe, separate from the person who brought them, and is written at their age level (p. 4 &5). *The study reports that there are multiple screening tools for child sex trafficking but that there are very few that are clinically verified (p. 5). Study's author states the need for a verified tool and for a study to determine		

				what are the factors that influence a potential victim to disclose that they are being trafficked (p. 5). There also is a need to study the best ways to interview and gather information from children at different ages (p. 5). Some examples the author gave were "written versus verbal versus web-based questions and the appropriate time to conduct the assessment during the visit" (p. 5).		
Greenbaum, J., Bodrick, N., Committee on Child Abuse and Neglect, & Section on International Child Health. (2017). Global human trafficking and child victimization. *Pediatrics*, *140*(6), Article e20173138. https://doi.org/10	*This article is a policy statement from the American Academy of Pediatrics with the aim of outlining "major issues regarding public policy, medical education, research, and collaboration in the area of child labor and sex trafficking and	*The subjects of this article are children and adolescents who are enslaved in human trafficking.	*This is an article is a policy statement describing evidence in literature on child human trafficking, trafficking policies, education in medical fields on the subject, pertinent research, and a discussion on collaboration efforts (p. 1-6). The article then gives	*Recommendations give for healthcare professionals who treat children in order to prevent, identify, and rescue victims of child trafficking relevant to victim identification in healthcare: -Medical Education 1. "Advocate for training of health care professionals on human trafficking issues, including recognition, assessment, treatment, and referrals for	**Level 7 Expert Opinion	*Limitations -Limitations were not given by the authors.

.1542/peds.2017-3138	provides recommendations for future work" (p. 1).		recommendations based on expert opinion on these areas.	services by using a trauma-informed, culturally sensitive, rights-based approach" (p. 7). 2. Advocate for educating of resident trainee providers to the American Board of Pediatrics (p. 7). 3. Implement curriculum to be added to medical education that teaches on "social determinants of health, in particular including questions about adverse childhood events in the patient assessment, connecting to community resources, and building community resilience" (p. 7). 4. There needs to be advocating for financial support and continuing education credit for human trafficking and trauma-informed education for medical professionals (p. 7 & 8). -Collaboration		

				3. There needs to be advocacy centered around protocol and process development for identifying and intervening in child trafficking cases (p. 9).		
Greenbaum, J., & Crawford-Jakubiak, J. E. (2015). Child sex trafficking and commercial sexual exploitation: Health care needs of victims. *Pediatrics, 135*(3), 566–574. https://doi.org/10.1542/peds.2014-4138	*The purpose of this article is to inform pediatricians on the sexual trafficking of children and commercial sexual exploitation of children (CSEC) and to suggest ways they can work to protect children (p. 566)	*Subjects of this article are pediatricians and child human trafficking and CSEC victims	*This is a descriptive study using evidenced-based literature to inform the reader on human trafficking; risk factors for CSEC; identifying and evaluating potential victims; and discuss referrals, resources, and multidisciplinary interventions.	*Identifying victims of commercial sexual exploitation of children (CSEC) is made harder by identifying youth as prostitutes or criminals instead of victims of exploitation (p. 567). *Article defines severe trafficking in persons, CSEC, and survival sex (p. 567). *Risk factors for CSEC: -Average age children are pulled into trafficking is between 12 to 16 years old (p. 567). *immature prefrontal cortex= affects impulse control, critical thinking skills, and risk versus benefit of behavior (p. 567) *Children are easier to manipulate (p. 567)	*Level 6: Descriptive study	*Limitations -Authors did not disclose limitations

				*Homeless, runaways, and throwaway youth, hx of abuse (both physical and sexual), those with family dysfunction or family violence, LGBTQ youth, alcohol or drug addiction, disabilities, living in poverty, or living in areas with a lot of transient males (p. 567) *Can be "recruited by peers, relatives, or strangers who groom children and seduce them with promises of love, money, attention, acceptance, jobs, acting/modeling opportunities, drugs, or other desirables" over the internet or in person (p. 567-568). *Traffickers instill control over them through repeated assault, violence, threats, mental abuse, and blackmail which makes it harder to identify victims and have them willing to disclose that they are trafficked (p. 568).		

				*Can alternate between cruelty and love to keep the victim loyal (p. 568). *Identification and Evaluation -Healthcare places victims present, "emergency departments, family planning clinics (including Title X clinics), public clinics or private offices, urgent care centers, or institutional settings" (p. 568). *Victims can present with any of the many common complaints but are hard to identify because they rarely self-identify and there is not validated screening tool that can be used in health care (p. 568). *Three examples of direct questions a pediatrician or provider can ask if they suspect a patient is a CSEC or trafficking victim (p. 568):		

				"1. Has anyone ever asked you to have sex in exchange for something you wanted or needed (money, food, shelter, or other items)? 2. Has anyone ever asked you to have sex with another person? 3. Has anyone ever taken sexual pictures of you or posted such pictures on the Internet?" *Victims may have been asked to lie, can be hostile, protective of the trafficker/handler, scared, ashamed, or depressed (p. 568). *Give trauma-informed care (p. 568) *Page 569 has a table listing potential indicators *Page 569 discusses 10 focuses of evaluating a potential victim of trafficking once the provider identifies them as such.		
Greenbaum, V. J., Dodd, M., & McCracken, C.	The purpose of this study was to "describe	*108 participants ages 12 to 18	*Cross-sectional study comparing CSEC/CST	*Variables more common in the CSEC/CST group than	Level 4 cross	Limitations:

(2018). A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatric Emergency Care, 34*(1), 33–37. https://doi.org/10.1097/PEC.0000000000000602	characteristics of commercial sexual exploitation of children/child sex trafficking (CSEC/CST) victims and to develop a screening tool to identify victims among a high-risk adolescent population" (p. 33)	years who were seen in 1 of 3 metropolitan pediatric EDs or 1 child protection clinic (p. 33) *25 out of 108 were CSEC/CST and 83 were acute sexual assault/sexual abuse (ASA) without evidence of CSEC/CST (p. 33) *All of the CSEC/CST patients were female and 95% of the ASA patients were female *English speaking *Excluded those with extreme developmental delays, those who appeared intoxicated, and those deemed unable to	victims verses ASA victims to test compare variables to identify 5-7 screening items that would identify a CSEC/CST adolescent victim. *Interviewed away from caregiver or the accompanying person (p. 34) *Clinicians used a trauma-informed approach asking a series of questions "related to medical history, reproductive history, substance use, and other high-risk behavior, mental health issues, and abuse/injury history" (p. 34). *Clinician recorded their observation of appearance and behavior and that of the accompanying	the ASA group: presence of any tattoo; lifetime hx of fractures, significant wounds, or traumatic LOC; hx of sexual activity; hx of violence from a parent/caregiver or others; drug use; hx of running away; hx of involvement with police or child protective services; more likely to have an STI and hx of pregnancy (p. 34) *6-question screening tool developed with 0.97 area under the receiver operating curve (AUROC) discrimination of CSEC/CST victims *Sampled 1000 times and found that those who had "positive responses to at least 2 of the 6 screening questions" had a 22 times higher chance of being a CSEC/CST victim than someone with 2 or fewer positive responses; had sensitivity of 92%, specificity of 73%,	sectional study	*Only identified 3 males who all were in the ASA group (p. 36). *No international trafficking victims identified; all were domestic (p. 36) *Small sample size and done in one pediatric healthcare facility (p. 37). *Many of the CSEC/CST victims had been identified as trafficking victims by police so the tool was used to see if they said yes to any of the questions to verify if the tool would identify them as well (p. 37).

		answer questions accurately (p. 33-34)	individual(s) (p. 34) *There were 50 questions but not all were asked depending on the receptiveness of the patient or the circumstances (p. 34) *They were then classified as CSEC/CST or ASA; descriptive statistics were done for all the identified variables with those having a significance of 0.1 selected to be used for screening (p. 34)	positive predictive value of 51% and NPV of 97%. *Six screening questions listed on page 36		
Greenbaum, V. J., Livings, M. S., Lai, B. S., Edinburgh, L., Baikie, P., Grant, S. R., Kondis, J., Petska, H. W., Bowman, M. J., Legano, J., Kas-Osoka, O., & Self-Brown, S. (2018). Evaluation of a	*The purpose of the study was to "estimate the prevalence of child sex trafficking" within the patient populations in differing healthcare settings and then evaluate the ability of a	*Subjects were "English-speaking youth ages 11-17 years" (p. 745) *810 participants varying ethnicities. *15.3% male, 84.3% female	*Cross-sectional observational study *Study was conducted within the United States in 16 different healthcare sites: pediatric EDs, child advocacy centers, and teen	*90 patients out of 810 were identified as victims of child sex trafficking by the health care providers using the screening tool and participating in the study. *13.2% were identified in an ED	*Level 4: Cross-sectional observational study	*Limitations identified by the authors of the study: -Excluded non-English speaking participants -Minimum age varied between the 16 sites between 11 and 13 years of age.

tool to identify child sex trafficking victims in multiple healthcare settings. *Journal of Adolescent Health, 63*(6), 745–752. https://doi.org/10.1016/j.jadohealth.2018.06.032	screening tool to detect potential trafficking victims within the healthcare setting (p. 745)	*11.2% were seen in EDs *48.8% were seen in child advocacy centers *40% were seen in teen clinics	clinics in urban settings. *Data collection lasted from May 1, 2015 to November 15, 2016 *Inclusion criteria: English-speaking, 11 to 17 years old, with chief complaint of "acute sexual assault/abuse, or concern for CST [child sex trafficking]" (p. 746) *Exclusion criteria: "extreme developmental delays, those who appeared intoxicated or in marked distress, those who declined to answer questions, or […] deemed unable to answer questions accurately" (p. 747). Also excluded if already participated in one of the other	*6.3% were identified in a child advocacy center *16.4% were identified in a teen clinic *The screening tool was found to have a sensitivity of 84.4% and specificity of 57.7% across the entire sample size. In the ED setting, the tool had a sensitivity of 83.3% and a specificity of 49.4%. In child advocacy centers it had a sensitivity of 84% and a specificity of 61.4%. In teen clinics the tool had a sensitivity of 84.9% and a specificity of 54.6%. *There were 121 male participants out of the total 810 participants and were found to make up 17% of the identified trafficking victims. *Authors speculated that the higher rate of identified victims in the teen clinics was due to the larger number of		-There is no gold standard for identifying a victim of sex trafficking, therefore identification of victims fell to the judgement of the providers based on the information they were able to glean from participants. This introduces bias and reliance on participants to be forthcoming with information consistent with known identifiers which could lead to missed cases or misclassification of patients. The authors felt that this limitation led to under reporting and not over reporting of cases. -Not all providers gave support data or reasoning behind why they classified a patient as a potential child

			facilities or if time constraints were an issue. *Participants were asked to complete a 17-item questionnaire asking them about "high-risk behaviors, law enforcement involvement, and sexual history" (p. 747). It was given verbally if participants were illiterate. *Participants had follow-up questions asked by providers based on their responses.	higher risked youth that are regularly seen in those clinics. One of the teen clinics that participated in the study is geared toward caring for youth who are suspected of being abused, homeless, or are runaways (p. 750). *Authors of the study report that their findings cause them to suggest that practitioners who care for pediatric patients that are seen for sexual assault or are a higher risk population should consider if their patient could be a trafficking victim. Suspicion should be increased if they meet risk factors that include "running away from home, prior involvement with law enforcement, history of STIs, >5 sex partners, and/or drug/alcohol use" as these attributes were found in 40% to 80% of the identified sex trafficking victims in this study (p. 750).		sex trafficking victim. They did undergo training, therefore there is lower risk of misclassification, but the authors mention that future studies need to focus on verifying the reasoning behind classification of victims. -The 16 sites for the study differed in the routine of asking the questionnaire. Some sites had added questions that the others did not use which may lead to a victim choosing to answer the questions differently than other sites. -Research coordinators were not a part of the study. It relied upon the providers to gather the information and

				*Results show that providers should not assume a victim will self-disclose without being prompted. Providers need to ask patients questions that are known risk factors for trafficking victims (p. 750). *The sex trafficking screening tool used in this study was designed to be specifically to identify children. It is also the first screening tool of its size, meant to be smaller than the traditional screening tool and therefore easier to use in the healthcare setting. *Those who are identified as victims should be "offered resources that could be helpful regardless of whether the youth is a victim of CST" as it could help reduce the likelihood of the child becoming a victim of sex trafficking in the future (p. 751). *The introduction of the study has a lot of		report it. This also led to the limitation of learning the number of excluded patients with the reasons for exclusion.

				helpful background information on human trafficking identification in the country.		
Hachey, L. M., & Phillippi, J. C. (2017). Identification and management of human trafficking victims in the emergency department. *Advanced Emergency Nursing Journal*, *39*(1), 31–51. https://doi.org/10.1097/TME.0000000000000138	The purpose is article was to inform healthcare staff within an ED about human trafficking, identification of victims, and management once identified.	Subjects are human trafficking victims seen in an ED setting.	Descriptive study review of human trafficking	*The International Labor Organization (ILO) estimates that there are 3 HT victims per 1,000 persons in a $150 billion dollar per year industry (p. 33). *20.9 million people globally in forced labor or sex trafficking. 11.4 million women and girls in trafficking with 4.5 million of them in sex trafficking (p. 33). *Unsure number of victims in the US but the government estimates 14,500 to 17,500 foreign nationals are trafficked into the country yearly; does not include domestic trafficked individuals (p.33). *Canada and the US are "considered destination countries for sex and labor trafficking" (p. 33).	Level 5: descriptive study	*Limitations -None were stated by the author.

				*Has been reported in all 50 states, US territories, and Washington, D.C. (p. 33) *Largest number of victims in California (p. 33) *Sex trafficking victims "most likely to be White (26%) or Black (40%), whereas labor trafficking persons were identified as Hispanic (63%) or Asian (17%) (p. 34) *The average age of entering sex trafficking is 12-14-year-old girls and 11-13-year-old boys (p. 34). *Studies believe that men and boys are underestimated and underreported as sex trafficking victims because it is considered taboo. These individuals are often explained away as gay, willing, bisexual, traffickers themselves, or buyers (p. 34). *Table of social determinant and risk		

				factors for trafficking in persons on page 35 compiled from several studies. *Victims may not escape when given the opportunity due to psychological entrapment (p. 36). *A mixed-method study showed that 63% of trafficked victims reported having been in an ED during captivity but never were identified or offered assistance (p. 36). *Several research studies showed that victims presented to the ED "with evidence of neglect, STIs, addiction disorders, pregnancy, and advanced disease" (p. 36). *A study in England found that 91% of respondents felt responsible to help victims when they suspect it. 80% of the same individuals felt they lacked training to help them (p. 36).		

				*A feeling of lack of training in identification and management with human trafficking is a common reported barrier reported amongst health care workers in multiple studies (p. 36). *Stop Observe Ask Respond (SOAR) was developed by the Department of Health and Human Services in response to multiple studies citing "no evidence of a rigorously evaluated educational module" (p. 37). *SOAR was developed with the help of health care providers, human trafficking survivors, and experts (p. 37). *Neurological issues reported 91.5% of women who were sex trafficked including headaches/migraines (53.8%), memory issues, insomnia, poor concentration which may be due to common		

				occurrence of being hit in the face/head (p. 38). *Numerous psychological health consequences reported in studies due to history of intimidation, violence, threats against loved ones, and death during captivity: "depression (88.7%), anxiety (76.4%), nightmares (73.6%), flashbacks (68%), low self-esteem (81.1%), and feelings of shame and guilt (82.1%)" (p. 38). * Survivors end up with "acute stress (38.7%), bipolar disorder (30.2%), depersonalization (19.8%), multiple personality disorder (13.2%), and borderline personality disorder (13.2%)" (p. 39). * "Victims have been groomed to conceal their abuse" with made up stories (p. 39). * "Potential warning signs and/or clinical health indicators of		

				trafficking may include evidence of physical and/or sexual violence, discrepancy between suspected and reported age, self-inflicted injuries, addiction use disorders, chronic medical conditions, multiple or recurrent STIs, and the presence of a controlling person" (p. 39). * "Although some symptoms may be subtle, any patient with multiple or new STIs or signs of physical, emotional, or sexual trauma should be screened. If an individual does not have access to valid identification or is unable to state a verifiable residential address, screening should be conducted. Any of these clinical indicators warrant sensitive verbal screening" (p. 39). *Trauma informed care training to learn rapport, flexibility, respect, and patience to		

				help the victim feel safe, in control, and respected (p. 40). *Once consent is obtained, a complete screening and physical exam should be performed (p. 40). *Use open ended direct questions with cultural sensitivity (p. 40). *Refusal of a visitor to leave the room is a red flag that patient is a trafficking victim (p. 40). *Table of potential examination findings of trauma associated in human trafficking (p. 43-44). *Comprehensive referral list pg 45		
Kaltiso, S. O., Greenbaum, V. J., Agarwal, M., McCracken, C., Zmitrovich, A., Harper, E., & Simon, H. K. (2018). Evaluation of a screening tool for child sex trafficking	The purpose of this study was "to apply and evaluate a screening tool to identify victims of child sex trafficking (CST) in a pediatric emergency department (PED)	*203 patients ages 10 to 18 years of age who presented to a free-standing inner-city children's hospital with complaints related to high-risk social or sexual	Prospective observational study using a convenience sampling and a six-item previously developed screening tool (p. 1194) *Sampling from day, evening, and	*Out of 203, "100 (49%) screened positive with the screening tool. The total number of identified CST victims was 11, yielding a prevalence rate of 5.4% (95% CI = 2.88%–8.9%). Ten of these patients screened positive with the	Level 4 Prospective Observational study	Limitations: *Convenience sample only when the researcher was in the ED (p. 1201) *Did not study all known risk factors for sex trafficking therefore possible did not identify all

among patients with high-risk chief complaints in a pediatric emergency department. *Academic Emergency Medicine, 25*(11), 1193–1203. https://doi.org/10.1111/acem.13497	population" (p. 1194).	behaviors (p. 1194, 1198)	night shifts (p. 1196) *Inclusion criteria: English-speaking male and females between 10 and 18 years with high-risk complaints associated with CST such as vaginal/penile discharge, pelvic/groin pain, request for STI testing, request for pregnancy testing, intoxication/ingestion, suicide attempt or ideation, homicidal ideation, acute sexual assault, traumatic assault, behavioral complaints, or clearance for social services (p. 1196) *Exclusion criteria: non-English-speaking, intellectual disability, those with acute	screening tool. Eight (72.7%) were newly identified as victims during their visit and five (45.5%) were detected only by the interviewer's questions" (p. 1198) *Tool showed a 90.9% sensitivity, 53.1% specificity, 10% PPV, 99% NPV (p. 1198) *Nine of the CST victims were females and two males; four came alone, four with a parent/guardian, one with a friend, and one with an officer (p. 1198) *5/11 victims had behavioral complaints; 4/11 had genitourinary complaints or sexually related issues (p. 1198) *The 11 CST victims were considered true positives because: 4 exchanged sex for money; one exchanged sex for a job; two exchanged sex for food or shelter; one for luxury items; one for drugs or alcohol; and		possible victims (p. 1201) *Only 11/203 CST patient size with only one site limits generalizability (p. 1202) *Was not done with staff using the questionnaire therefore results could be different if untrained people used it (p. 1202)

			emergencies, or ones the physician asked to not be included (p. 1196) *Chart review determined if they had already been a part of the study to not re-interview them (p. 1196) *Interviewed in private with 6-question survey tool, history and demographic questions, and conclusive questions the interviewer needed to decide if they were CST (p. 1196) *All participants given information about resources for help and safe locations (p. 1196) *Identified as true CST if answered positively about sex for money, subsistence items or luxury items, in exchange for gain, or in making child	two identified themselves as sex trafficking victims (p. 1198).		

			pornography or other child sexual business (p. 1196)			
Lamb-Susca, L., & Clements, P. T. (2018). Intersection of human trafficking and the emergency department. *Journal of Emergency Nursing, 44*(6), 563–569. https://doi.org/10.1016/j.jen.2018.06.001	*The purpose of the article is to examine "implications that human trafficking has for ED nurses and the health care industry at large" (p. 563)	*The subjects are sex and labor trafficking victims globally and in the US.	*Meta-synthesis of scholarly literature on human trafficking	*The article discusses studies that describe the dynamics of the traffickers and how they find, coerce, and use their victims to make the provider more aware of how to provide preventative education to parents and youth (p. 565-566). *Interactions with healthcare are increased in pregnant trafficking victims (p. 566) *It is important to use certified medical interpreters to ensure that the person in the room that came with them are not inhibiting conversation and to give the patient a voice (p. 566). *Attempt to speak to patient privately and do everything to maintain safety of patient and staff (p. 566) *Identification/Assessment section discuses	Level 5: systematic review of descriptive or qualitative studies	*Limitations -The author did not identify any limitations.

				the most common signs of trafficking; going in depth into most common physical, psychological, and social aspects (p. 567). *As of 2018, there were no validated screening tools for straightforward identification of trafficking victims (p. 567). *A major role of ED nurses is to provide preventative care and teaching to human trafficking victims as they may be the only healthcare they see (p. 567).		
Lawrence, M., & Bauer, P. (2020). Knowledge base of nurses before and after a human trafficking continuing education course. *The Journal of Continuing Education in Nursing, 51*(7), 316–321.	*The purpose of the study is to discuss the need to educate nurses on human trafficking identification and to present the findings of an educational intervention.	*Nurses who work within a healthcare facility with a focus on nurses working in EDs, urgent care, OB/GYN, and primary care (p. 317).	*Human trafficking education was offered for continuing education hours by web access (p. 317). *Learning outcomes of the course were that nurses would (p. 317-318):	* "Nurses learning about human trafficking through continuing education courses can be invaluable in identifying and helping trafficked victims" (p. 316). *Study cited Lederer and Wetzel (2014) study that reported ~88% of human trafficking victims are	*Level 6 Descriptive study	*Limitations -The authors did not disclose any limitations.

https://doi.org/10.3928/00220124-20200611-07			"-Demonstrate increased knowledge scores of assessments of signs and symptoms of trafficked victims on a postcourse survey. -Demonstrate increased knowledge scores of the incidence of human trafficking and laws in their own state on a postcourse survey. -Report contacting appropriate hospital supervisors when a patient was suspected of being trafficked in the 3- to 6-month postcourse survey. -Report using hotlines for reporting human trafficking at the National Human Trafficking Resource Center in the 3- t 6-month postcourse survey.	seen in a healthcare setting at least once while captive (p. 316). *Healthcare settings present a safe and isolated opportunity to identify and question potential victims (p. 316). The article reports that in 2018 there were approximately 3 million nurses in the United States which would make a large task force for victim identification if all nurses were mandated to be trained in human trafficking victim recognition (p. 316). *The Florida Board of Nursing requires nurses to take a human trafficking course every two years and The Michigan Board of Nursing requires nurses to take a human trafficking course at least once (p. 317). *Course taught participants on the background of human trafficking, information about victims,		

			-Report using appropriate referral centers for legal and social services for trafficked victims in the 3- to 6-month postcourse survey." *10 nurses took a pilot course before it went live (p. 318).	traffickers and venues, state laws, trafficking laws, and what to do when talking to and assessing a victim (p. 319). *Only 15% of the participants reported that they were "extremely or very comfortable" in their knowledge of assessing a potential trafficking victim prior to taking the course but increased to 65% postcourse (p. 318 & 319). *11% of participants responded that they were "extremely or very comfortable knowing what to say" when talking to a potential victim before the course and increased to 60% postcourse (p. 319). *65% did not know who they should contact for victims before the course and increased to 76% after the course (p. 319).		

				*All three pre-test indicators improved after education. The researchers did not provide exact numbers for all three but did put it into a graph (p. 319). *Two out of 24 participants reported identifying and reporting a trafficking victim after within 3- to 6-months following the education (p. 319).		
Leslie, J. (2018). Human trafficking: Clinical assessment guideline. *Journal of Trauma Nursing, 25*(5), 282–289. https://doi.org/10.1097/JTN.0000000000000389	*The purpose of this study was to "review the HT victim identification process for health care settings" (p. 283).	*Review of articles discussing the identification of human trafficking victims within the hospital setting in order to form a clinical guideline.	*Literature search of scholarly articles focused on identifying human trafficking victims. *The research was then narrowed to the identification of victims in health care settings. Those articles were then reduced to focus on identification protocols hospitals implemented to identify human trafficking victims.	*Literary search analysis concluded: - A comprehensive list of indicators of human trafficking to be used in a national protocol for victim identification could be difficult to achieve per the Stoklosa et al. (2017) article the author reviewed. The author does not explain why she or the authors of the article she reviewed came to this conclusion. -Patients are not forthcoming about being victims of trafficking due to "fear	*Level 7: Expert opinion	*The author failed to give limitations to the study within the body of the article. *This was not a full literature review, systematic review, or a clinical guideline based on one. It is subject to the author's bias in article selection.

				of further abuse by the trafficker, fear of being reported to immigration, inability to pay for services, shame and stigma, prior criminal record, and judgmental or discriminatory treatment by health care worker" (p. 288). -Patient-centered and trauma-informed approach would be ideal in screening patients to help negate barriers per Hachey and Philippi (2017) (p. 288). The author of the study states that this approach may not be enough to overcome the barriers to victim identification due to Hachey and Philippi not disclosing in their article how a health care worker can manage the fears potential victims may have. -Social workers should be trained to aid in identifying and helping trafficking victims. More research needs to		

				be on how social workers can work in interdisciplinary teams and collaborate with others in the effort of victim identification (p. 288). -Offer the patient the option of talking to a male or female, the use of an interpreter, and to separate them from visitors so that questioning can be done in a private and secure setting (p. 288). - Build rapport to increase chance of patient trusting the medical worker giving the screening questions for identification of potential victims (p. 288) -The use of a screening tool was found to be more sensitive in identifying potential victims than the provider alone (p. 288). -The author of the study concluded that the National Human Trafficking Resource Center's screening		

				tools should be used in the absence of a national guideline for screening the hospital setting (p. 288).		
Long, E., & Dowdell, E. B. (2018). Nurses' perceptions of victims of human trafficking in an urban emergency department: A qualitative study. *Journal of Emergency Nursing, 44*(4), 375–383. https://doi.org/10.1016/j.jen.2017.11.004	* The purpose of the study was to understand the "perceptions of emergency nurses about human trafficking, victims of violence, and prostetution" to aid in potential victim identification (p. 375, 377).	*10 ED nurses (4 males and 6 females) recruited through purposeful sampling over three months through flyers and shift change meetings with the criteria of having a Bachelor of Science in nursing and having worked in the ED for the past 2 years (p. 377) *The ED was located in a city identified has having a high human trafficking population (p. 377). *The hospital in which the ED was located had	*Qualitative descriptive study that utilized interviews that were semi-structured (p. 375). *Interview were structured to collect data on the perceptions of the ED nurses based on their experiences with "human trafficking, prostitutes, and victims of interpersonal violence (IPV)" (p. 377). *Interviews were transcribed from audio-recordings (p. 378). *12-open ended questions were asked to learn what the nurses had experienced	*6 Core Themes (p. 378-380) 1. "Human trafficking exists in the patient population, but no screening is performed." -None of the participants had knowingly treated or screened a human trafficking victim (p. 378). -The participants reported awareness about human trafficking and that patients could be a potential victim, but, had "never" screened or worked with a victim before to their knowledge (p. 378). -Participants in the study commonly reported thinking that human trafficking victims would present to the ED similarly to an IPV victim (p. 378).	Level 6: Qualitative Descriptive study	*Limitations: -Small sample size (p. 381). -All participants were from a single department and hospital (p. 381). -Results could have been skewed with the sexual assault nurse examiner participating as she has more training than the other participants (p. 382). -Unable to asses if hospital policies change the perceptions or ability to identify human trafficking victims because this hospital did not have one in place (p. 382). -Lack of diversity amongst the participants: only

		a "progressive IPV policy" (p. 377). *Four of the participants were certified emergency nurses and one participant was a sexual assault nurse examiner (p. 378).	working in the ED with human trafficking victims, prostitutes, and victims of violence (p. 378). *Information on the participants were collected to gather sociodemographic data: gender, ethnicity, age, years working in the ED, area of specialty from previous positions, and what was their highest level of education completed (p. 378). *Data was analyzed systematically using content and thematic analysis after the interviews were transcribed using two authors to confirm the transcriptions were verbatim to	They also showed uncertainty with handling a human trafficking patient due to inexperience (p. 378). 2. "Human trafficking victims are 'young, female, and foreign born'" (p. 378). -Common misconception amongst the nurses interviewed was that human trafficking victims were foreign born females/young girls (p. 378). -One participant reported thinking that a victim would present looking "very traumatized…be scared" (p. 378). Shows a misconception which could lead to missed opportunities of identifying trafficking victims. -Another participant thought the person who would accompany the victim would present with an "overbearing man," but this is more		two were not Caucasian; age range was 29 years to 57 years (p. 377).

			the audio recordings (p, 378). *During the interview, notes on nonverbal cues were taken (p, 378).	common in IPV cases (p. 378). Those who present with trafficking victims present as "charismatic, well-mannered 'boyfriends' or 'family friends'" (p. 378). Shows a need to educate frontline workers on the presentation of a handler. -Commonly told interviewers that what they believed of victims and traffickers was learned through media and not formal education (p. 379). 3. "Identifying victims of violence" (p. 379). -All 10 participants had taken care of and screened IPV victims on a consistent bases (p. 379). -Participants were confident in their abilities and skills to identify and manage the care of IPV victims (p. 379). -The ED the 10 participants worked in had policies and several		

				in-service education modules which most likely led to the confidence and ability to identify and care for IPV victims (p. 379). 4. "Victims of violence viewed as 'sad and grieving'" (p. 379). -Participants were perceptive of the feelings and insecurities of the IPV victims. 5. "Prostitutes are seen as 'hard and tough'" (p. 379). -Prostitution and sex trafficking are related, therefore the perception of prostitutes was asked of the participants (p. 379). -Participants did not indicate that they saw a relation between prostitution and being a victim of human trafficking (p. 379). Participants believed prostitutes were "hard and tough, because they have chosen their lifestyle" (p. 379).		

				-There was a large difference between participants perception of IPV victims and prostitutes. -Being “hard” or “tough” was commonly said by the participants of prostitutes they had cared for (p. 380). The 10 participants stated that prostitutes are not commonly seen as victims because they “have chosen this lifestyle” and did not think that prostitutes “were forced into a life of prostitution or that there was a link between sex trafficking and prostitution” (p. 380). -Having this viewpoint about prostitutes could hinder identifying if they are trafficking victims. 6. “No human trafficking education for emergency nurses” (p. 380). -All participants: stated they were formally educated on IPV but		

				not human trafficking (p. 380). -Described uncertainty in what resources are available but that they would call social workers first (p, 380). At this facility, there were no social workers on night shift for nurses to ask for help (p. 380). Participants did not know where local shelters would be to send human trafficking victims (p. 380). -The sexual assault nurse examiner for the ED reported not receiving training on human trafficking victim identification and management in their certification program (p. 380). *Affordable Care Act "mandates that health care providers screen for victims of violence including all women ages 14 to 46" and was shown to be an effective screening in this ED (p. 381). It is plausible to infer that a similar mandate for		

				human trafficking screening could yield similar results. *The participants saw prostitutes as hardened individuals who chose their profession and did not see them as victims of human trafficking (p. 381). *43.8% of victims in this country are US citizens and there are male trafficked victims with 50.9% in labor trafficking (p. 381) *They had resources available in their ED for victims of human trafficking but found them difficult to use; shelters were hard to get into contact with (p. 381)		
Macias-Konstantopoulos, W. (2016). Human trafficking: The role of medicine in interrupting the cycle of abuse and violence. *Annals of Internal*	*The purpose of this study was to inform the reader on human trafficking health outcomes; population health implications; access to health care; barriers to identification,	*Human trafficking and health care professionals	*A descriptive review of literature on human trafficking and health care	*There are several tables throughout the article that describe health issues associated with trafficking; indicators of trafficking; framework for developing HT protocols in health care; and a list of	*Level 6 descriptive study	*Limitations -Reports on what has been discovered in literature but does not study if the suggestions in literature are effective.

Medicine, 165(8), 582–588. https://doi.org/10.7326/M16-0094	disclosure, and assistance; improving health care's response to HT victims; and prevention using public health.			resources for medical professionals. *Human trafficking effects population health: 90% of children who are sex trafficked end up with a substance use disorder; 12% are made to have abortions; 16% report at least one suicide attempt (p. 583). HIV transmission is a concern and there is strong evidence of mental health disorders, including PTSD, that occur due to trafficking (p. 583). *Survivors are receiving medical treatment while being trafficked: one study showed 87.8% of victims had at least one encounter with health care while in captivity (p. 583). -63% in an ED -22.5% in primary care -21.4% in urgent care -19.4% in community health clinics and reproductive clinics **Survivors report that victims can still be in		

				trafficking and "continue to live at home, attend school, and even maintain contact with their primary care physicians" (p. 583). *Article states that there is still no "highly sensitive or specific clinical feature for reliable detection of at-risk or trafficked persons in the health care setting" (p. 583). *Barriers to Identification, Disclosure, and Assistance (p. 584): "disclosures may be hindered by a general distrust of authority; guilt or shame because of a sense of complicity; fear of judgmental treatment; threats of physical harm by the trafficker; fear of retaliation against loved ones; fear of deportation; and, in the case of minors, fear of being reported and returned to an abusive home" (p. 584). Providers must take the		

				time to gain their trust and build rapport to overcome disclosure barriers. *Lack of privacy is another barrier and potential victims need to be interviewed away from those who brought them (p. 584). *Improving Health Care Response to HT (p. 585-586): -Education and training -Trauma-informed, patient-centered care -Health care preparedness and multidisciplinary response protocols: allow for resources and training to guide frontline staff; should be survivor-centered (p. 585). -Research: screenings, identification tools, prevention, and intervention (p. 586). -Policy Advocacy: health care workers need to advocate for implementation of policy and procedures in health care settings;		

				training of frontline staff (p. 586). *Prevention -"Public health provides a framework for primary, secondary, and tertiary prevention that takes a broader look at the root causes, risk and protective factors, and consequences of a health-related social problem across the 4 levels of the socioecological model" (p. 586).		
McCarthy, C., & Marshall, J. (2018). The role of the nurse leader in battling human trafficking in rural hospitals in Texas. *Nurse Leader*, *16*(6), 375–378. https://doi.org/10.1016/j.mnl.2018.07.013\	*The purpose of this article was to make a call to action for health care workings, highlighting human trafficking in the setting of rural Texas as well as discuss the role of the nursing leader in identifying victims of human trafficking (p. 376).	*Human trafficking in rural Texas *Healthcare leaders who come into contact with human trafficking victims	*Descriptive study on human trafficking in rural Texas discussing the background, significance of the problem, health care opportunities, and the role of the nurse leader in identifying trafficking victims.	The Issue: *Human trafficking is the "second most profitable criminal industry" (p. 376). *Once thought to only occur in urban settings, it is now increasing in prevalence in rural communities due to a lower presence of law enforcement, truck stops and rest areas to sell victim to new customers nightly, low income residence, geography and isolated	*Level 6 Descriptive Study	*Limitations -The author did not disclose any limitations. -Focus was on rural Texas which can have a different mix of types trafficking than other rural settings.

				areas that makes it easier to hide (p. 376). *2016 study by University of Texas at Austin found the human trafficking statistics in Texas were (p. 376): -300,000+ human trafficking victims -Approximately 79,000 minors and youth who were sex trafficking victims and 234,000 adult labor trafficking victims. *Rural areas are being targeted as smaller police forces make it easier for traffickers to not be discovered (p. 376). *The University of Texas at Austin study estimated that traffickers were making $600 million annually in labor trafficking through “migrant farm work, construction, kitchen work, and landscaping services” (p. 376). The same study approximated that $6.6 billion was		

				made in sex trafficking of minors and youth in Texas between 2014 and 2017 (p. 376). Opportunities for Health Care Identification: *Trafficking occurs in every state and frontline nurses should be aware that it is a possibility among their patients (p. 376). * "Outside of law enforcement, health care settings, in particular emergency departments (EDs), are among one of the few places that the victims of HT may cross paths with the rest of society" (p. 376). *Victims are seen in health care settings for many reasons, including sexually transmitted disease/infections, mental health complaints, assaults/abuse, and addiction (p. 376). *Nurses have the unique role of being		

				able to gain the victims trust so that they may self-identify as a trafficking victim; more so than with law enforcement (p. 376). *Nurses need to be educated and given information on helping and identifying human trafficking victims (p. 376). Educating and training nursing will lead to a higher incidence of identifying actual trafficking victims and properly referring them to short- and long-term assistance (p. 376). *Focus should not be only in the ED setting as victims are seen in other locations. It needs to be a collaborative effort amongst the medical community in order to help the most people (p. 376). *Nursing leaders need to be proactive in educating and providing resources to frontline staff (p. 376). Nurse Leaders		

				* “Nurse leaders need to take the lead in setting the expectation for and ensuring the education and training of their nursing staff on identification of HT victims” (p. 376). *The first step is to increase awareness amongst nursing staff (p. 377). *Advocating for human trafficking education and identification strategies may be harder in rural communities. It will take a strong nursing leader to advocate for change (p. 377). *They are the advocate for policy changes in the hospital and legislation to gain support in victim identification education and resource allocation for training and victim support (p. 377). *Challenges facing rural health leaders include lack of resources and financial backing, as well as		

				getting the rural community to understand that trafficking occurs in small towns and not just urban areas (p. 377). *Nursing leaders need to employ interprofessional collaboration as registration, security, and other health care staff also come into contact with potential victims and can help with identification (p. 377). Other collaborations include community leaders, legislators, pastors, and local officials.		
Mumma, B. E., Scofield, M. E., Mendoza, L. P., Toofan, Y., Youngyunpipatkul, J., & Hernandez, B. (2017). Screening for victims of sex trafficking in the emergency department: A pilot	*The primary purpose of the study was to "evaluate the feasibility of a screening survey to identify adult victims of sex trafficking in the ED" (p. 616, 617). *The secondary purpose was to compare "the	*143 medically stable female ED patients, "age 18-40 years" with the median age of 27 who were seen in one academic ED between March to October 2015 (p. 616-617). *Physicians in the ED also	*Observational cohort convenience sampling during all shifts (p. 617). *Over 7-months, employed a ing survey consisting of 14 questions that took 5-10 minutes during ED visit (p. 617). These questions were tested during	*46 tested patients screened positive for potential sex trafficking; 30 of these were screened positive only using the screening survey, seven based on physician concern alone, and nine with both (p. 617) *10 patients out of the 46 were confirmed as sex trafficking victims and "none were	*Level 4: observational cohort study	Limitations: *It is possible that there were more sex trafficking victims than discovered or reported because of false negative screenings or they denied the validity of a positive screen (p. 619)

program. *The Western Journal of Emergency Medicine, 18*(4), 616–620. https://doi.org/10.5811/westjem.2017.2.31924	sensitivity of emergency physician concern and a screening survey for identifying sex trafficking victims in the ED and determined the most effective question(s) for identifying adult victims of sex trafficking" (p. 616, 617).	surveyed who worked during sampling times (p. 617). *Able to read and understand either English or Spanish. Pregnant women included but minors excluded due to IRB required informed consent (p. 617).	a pilot study on 15 patients seen in the ED (p. 617). *Survey was given in private treatment rooms within the ED by a trained team member without the presents of any visitor who accompanied the individuals (p. 617). *ED social workers had education "on sex trafficking and local resources available to victims" prior to the study start (p. 617). *Physicians caring for these patients where surveyed to see if they perceived the patient was a victim of trafficking prior to informing them of the screening tool result (p. 617). A positive result from the provider	identified by physician concern only" (p. 617) *All 10 of the confirmed victims reported they were US citizens and the US was the country of origin (p. 617) *80% of the victims reported having been in an ED within the last two years and one was seen in a clinic in the last two years (p. 617) *Sensitivity of the screening (100%; 95% CI [70%-100%]); Physician concern (40%; 95% CI [12%-74%]) (p. 618). *Specificity of the physician (91%) was better than the survey (78%) (p. 618). *All 10 confirmed positive sex trafficking victims positively answered the screening question, "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		*Screening questions used were made for a different setting than an ED (p. 619) *Study population small and from one ED (p. 619) *Could not do long term follow up of the 10 victims identified for this study (p. 619)

			was a “yes” response after they had done their initial patient medical and social history screening (p. 617). *All positive screens, with either the survey or a physician who indicated they were concerned, had a social work consult placed and the ED social worker saw the patient in the ED prior to discharge or admission (p. 617). The social worker would then interview the patient and determine what was needed (p. 617). *Data was collected on results and patient demographics from the HER (p. 617). *True positive identification	trying to leave?” (p. 618). *Authors concluded that it is “feasible” to identify sex trafficking victims in an ED setting using a “brief screening survey” (p. 618). *Clinical complaints of the 10 true sex trafficking victims were: gynecological (3), GI/abdominal pain (2), neurologic (1), trauma or injury (1), substance use (1), and other for two of them (p. 618) *Confirmed victims in this study did report receiving most of their healthcare at an ED (p. 618). *Concluded that a “multidisciplinary approach [including local resources, community outreach, ED physicians and nurses, and social workers] to caring for victims of sex trafficking […] is important for providing		

			occurred when a survey or physician concern alerted for a possible victim and then the victim reported they were in fact a victim of trafficking or it was found the social worker had documented the patient was in fact being sex trafficked (p. 617).	the ongoing support that these victims require" (p. 618). *Authors state that further studies on if utilizing the single question that all 10 answered affirmatively too could work as its own short screening tool, as well as the "effectiveness of physician or nurse administered screening questions integrated into patient care" (p. 619).		
Nazer, D., & Greenbaum, J. (2020). Human trafficking of children. *Pediatric Annals*, *49*(5), e209–e214. https://doi.org/10.3928/19382359-20200417-01	*The purpose of this article is "to provide an overview of human trafficking and the red flags that may alert the pediatrician to the possibility of exploitation" (p. 2019).	*Subjects are trafficked children and youth, including immigrants and natural born citizens, and the pediatricians who may encounter them.	*Descriptive review on human trafficking of children discussing forms of trafficking, health impact, presentation, vulnerabilities particular to children, medical evaluation of at-risk children, potential indicators of trafficking, reporting and referring of victims, and	*Discusses homeless, runaways, and immigrant children as highly vulnerable populations (p. 209-210). *Forms of trafficking commonly found in child victims: "sex trafficking, forced illicit activities (often involving drug trade), and travelling sales crews;" "work in the massage, health, and beauty industry (eg. nail salons, hair-braiding), domestic work, work in cantinas,	*Level 6: Descriptive Study	*Limitations -The author did not disclose any limitations.

			resources available.	bars, and strip clubs […], work in agriculture and animal husbandry, factory work, work in commercial cleaning, and construction work" (p. 210). *Health impact is based on type of trafficking the child endures with medical complaints also being just as varied (p. 210). Some health impacts include "exhaustion, chronic pain, malnutrition, infections, […] untreated medical conditions," exposure to multiple inhalants, and mental health issues (p. 210). *Cited a study that reported 81% of the children surveyed had seen a provider within a year of being identified and referred for trafficking; 32% of the children surveyed had STIs, 20% had acute suicidality, 46% reported being admitted for psychiatric care at least once, and 88%		

				used illegal substances (p. 210). 63% of the children in the cited article reported running away before (p. 210). *Multiple barriers to healthcare such as expense, not being allowed by trafficker, language barriers, fear of law enforcement and deportation, and not knowing what resources they have (p. 210). *As child victims seldom self-identify, medical personnel need to make themselves aware of indicators of trafficking (p. 210-211). The article lists indicators in Table 2 page 212. Not only can they help identify a trafficked child, but they can identify at-risk children so that preventative measures can be taken. *There is a lack of a validated human trafficking screening tool for healthcare facilities, including one		

				specific to immigrant children (p. 211). *Use trauma-informed approach (p. 211) *Discusses a screening tool in California that has been validated in EDs, teen clinics, and child advocacy centers aimed at discovering youth sex trafficking victims, but it was mainly tested in Asian populations (p. 211). *A second screening tool for youth that are sex trafficked was validated in EDs, teen clinics, and child advocacy centers within the US (p. 211). Neither screening tool was validated for immigrant and refugee children (p. 211). *Clinicians and healthcare workers need to evaluate patients using "a trauma-informed, human rights-based, culturally appropriate, and gender-sensitive approach" (p. 211).		

				*Make sure you inform the patient of confidentiality rights; in the case of minors, medical personnel are mandatory reporters (p. 212). *Page 212 has a list of medical examinations and tests that can be helpful for the pediatrician to do for exploited children. *Table 3 on page 213 lists immediate, short-term, and long-term health needs.		
Nguyen, P. T., Lamkin, J., Coverdale, J. H., Scott, S., Li, K., & Gordon, M. R. (2018). Identifying human trafficking victims on a psychiatry inpatient service: A case series. *The Psychiatric Quarterly*, *89*(2), 341–348. https://doi.org/10	*The purpose of this article was to "provide case examples of the various ways in which trafficking victims with psychiatric issues may present to an urban inpatient psychiatric unit" in order to inform identification of victims who may present in a psychiatric facility or unit (p. 342).	*One male and five female adult psychiatric inpatients from a single institution who were identified through a retrospective review of their charts as potentially being trafficked (p. 343). The male and one female identified themselves as being labor	*Researchers gathered retrospective data from patient charts on 6 individuals in order to make six case examples of trafficking victims presenting to a single inpatient psychiatric unit (p. 343). These individuals were chosen after months of looking through charts to identify the best representations of	*Case 1: Labor Trafficked Adult Hispanic Male -The patient reported being "forced to transport illicit drugs" into the US by a drug cartel (p. 343). -He was found in a busy intersection and transported to the ED by police where he said he had done that to get help because he was fearful that he would be killed (p. 343). -He had symptoms of auditory hallucinations	*Level 6 Qualitative study	*Limitations -Small sample size and only a single inpatient psychiatric unit

.1007/s11126-017-9538-3		trafficked (p. 343). The other four female patients confirmed or were suspected of being sex trafficking victims (p. 343).	suspected trafficking victims (p. 343).	and paranoid delusions that resolved with psychiatric medications (p. 343). He then underwent therapy for social stress related to trafficking, fear of being found as undocumented, and wanting to get back to his country (p. 343). *Case 2: Labor Trafficking of an Adult Caucasian Female -Homeless, middle-aged, with history of schizophrenia due to noncompliance with her psychiatric medications (p. 343). -Frequent-flyer of the ED due to non-compliance of meds causing “episodes of disorganization and bizarre behavior” (p. 343). -Labor trafficked to clean homes for $3 a day and did not recognize that this was not a living wage, causing her to refuse income assistance or		

				government help (p. 344). -Her background before schizophrenia was married, dental hygienist, who lived in a richer section of the suburbs (p. 343-344). -Researchers report that her schizophrenia increased her vulnerability to trafficking and that "treatment of the underlying psychiatric vulnerabilities may improve patients' level of functioning and may reduce their likelihood of being re-victimized" (p. 344). *Case 3: Sex Trafficking of an Elderly, Homeless, Caucasian Female -Admitted to the inpatient unit for "severe aggression, agitation, disorganization, and psychosis" with a history of schizoaffective disorder and probable		

				molestation as a child (p. 344). -Once treatment allowed her to be less aggressive, she voluntarily told staff that she had been forced to have sex with men by a gas station employee who took her identification and money and would also rape her (p. 344). -She declined help and at discharge wanted to go back to a homeless shelter near the offender's work (p. 344). -The researchers report that this case was not originally identified by the inpatient team even though she was screened for human trafficking due to the policies in place at the facility (p. 344). Highlights the need to rescreen patients as their mental state improves with treatment and therapy (p. 344).		

				*Case 4: Sex Trafficking of a Middle-Aged Caucasian Female -Admitted to inpatient psychiatry due to suicidality and chronic self-harming with a history of "depression, anxiety, and borderline personality disorder" (p. 344). -Identified herself has being sexually abused as a child by her father, had sex with older men, and sexually trafficked as a child (p. 344). -Patient reported "significant relationship problems, difficulties regulating her emotions, a poorly, defined sense of self, as well as significant suicidal ideation and engagement in chronic non-suicidal self-injurious behaviors" as an adult (p. 344). -Individuals who have childhood experiences like this patient are at a higher risk of victimization and re-		

				victimization (p. 344-345). It is important to identify and offer long term solutions to reduce their risks (p, 345). *Case 5: Sex Trafficking of Young Adult Caucasian Female -Admitted for illegal psychoactive drug intoxication with a history of bipolar disorder and substance abuse (p. 345). -Once stable, reported to staff that she underwent "severe physical and sexual abuse and neglect and was placed in the foster care system at a young age" (p. 345). She also worked as a prostitute and had tattoos recognized in that area as branding signs for traffickers (p. 345). She denied current trafficking. -Authors of the study report that human trafficking victims do not always disclose that		

				they are being trafficked, even when there is evidence of it occurring (p. 345). In this individual's case, the history of trauma and abuse was cited as a plausible reason for her to not be able to recognize that she was being exploited (p. 345). *Case 6: Sex Trafficking of a Young Adult African American Female -Admitted to inpatient psychiatric care due to "increased suicidality" (p. 345). -Later reported to staff that she was homeless and recruited to be in a sex trafficking ring and "was required to meet a daily quota" (p. 345). -The trafficker would give her methamphetamines to control her and reward her (p. 345). She reported having an addiction to illicit substances prior to		

				being trafficked as well (p. 345). -Highlights the need to ask patients how they get their drugs and, if they present for drug use, to also ask about trafficking (p. 345). *Need for routine screening of patients for trafficking regardless of age, gender, ethnicity, appearance, or level of education (p. 345). *There are no validated screening tools but there are screening tools that can be utilized (p. 345-346). *Important to rescreen patients as they begin to mentally stabilize with treatment (p. 346). *Inpatient settings, including psychiatric units, are areas where the staff have time to build relationships and rapport which can aid in victim disclosure (p. 346). *Inpatient psychiatry units allow for multidisciplinary		

				approach to care to aid these victims in getting the short- and long-term help they need (p. 346).		
Nierengarten, M. B., & Goldberg, A. P. (2018). Identify, screen, treat, and advocate for child victims of sex trafficking/COMMENTARY. *Contemporary Pediatrics*, *35*(12), 8–10.	*The purpose of this article was to share the information on human trafficking victim identification, screening, treatment, and advocacy based on a podium presentation given at the American Academy of Pediatrics' National Conference.	*The subject of the article is child victims of human trafficking and the pediatric providers who care for them in their healthcare organization.	*This is an article reviewing the expert opinion given during a podium presentation.	*Pediatricians can aid in child trafficking identification and treatment. *Within the United States, "1 in 5 teenagers run away from home; 1.3 to 2.8 million children are runaways/throwaways or homeless; and that 1 in 3 teenagers are lured into prostitution within 48 hours of leaving home" (p. 9). *The article described how pediatricians can identify victims through learning the red flags and indicators associated with child trafficking victims (p. 9). *It is important the pediatrician develops trust with the child and makes them feel safe. One way this is accomplished is through allowing the	*Level 6 Descriptive study	*Limitations -None were given by the author.

				child to choose the gender of the provider who sees them (p. 9). *The National Human Trafficking Resource Center hotline is a resource for both providers and victims. *Utilize a multidisciplinary approach to their care (p. 9). *Post-identification care is discussed.		
Normandin, P. A. (2017). Child human trafficking: See, pull, cut the threads of abuse. *Journal of Emergency Nursing, 43*(6), 588–590. https://doi.org/10.1016/j.jen.2017.07.014	*The purpose of this article is to inform emergency nurses on identifying and intervening with victims of child human trafficking.	*Subjects of this paper are children who are trafficked and seen in the ED setting.	*This is a descriptive article discussing observable signs of child trafficking, the need for ED nurses to educate themselves on the topic, and admonishing ED nurses to know what resources are available to them locally and nationally on the subject.	*Observe patients for red flags: how they interact with the adult or other children in the room; does the child appear gaunt, malnourished, disheveled; does the story of the complaint match the injury or illness (p. 588)? -Does the adolescent or school aged child know where they live or what day it is (p. 588)? -While taking their medical history, are they up to date with immunizations and have they had regular	*Level 7 Expert Opinion	*Limitations -No limitations are given.

				well child checks (p. 588)? -Is the child acting their age, nervous, avoiding people, or scared (p. 589)? -Do they have weird markings or tattoos (p. 589). -Does the adolescent report multiple pregnancies or abortions (p. 589). *ED nurses can educate themselves on child trafficking utilizing resources from the National Human Trafficking Resource Center and government and private organizations (p. 589).		
Ravi, A., Pfeiffer, M., Rosner, Z., Shea, J., Pfeiffer, M. R., & Shea, J. A. (2017). Identifying health experiences of domestically sex-trafficked women in the USA: A	*The purpose of this article was to "identify experiences of domestically sex-trafficked women regarding healthcare access, reproductive health, and infectious disease while trafficked" (p. 408).	*21 women ages 19 to 60 years old who identified as being trafficked and were imprisoned at Rikers Island women's jail in New York (p. 408, 409). *Only women who could	*Over 3 months, recruitment and interviews were conducted by two of the of the authors in private interview rooms. The interviews "were audio recorded" (p. 409). *Recruitment was done two ways:	*Types of traffickers who exploited the participants identified (p. 410): -42.9% in trafficking rings -23.8% by drug dealers -9.5% by their mothers -9.5% by intimate partners -9.5% sold themselves	*Level 6 qualitative study	*Limitations *Recall bias (p. 415) *Non-trafficking health related issues could have influenced some of the reasons the participants went to medical care (p. 415).

qualitative study in Rikers Island jail. *Journal of Urban Health*, *94*(3), 408–416. https://doi.org/10.1007/s11524-016-0128-8		complete an interview in English were asked to join the study (p. 409). *Further eligibility was obtained if potential subjects answered yes to the question, "Were you ever forced into prostitution or made to turn tricks by family members, boyfriends, friends, pimps, or other people you met?" (p. 409). *Women self-identified as Caucasian (6), African/Caribbean American (9), Hispanic (5), and Mixed (1) (p. 410).	announced in the weekly health education programs and through the "therapeutic programming coordinators" who identified people who the authors should approach for interviews (p. 409). *A script for the interview was piloted before being used and was focused on "healthcare access, reproductive health, and infectious diseases" (p. 409). *Interviews were transcribed using a third party, and then were screened to make sure only ones that fit the legal criteria of sex trafficking were used (p. 409).	-One participant (4.8%) was kidnapped twice by a stranger and sold for the day to the stranger's friends. *All women in the study report using illegal drugs while being trafficked (i.e. cocaine or heroin) (p. 410). *Most common reasons participants sought medical care: "STI and HIV testing, unintended pregnancies, acute, violence-related issues (such as rape, traumatic injury, and suicide attempts), and chronic disease management" (p. 410). *Participants who were trafficked in the sex-trafficking ring reported paying for their medical care out of pocket; those who were otherwise trafficked stated they used Medicaid (p. 410). *Most common places participants reported receiving medical care		

				were “EDs, jails, women’s health clinics such as Planned Parenthood and free or Department of Health clinics” (p. 410). Those who were not in sex-rings also reported going to primary care and GYN locations (p. 410). *Participants reported that they chose EDs because they did not have ID cards or health insurance (p. 410). *Some participants reported learning of medical issues when being booked into jail after going through health screenings mandated there because they weren’t able to have medical care otherwise (p. 410). *Reported that traffickers were hesitant to allow some of them access to medical care because they were worried victims would try to escape or that it would mean the victim would be seeking treatment		

				instead of making money being trafficked (p. 412). *Survivors of sex trafficking rings reported the handlers would try to treat medical issues themselves with pharmacy supplies or hiring someone to come to a private location to treat them (p. 412). *Fear of retaliation: common theme found among the participants. Diagnoses such as pregnancy, HIV, and infections could lead to violent outburst from the handlers (p. 413). Participants reported hiding these diagnoses. *The trafficker or another trafficked female would go with the participants to healthcare visits when they were allowed to go (p. 413). *Reported being other hinderance to care was fear of being arrested when they would seek		

				treatment due to warrants (p. 413). *Described barriers in going to follow-up appointments such as lack of permanent address, access to phone, and giving fake information during registration (p. 413). *Unable to take medications appropriately, for example, taking STI treatment but still having to have sex with buyers while on treatment; or unable to afford medications (p. 413). *Women reported being seen in healthcare facilities for depot medroxyprogesterone acetate injects, IUDs, and abortions (p. 414). *Non-sex trafficking ring participants reported going to "hospitals, clinics, or needle exchange programs" for free condoms (p. 414).		

				*Would be seen at healthcare facilities for HIV testing; worried about getting it and retaliation from traffickers or buyers; worried that others (such as other prostitutes or traffickers) would purposefully send buyers who were HIV positive to them for revenge (p. 414).		
Shandro, J., Chisolm-Straker, M., Duber, H. C., Findlay, S. L., Munoz, J., Schmitz, G., Stanzer, M., Stoklosa, H., Wiener, D. E., & Wingkun, N. (2016). Human trafficking: A guide to identification and approach for the emergency physician. *Annals of Emergency Medicine*, *68*(4), 501–508. https://doi.org/10	The purpose of the article is to outline "the clinical approach to the identification and treatment of a potential victim of human trafficking in the emergency department" (p. 501).	Sex and labor human trafficking victims in the United states and globally	*A systematic review of the background of human trafficking in the world and the US; red flags; and a discussion on the physical, sexual, and psychological abuse and substance misuse, and potential health consequences that are associated with human trafficking and its victims (p. 502). *The role of ED providers and staff in identifying and	*Studies show that health care providers are under trained to handle and identify victims of human trafficking (p. 503). *One study showed that only 4.8% of ED clinicians felt confident in their abilities to correctly identify a trafficking victim (p. 503). *Clinical tools specific for the ED are lacking (p. 503). *First step in change is helping health care workers learn to identify potential victims (p. 503).	Level 5: systematic review of descriptive studies	Limitations: Does not go into screening tools that have been used. It only states that there is a lack of them.

.1016/j.annemergmed.2016.03.049			helping those who are trafficked (p. 502-503)	*ED personnel need to be aware of the red flags and signs that indicate an individual is a victim of trafficking. List of red flags given (p. 503). * Authors compiled a list of tips for interviewing potential victims based on studies (p. 504). *empiric STI treatment should be given (p. 506) *Be careful in documentation (p. 505)		
Stoklosa, H., Lyman, M., Bohnert, C., & Mittel, O. (2017). Medical education and human trafficking: Using simulation. *Medical Education Online*, *22*(1), Article 1412746. https://doi.org/10.1080/10872981.2017.1412746	*The purpose of this article was to outline the development and implementation of human trafficking simulation-based medical education (SBME) at the University of Louisville School of Medicine for third-year medical students (p. 2).	*The sample consisted of third-year medical students at a single university.	*Curriculum was developed over 16 months after a literature review encompassing human trafficking education and education platforms (p. 2 & 4). *Pre-developed education material that fit the needs of this study were not found; therefore, the researchers developed their	*Education on human trafficking victim identification needs to occur at the undergraduate level for providers as victims can present to any specialty (p. 1). *Cited a research article that found 63% of medical professionals reported no previous training on human trafficking (p. 1). * "Practical change in care for trafficked patients, future	Level 6: Descriptive Study as its purpose was to describe how the program was developed and implemented and not the outcomes that it produced.	*Limitations -Evaluation of students utilized the same questions in the pre- and post-assessment quiz. The authors states to correct this they should have used similar but not the same questions (p. 4). -Did not give data on the outcomes of the education but reported that there will be

			own curriculum named Medical Student Instruction in Global Human Trafficking (M-SIGHT) (p. 2). *The curriculum used "online learning, medical documentation, and standardized [patients]" to teach and evaluate the students on their abilities to identify and intervene in potential human trafficking cases (p. 2). *The team developed objectives and assessment tools reflecting the goals to "prepare every graduating medical student with the knowledge needed to identify human trafficking victims, the skills to communicate with victims and	providers must not only acquire knowledge of what defines trafficking, but also demonstrated skills of trauma-informed care (TIC)" (p. 1-2). *Using simulation to train students in human trafficking identification and management allows for feedback and identification of areas for improvement (p. 2). *First simulations were to teach trauma-informed communication and not to identify human trafficking or the disease they came with (p. 3).		another publishing with it included once data collection and assessment is complete (p. 4). *Only had limited follow up with those who went through the program so data on effects on long term practice was not collected (p. 4).

			other HCPs, and the resources to refer patients to local agencies" (p. 2).			
Tiller, J., & Reynolds, S. (2020). Human trafficking in the emergency department: Improving our response to a vulnerable population. *The Western Journal of Emergency Medicine, 21*(3). https://doi.org/10.5811/westjem.2020.1.41690	*The purpose of the article is "to provide guidelines on the implementation of a human trafficking recognition and response program in the community hospital setting" (p. 550). *The goals of the response program are to "expertly assess the victims' safety as they are being cared for as patients, to provide both medical care and social resources for human trafficking victims, and to advocate for their rights" (p. 550).	*Setting of implementation and sample population of ED patients was in an "academic, urban, county ED serving 85,000 patients" a year that had a children's ED that saw 35,000 patients a year in North Carolina (p. 550).	*The HEAL Trafficking Protocol Toolkit was modified into a smaller, easier to implement, "initial human trafficking recognition-and-response protocol" to be utilized within a hospital that did not have a protocol or community resources in place at the start of the project (p. 550).	*Utilize trauma-informed, patient-centered care (p. 550). *Article is broken into sections of what was done to develop and implement the protocol for human trafficking identification. -Step One: Understand Human Trafficking and Health Generally and Locally (p. 551). Looked at National Human Trafficking Network data and talked to local law enforcement (p. 551). -Step Two: Understand How Survivors Gain Assistance from Non-Medical Stakeholders in the Community (p. 551). They gathered information on local multidisciplinary resources using including "local antitrafficking agencies, legal service	Level 7 Expert Opinion	*Limitations -No limitations were given. The authors did address that it was not a complete identification response and that they were in the process of adding other components. This was just the beginning of initiating an identification protocol.

				providers and translation services, as well as housing and substance abuse resources" (p. 551). They also teamed up with the hospital social worker, police victim advocate, and the domestic violence advocacy program that was in place at their hospital (p. 551). -Step Three: Organize the Medical Community to Provide a Safety Net for Survivors (p. 551). -Step Four: Create and Convene an Interdisciplinary Protocol Committee (p. 551). This team was created to meet on a regular basis to look at what was occurring with the new protocol and update it as necessary based on data (p. 551). *Identification protocol should contain: -Screening questions: This study adapted questions from		

				evidence in literature of other study's screening questions as there is currently not a validated ED screening tool (p. 551-552). They utilized red flag signs and symptoms and medical exam criteria as indicators so that observational and assessment data could be used to identify potential victims (p. 552). They only screened patients who demonstrated red flags of trafficking for the purpose of the study (p. 552). -Interviewing the patient should be done in privacy, without multiple interviewers, and to not ask probing questions that are not needed to care for the patient or identify them as being trafficked (p. 552). Only official interpreters should be used (p. 553). -Safety of the staff and the patient need to be taken into consideration;		

				involving hospital security when necessary (p. 553). -Ensure that HIPAA is being maintained and only report adults if given permission by the patient (p. 553). Know when reporting is mandatory (p. 553). -Create a protocol that deals with patients who decline help (p. 553). -Determine what should and should not be documented in the medical record due to legal reasons and develop a protocol for staff and providers to follow (p. 553). -Forensic examination protocols need to be written (p. 553).		

Appendix C

CITI Training Certificates

CITI PROGRAM

Completion Date 02-Mar-2017
Expiration Date 01-Mar-2020
Record ID 22497057

This is to certify that:

Jami Castellucci

Has completed the following CITI Program course:

Social & Behavioral Research - Basic/Refresher (Curriculum Group)
Social & Behavioral Researchers (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Liberty University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w5fc16f66-2300-4a40-a160-482d8b0deece-22497057

CITI PROGRAM

Completion Date 28-Aug-2019
Expiration Date 27-Aug-2022
Record ID 32928709

This is to certify that:

Jami Castellucci

Has completed the following CITI Program course:

Biomedical Research - Basic/Refresher (Curriculum Group)
Biomedical & Health Science Researchers (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Liberty University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wf0209b86-4f8b-4593-8eca-392e8d339b9f-32928709

Appendix D

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

July 16, 2020

Jami L. Castellucci
IRB Application 4194: Identification of Human Trafficking Victims in the Health Care Setting: An Integrative Review

Dear Jami L. Castellucci,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your research with the data safeguarding methods mentioned in your IRB application.

Your study does not classify as human subjects research because it will not involve the collection of identifiable, private information.

Please note that this decision only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued non-human subjects research status. You may report these changes by submitting a new application to the IRB and referencing the above IRB Application number.

If you have any questions about this determination or need assistance in identifying whether possible changes to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,

[redacted]

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office

LIBERTY
UNIVERSITY.
Liberty University | Training Champions for Christ since 1971