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DOCTOR OF NURSING PRACTICE PROJECT

Human Trafficking Recognition and Response Training for Sexual Assault Nurse Examiners in

New Hampshire Emergency Departments

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Abstract

Human trafficking is a pervasive yet under-recognized public health epidemic.

Traffickers use various forms of manipulation to control their victims for the benefit of

the trafficker with little regard for the victims' well-being. This leads to victims of human

trafficking suffering short- and long-term health problems. Trafficking victims may

subsequently access healthcare during their time in captivity as a result of a direct harm

caused to them due to their victimization from neglect, injury or disease. Unfortunately,

victims often do not see themselves as victims or are too afraid to let their healthcare

provider know that they need help. Warning signs may be subtle. Educating healthcare

providers most likely to come into contact with victims of human trafficking can lead to

increased recognition and appropriately provided services to assist this population.

Emergency services healthcare workers already trained as sexual assault responders are

specially positioned for this role. In the state of New Hampshire, these Sexual Assault

Nurse Examiners (SANEs) work exclusively in emergency departments responding to

concerns of sexual assault and domestic violence. SANEs are trained through a state-run

program called the New Hampshire Coalition Against Domestic and Sexual Violence.

This training has room for growth to include recognition and response to victims of

human trafficking.

       Keywords: Human trafficking, education, training, sexual assault nurse
examiner, nursing, emergency department

Human Trafficking Recognition and Response by Sexual Assault Nurse Examiners in

New Hampshire Emergency Departments

Introduction

Human trafficking is a global issue that violates human rights for the purpose of

exploitation. The United Nations Convention against Transnational Organized Crime

defines human trafficking as "the recruitment, transportation, transfer, harboring or

receipt of persons by means of the threat or use of force or other forms of coercion, fraud,

or deception, …to achieve a person having control over another person, for the purpose

of exploitation" (UNODC, 2000). It is a common misconception that human trafficking is

a crime that involves a form of travel, transportation, or movement across state or

national borders. In fact, it involves a range of victims from native-born citizens to

foreign immigrants, male and females, children and adults, and may not involve any

travel at all. Human trafficking exists amongst all demographics and in all countries. Its

influence is indiscriminate and its reach knows no boundaries.

The most common forms of human trafficking globally involve sexual

exploitation (79%) and forced labor (18%) (UNODC, 2009; Polaris Project, 2017b).

Forced labor can include various settings such as domestic, agricultural, construction,

mining, and manufacturing (International Labor Organization, 2014). The remaining

cases (3%) include a mix of child soldiers, forced begging and marriage, and organ

removal (Ochab, 2017). Women and girls are disproportionately recruited, especially

those of racial minorities (Skinner, 2008). In human trafficking cases that involve

international movement of people, the United States is ranked as one of the most popular

'destination' countries with the states of California, New York, and Texas having the

highest incidence of both international and domestic trafficking in the country (Lillie, 2013).

Traffickers are able to manipulate their victims in a number of ways which can physically and psychologically prevent escape. These same tactics can reduce the ability of the person being trafficked to recognize their own victimhood. This manipulation often involves a process of desensitization to the work. Over time the victims' perceived or actual independence and/or earned income is reduced or eliminated as the workload, threats, and punishments increase based on the proclivity of the trafficker (Reid, 2016). The trafficker may also initially offer a loving relationship in order to gain control of their victim. This love is then used to increasingly control the victim's actions.

When defining human trafficking (HT), it is important to distinguish it from smuggling because often the two are incorrectly conflated. Smuggling involves the transportation of a human across international borders that would otherwise prevent their entry. Trafficking does not require any movement at all although it can involve victims crossing town, state, or international borders. People who are smuggled choose to be transported. Victims of HT do not have the autonomy to choose; though they may initially give consent, it is subsequently rendered meaningless due to coercion or deception by the trafficker. Smuggling ends with the arrival of the person at their destination while trafficking maintains a relationship of unequal power and exploitation. Smuggling is considered a crime against the state and human trafficking is a crime against the individual (U.S. Department of State, 2017). Importantly, smuggling may lead to trafficking, and trafficking may involve smuggling, but the two are not synonymous.

The most powerful motivating factor behind the business of human trafficking is profit. UNICEF has found that the annual profit acquired from HT is $150 billion and rising (International Labor Organization, 2014). Unlike other forms of illicit yet lucrative crimes, HT is unique that is has a low risk for prosecution and a high potential for profit. It is not only challenging to prove the occurrence of HT in court, but it also typically carries much less severe repercussions than, for example, for those accused of selling illicit drugs. Additionally, unlike a counterfeit bill or an illegally acquired firearm, humans can be sold and used repeatedly for profit by the same trafficker. Furthermore, humans do not necessarily require a significant cost for care beyond the basics of food, water, and shelter.

But what about healthcare? Healthcare is the one need that most humans require in their lifetime that cannot necessarily be provided by an untrained professional. This is where the role of educated healthcare workers becomes an essential component in recognizing potential victims of human trafficking.

Background

Nurses in the emergency department are ideally equipped to respond to the needs of human trafficking victims. In one US-based study published in 2014, it was found that up to 87.8% of active victims of human trafficking access health care at least once during their captivity and the majority of those (63.3%) are seen in the emergency setting (Lederer & Wetzel). This study involved over one hundred domestic sex trafficking victims and survivors who electively participated in surveys and focus groups to learn more about their experiences. An earlier study of 21 HT victims in the US found that 28% had a healthcare interaction during their time being trafficked (Family Violence

Prevention Fund, 2005). A more recent study of 12 HT victims in the US found that 50%

of them received medical care while under their trafficker's control (Baldwin, Eisenman,

Sayles, & Chuang, 2011). Although it is not known how generalizable these numbers are

to the entire population of U.S. HT victims due to a paucity of research, it is clear that

there is an opportunity for improved recognition in the healthcare setting. It is known that

the physical and mental health impact of trafficking can ultimately necessitate visits to a

medical professional. The health consequences of HT occur often as a direct consequence

of the trafficking, ranging from injuries related to forced labor and abuse, illness related

to insufficient primary care, sexual and reproductive health problems, mental health

concerns, and substance abuse (Zimmerman & Borland, 2009).

      As the frontline of healthcare, nurses are perfectly situated to both recognize

warning signs of HT victimization and respond appropriately. Nurses are already known

advocates for their patients. They have consistently been ranked nationally as the most

trusted profession in the United States with the highest perception of honesty and ethical

standards from the general population (Brenan, 2017). Nurses are the ones who spend the

most time at the bedside, translate the more technical doctor-speak to colloquial

language, and are trained to care for the entire person rather than their individual medical

needs.

      This trust is a critical component in determining whom to train to identify

warning signs of human trafficking and respond appropriately. Unfortunately, healthcare

workers largely feel unable to recognize potential victims of human trafficking (Stoklosa,

Grace, & Littenberg, 2015). Furthering this problem is the lack of nation-wide mandatory

reporting of suspected cases of human trafficking; laws governing mandatory reporting

are state-specific and variable. While all states require that healthcare providers report suspected cases of child abuse or neglect and most states require reporting of abuse or neglect of an elder, only seven states have mandatory reporting for suspected victims of human trafficking and these only involve reporting of involved minors (Curnin & Hanson, 2016; Stiegal, 2017). Furthermore, there is no mandated reporting required of domestic violence or sexual assault in non-dependent adults with a few exceptions of non-accidental serious injuries like gunshot wounds or stabbings in most states (Victim Rights Law Center, 2014). However, lack of mandated reporting does not mean lack of responsibility of the healthcare team to identify and respond to victims of human trafficking. Recognition and response is crucial to that individual's physical and psychological health.

National Raising of Awareness in the Healthcare System

For the first time, starting in 2018, ICD-10 diagnosis codes specific to human trafficking abuse will be implemented. The National Center for Health Statistics at the CDC added 29 new diagnosis codes related to aspects of this type of abuse such as 'forced labor exploitation, suspected' (Office on Trafficking in Persons, 2018). Previously, providers had to choose from more generic diagnoses of abuse. This will increase data collection and awareness on a local and international level of the prevalence of HT in the healthcare setting.

Other exciting developments include the roll out of the National Human Trafficking Training and Technical Assistance Center from the U. S. Department of Health and Human Services in 2017. They have developed a free online and in-person

training program called SOAR for health care, behavioral health and social service workers. These are ideal resources for nurses to use.

In 2017 there was a 13% increase in HT cases reported to the National Human Trafficking Hotline and BeFree Text line from the year before (Polaris Project, 2017a). The percentage increase of trafficking-related contact from health care professionals during that time was 171%. It is essential to note that this does not necessarily indicate an increase in human trafficking cases, but rather an increase in awareness of hotline resources.

Problem Statement

The problem with the healthcare response to human trafficking is that although many victims seek healthcare at least one time during their captivity, healthcare workers feel ill-equipped to identify and respond to their needs (Stoklosa, Grace, & Littenberg, 2015). Often this contact with healthcare occurs in the emergency department. Some emergency department nurses in the State of New Hampshire (NH) undergo an additional 70+ hour training to become Sexual Assault Nurse Examiners (SANEs) through the NH Coalition Against Domestic and Sexual Violence. This training involves extensive education on the sociological, psychological, forensic, and legal aspects of trauma, domestic violence and sexual assault. SANEs have the potential to be trained to recognize warning signs that their patient may be a victim of human trafficking and to respond accordingly. The goal of this project is to implement a new component to the SANE training to improve the recognition of and response to victims of human trafficking using an evidence-based approach.

Organizational "Gap" Analysis of Project Site

For the past four years, the Human Trafficking Hotline has tracked reported cases of HT. Despite hundreds of reports to the hotline in the state of New Hampshire, not a single one since 2013 has come from a healthcare provider (National Human Trafficking Hotline, 2018). It is important to recognize that it is difficult to estimate the number of human trafficking victims in New Hampshire, let alone how many have been 'missed' in their interactions with emergency departments since underreporting is notorious for HT. What *is* known is that in 2016, there were 12 reported cases of HT in New Hampshire and 5 in 2017 (National Human Trafficking Hotline, 2017). It can be assumed that there are more victims than are reported.

Due to the paucity of reliable information regarding the number of HT victims and their access to healthcare, choosing to measure the efficacy of this project based on its effect on the number of identified HT victims in New Hampshire would be impossible and unreliable. Furthermore, measuring the impact of a study based on the number of reported cases of human trafficking by healthcare workers is challenging since reporting is not mandated or officially tracked. In addition, the number of cases are often so few that trying to perform statistical analysis on a comparison of reported HT cases between settings with trained groups and un-trained groups would have insufficient power to extrapolate results to a larger population or even provide insight into the efficacy in this local setting (Faber & Fonseca, 2014).

Instead, measuring the effectiveness of an educational program specifically created to increase SANEs' knowledge on HT recognition and response would have a more tangible and measurable benefit. There have been a few studies on human

trafficking trainings for emergency department nurses in small settings with positive reviews but none specific to trainings for SANEs (Donahue, Schwien, & LaVallee, 2018).

NH SANEs are primarily trained to respond in cases when a person comes into the emergency department reporting a sexual assault. Some hospitals also have their SANEs respond to concerns of domestic violence as well. There is room for the training to be expanded for the SANE to learn to recognize warning signs of HT and intervene as necessary. The benefit of the SANE response is not only their established experience in working with victimization and connecting with community resources, but the SANE cares for only one patient at a time. They can dedicate up to several hours working specifically with that one individual rather than share their time with multiple patients of variable acuities like their fellow emergency department nursing co-workers. SANEs optimize the care that victims receive in the emergency department while also improving prosecution results due to their specialized training in victim advocacy, trauma-informed care, multidisciplinary collaboration, and forensic evidence collection and documentation (Campbell, Patterson, & Bybee, 2012). It has been found that with the implementation of SANE programs, the average wait-time in the emergency department for victims is reduced, and both prosecution and compliance with chain of custody is higher than when non-SANE trained nurses care for victims (Campbell, 2004). There is support among the leadership of the New Hampshire Coalition Against Domestic and Sexual Violence for the inclusion of an HT educational component in the SANE trainings.

Goals, Objectives and Expected Outcomes

The primary goal of this project was to educate New Hampshire SANEs on how to recognize victims of human trafficking and respond to their needs. In order to achieve this goal, it was determined to be necessary meet the following three objectives: completion of a comprehensive and integrative literature review; creation and presentation of an evidence-based, comprehensive training program on the recognition and response to HT victims at the fourth quarterly NH SANE training in 2018; and request and evaluate feedback from participating SANEs on their perception of the training for further improvement.

The first objective was to complete a comprehensive and integrative literature review to search for evidence of human trafficking education and nursing's interventional role. The literature review involved searching through multiple online databases using related key terms followed by selection of quality studies that would support the creation of the training. The relevant articles were further reviewed and analyzed before being selected for their use in the development of the training.

The second objective was to create and execute an evidence-based, comprehensive training for NH SANEs to increase their ability to respond to possible and actual HT victims.at the fourth quarterly NH SANE training in 2018. To complete this objective, key topics were chosen based on the literature review. These following topics were chosen: the description of the role of victimization in human trafficking, the differentiation between human trafficking and smuggling, the identification of warning signs of human trafficking, the exploration of health problems associated with human trafficking, and highlighting resources available if the SANE has a suspected or actual

victim of human trafficking. Next, Orlando's Nursing Process Discipline Theory was used as a guiding principle for the formal nursing education component. Finally, a tool to guide identification of HT victims was selected then adapted for SANEs in the emergency department setting. The training was presented at the final quarterly SANE trainings for the state of New Hampshire November 29, 2018.

The third and final objective was to request and evaluate feedback from participating SANEs on their perception on the training for further improvement. There was an informal discussion and Q&A session following the training in addition to a formal, electronic post-presentation survey to gather feedback about the presentation itself and applicability of the information to their clinical work.

By achieving these three objectives, it was hoped that the primary goal of increasing NH SANE nurses' ability to recognize and respond to victims of human trafficking would be met.

Review of the Literature

The purpose of the literature review was to identify and review published educational programs about human trafficking for nurses in the emergency setting. The UMass Amherst W.E.B. Du Bois Library database was used to review Cumulative Index for Nursing and Allied Health Literature (CINAHL) and PubMed articles using the following search terms: human trafficking, nursing, education or training, and emergency or acute. There was a limited number of articles that reviewed already implemented training programs (<10 each). However, when the search was expanded to "human trafficking" and "emergency," there were 14 and 39 articles respectively with CINAHL Complete and PubMed that were published in the last five years in peer-reviewed

journals. Of these 53 articles, 11 were duplicates and 2 were from outside of the United

States. Those remaining were analyzed to determine usefulness in the formation of this

human trafficking educational program for SANEs.

  None of these published articles was specific to HT trainings for SANEs although

a few such trainings do exist for public access (International Association of Forensic

Nurses, 2017). The paucity in published works was significant in and of itself. Despite

the overlap in educational content, there was no commonly used tool to assist nursing in

systematically screening suspected victims of HT.

  This author ultimately utilized common, critical components from the articles

assessed in the literature review to create a unique HT recognition and response

educational presentation for SANEs in New Hampshire. Since the training is specifically

for SANEs rather than traditional emergency department nurses, forensic examination

and general victimization was determined to not be reviewed for this presentation since

that is already a key component of SANE training.

Overview of Critical Training Components

  The majority of the publications agreed that when there is suspicion that a patient

may be a victim of human trafficking, the primary concern should be for the patient's

immediate and future safety. This includes understanding that if the trafficker perceives

that the victim has purposefully or unintentionally done or said anything to compromise

their trafficking status, the victim may be subjected to retaliation by the trafficker

(Brunovskis & Surtees, 2007). To increase the likelihood of a victim sharing their

experiences and concerns with healthcare workers, isolation from the potential trafficker

is essential. Reducing language and cultural barriers is equally crucial. Simple measures

such as offering something to eat and drink can be quite impactful on a patient who has

had these and other necessities restricted by their trafficker (Vera Institute of Justice,

2014). Trafficking victims may believe that no one cares to help them and may have been

conditioned to think that by the trafficker (Polaris Project, n.d.). Nurses can work to break

though that misconception of lack of caring by providing support.

In addition to the general principles listed above, there were three essential

components of training identified within the literature review that were included in the

training to increase the SANEs' ability to recognize and respond to potential and actual

victims of human trafficking: understanding the victim-trafficker power dynamic,

identifying health effects of human trafficking, and optimizing the interview with the

patient.

Trafficker-Victim Power Dynamic. The trafficker plays an ongoing role in the

patient-nurse dynamic even if not physically present. A trafficker may not always

accompany a victim seeking care either because they are unaware the victims has left to

seek care or they believe their control over the victim will continue remotely, and thus the

victim will not seek help specific to their trafficking. It is also important that the SANE

be aware that the act of the trafficker bringing a person to seek care does not indicate

concern for that person's wellbeing, but rather an attempt to avoid legal or economic

consequences of that person's death or loss of ability to work due to the illness, injury, or

rescue (Bales & Soodalter, 2009). Victims may also not seek help to escape from the

trafficker if they do not see themselves as victims; this can occur due to the normalization

of their experienced abuse (Polaris Project, n.d.). Not all victims see themselves as

victims and even if they do, they may not be in an emotionally, physically, or

socioeconomically safe place to ask for or accept assistance. Consequently, it is the role

of the assessor to recognize warning signs despite the patient not asking for help.

   Health Effects of Human Trafficking. Understanding the health effects of

human trafficking is crucial to connecting the nursing role to aid victims of human

trafficking in the healthcare setting. It is important to note that the physical and

psychological impact and consequences of HT on its victims are not limited to the time

that they are trafficked. Many are persistent and become a chronic component of the

victim's life.

   Physical trauma. Physical trauma may be the primary type of healthcare need

nurses think of when imagining their interaction with a victim of HT. This could be the

result of purposeful violence perpetrated against a victim in the form of a physical or

sexual assault. This can include bite marks, broken bones or healing fractures, cigarette

burns, bruises, scars from stabbings and other assaults, or branding, tattoos, and more

(Sabella, 2011). Signs of exhaustion, dehydration, or malnutrition may also be apparent.

   It is important for nurses to know that in the case of sexual assault, physical

evidence is not present in the majority of cases (70%), even if the victim presents within

a 24 hours for a forensic assessment (Markowitz, 2012). It is even less common to have

findings of sexual assault in the bodies of children (90%) (Herrmann, Banaschak, Scorba,

Navratil, & Dettmeyer, 2014). The female genital area consists of primarily mucosal

tissue which has a rich blood supply as it is designed to stretch during childbirth. This

means that even forced penetration often does not cause local damage, and damage that is

incurred heals rapidly. It is essential that nursing staff do not make a conclusion on

whether or not they 'believe' their patient based on the presence or absence of physical

findings. A physical exam can be misleading especially to the untrained examiner. Just as a victim of domestic violence may report their broken bones and bruises to be consequences of a fall rather than the hand of their abuser, a victim of human trafficking may likewise obfuscate the true cause of an injury.

Drugs and alcohol. Especially in the case of sex trafficking, it is not uncommon for traffickers to use drugs and alcohol as a means to control their victims (Withers, 2016). Traffickers can use a preexisting addiction as a method of control by restricting the victim's access to a drug or offer substances to formerly sober victims looking to dull the pain of their situation. Addiction provides traffickers another way to manipulate their victims not only through controlling access to substances and threatening to withhold them, but also by the threat of reporting their victims to authorities for using illicit substances. (This threat of law enforcement involvement is even more acute in cases of sex trafficking in countries where prostitution itself is criminalized, such as in the United States). The use of substances also decreases the likelihood that safer sex practices like the use of condoms will be used, in addition to increasing the risk of acquiring other infections such as hepatitis C through the use of unclean needles (Azim, Bontell, & Strathdee, 2015).

Pregnancy and sexually transmitted infections. Undesired pregnancy is a potential consequence of any type of human trafficking. It is often considered in the setting of sex trafficking but an unwanted pregnancy is a possibility in any scenario with insufficient contraception. More tragically, the trafficker can dictate the fate of the pregnancy. A pregnant woman may be undesirable to them due to the physical changes in their body limiting the type of work they can do during and after the pregnancy.

However, some traffickers find this a desirable state as some buyers prefer pregnant women. Other traffickers may elect to impregnate their victims as another method of control by threatening to or actually harming the child or threatening custody battles (Hammond, 2014). In one study of human trafficking victims interviewed about their time being trafficked, 55% of female victims had at least one abortion and 30% had multiple abortions, compared to the U.S. national rate of just over 1% (Lederer & Wetzel, 2014; McCammon, 2017). If these abortions are performed outside of a medical center, there is a risk of higher morbidity and mortality compared to safe abortions (World Health Organization, 2018).

In addition to pregnancies, sexually transmitted infections (STIs) are also a persistent problem for victims of trafficking, especially sex trafficking. Sexual exploitation plays a major role in the spread of HIV (Destefano, 2007). Well known risk factors for contacting HIV include unprotected sex with multiple partners, receptive anal sexual intercourse, and concurrent sexually transmitted infections (Cohen, 2017). Untreated STIs can lead to issues with fertility, pelvic inflammatory disease, and severe, systemic infection. The presence of STIs, the use of alcohol and drugs, and lack of preventative care can all increase risk of miscarriages and birth defects (Tulandi & Al-Fozan, 2017). These are all health issues that any girl and woman of childbearing age who are victims of human trafficking can face regardless of the type of HT they are involved with.

Psychological trauma. In addition to visible signs of trauma and neglect, SANEs may also notice the psychological effects of HT. Depression, suicidal ideation, and post-traumatic stress disorder (PTSD) are common (Lederer, & Wetzel, 2014). Sexual

violence is correlated with the highest rates of PTSD. It is thought that this is not only

due to the actual trauma of sexual assault, but also related to the fact that victims of sex

trafficking frequently experience various types of violence in their lives prior to being

trafficked (Hossain, Zimmerman, Abas, Light, & Watts, 2010). Symptoms of depression

can include withdrawal, fatigue, psychomotor retardation, and agitation. The presence of

these can add an extra layer of difficulty to assessment and intervention.

Interview. Questions chosen for the screening of a patient should be used with

three primary goals; to determine if they are likely a victim of human trafficking, to

develop a rapport, and to address potential and actual misconceptions that cause the

patient to fear seeking assistance. The questions themselves should evaluate how much

autonomy they have and if coercion, deception, or abuse of power has been used to limit

their freedom (U.N. General Assembly, 2003).

Some of the interview questions should focus on evaluating if and how the

trafficker has prevented the victim from interacting with other people or the outside

world. This can be assessed relatively quickly by determining if the patient knows their

current location, home address and phone number, and what familial/friend contacts they

have. If the patient lacks some or all of this information, it is possible that it has been

purposefully withheld by the trafficker to reduce the victim's ability to seek help.

Depending on the context of the visit in the emergency room, it may be possible

to gather information about the patient's work situation. This sort of evaluation may be

helpful for the SANE to determine their patient's level of autonomy and recognize further

warning signs of trafficking. This sort of questioning must be done with caution, if at all,

as the goal in these visits is not only to care for the patient's health and safety, but also

develop rapport and trust. If the conversation comes naturally, the SANE should be aware

that red flags involve the patient explaining that their work is going towards paying a

'debt,' or that they feel forced to doing the work. The SANE may consider asking if the

patient's safety (or that of their children, significant other, or other loved ones) has ever

been in jeopardy. The SANE may also query if the patient is ever punished and if so, for

what and how. More conditions of autonomy can be assessed by asking if they can leave

the house or their work (temporarily or permanently) and if they have access to their

identification or other documents.

SANEs must also understand that the victim's priority may *not* be to leave their

situation. SANEs must remain supportive even if they disagree with that choice. Victims

of human trafficking often have very limited autonomy due to their trafficker(s)

controlling most aspects of their life and choices. Therefore SANEs must prioritize and

support the victims' independence and decision-making even if the SANE disagrees with

those choices. Acceptance of assistance exists on a continuum and available options must

be customized to the individual (Brunovskis & Surtees, 2007).

Use of a Tool to Guide Implementation of Learning into Practice

In addition to reviewing the literature for key components to include in the

training, this author also chose a validated tool for identifying victims of human

trafficking that SANE nurses could use in practice. The key was to provide a tangible

resource for the participants to utilize in everyday practice as a support to what

knowledge had been gained from the training. The Trafficking Victim Identification Tool

(TVIT) developed by the Vera Institute of Justice (2014) was ultimately chosen as it is

the only validated human trafficking screening tool (National Institute of Justice, 2016).

The TVIT has a high degree of reliability of identifying victims of human trafficking and has been validated in use of both U.S. and foreign-born victims (Vera Institute of Justice, 2014). The TVIT is a useful tool when there is a high degree of suspicion but not yet confirmation of victim status. There is a short and long version of the TVIT; the short version was further condensed for this training for SANEs for use in the emergency department setting. Its ability to be condensed is beneficial for when the patient is not in a position to dedicate an extended period of time to in-depth interviewing about their situation. That type of assessment could be warranted in a later stage by specialized professionals in the healthcare, social work, and legal systems. See appendix A for the official short version of the TVIT. See appendix B for the condensed version of TVIT adapted for this training.

Theoretical Framework

The guiding theoretical nursing framework for this project was Orlando's Nursing Process Discipline Theory (Orlando, 1972). Orlando's theory focuses on how to optimally determine and meet the patient's needs. It involves an understanding that the patient may not be aware of what his or her needs are due to ineffective coping and perception of helplessness (Abdoli & Safavi, 2010). Validation of that type of patient perception is an integral part of theory in addition to empathy and collaboration with the patient. Nursing care is a human not mechanical process and involves the development of the nurse-patient relationship. Negative behaviors and actions from the patient are an expression of an unmet need that the nurse must work to identify rather than respond directly to that behavior (May, 2013). An example of how the Orlando Nursing Process Discipline theory guided this project involves recognizing barriers to care unique to the victim of human trafficking. If

a trafficked patient is interviewed with their captor in the room or nearby, they may give a

limited or untrue accounting of the presenting problem to avoid repercussions. For

example, they may state that their STD was from consensual, unprotected sex with a

boyfriend rather than an assault from someone who paid their trafficker for sex. Nursing

must identify the presence of the other person as a barrier in order to more adequately

address the patient's concerns. See appendix C for a visual depiction of this theory.

Project Design

This project was an educational training for SANEs to improve their recognition

of and response to potential human trafficking victims with the utilization of an adapted

version of the Trafficking Victim Identification Tool (TVIT) created by the Vera

Institute. To accomplish this goal of increasing the SANEs' knowledge of human

trafficking, the following expectations were created and then evaluated:

- o Describe the role of victimization in human trafficking including

    - How traffickers identify potential victims
    - How traffickers maintain control over actual victims
- o Differentiate between human trafficking and smuggling
- o Identify warning signs of human trafficking
- o Describe health problems associated with human trafficking
- o Highlight resources available if the SANE has a suspected or actual victim
  of human trafficking

Project Site and Population

This project was conducted at the fourth quarterly SANE training hosted by the

New Hampshire Coalition Against Domestic and Sexual Violence on November 27,

2018. Between twenty to thirty New Hampshire SANEs are typically present at these 8-

hour-long trainings. All participants are NH registered nurses who have already

completed the SANE training, the majority of which are primarily employed by the

emergency department and work on-call hours are SANEs. Being "on call" means that during a specified period of time, if a patient in the emergency department reports being a victim of sexual assault (or domestic violence in some hospitals), the on-call SANE comes into the hospital to respond to that case. All participating SANEs have been nurses for a minimum of two years. Currently, all SANEs in New Hampshire are women. The participants at the quarterly trainings occasionally include SANEs that no longer practice but remain involved in non-clinical aspects of this field.

*Setting barriers and facilitators***.** The author's most anticipated barrier was that participating SANEs would doubt the importance of this training due to the lack of known cases of human trafficking in their area of practice and the state. It was hoped that the SANEs would recognize overlapping characteristics between victims of human trafficking and victims of sexual assault and domestic violence such as fear, shame, lack of desire to work with law enforcement, traumatization, worry they won't be believed or that they will be deemed complicit, and concerns about personal health and safety. The goal was that the SANEs would find this training beneficial should they encounter a possible HT victim and feel qualified to respond due to a combination of this training and their previous experience working with sexual assault victims. They would have more tools to be able to respond and thus feel more confident in their abilities. Additionally, the leaders at the New Hampshire Coalition Against Domestic and Sexual Violence were motivated and supportive of the addition of this training.

Implementation Plan/Procedures

This training was conducted in-person as a 60 minute education course for the participants in the fourth quarterly SANE training in the fall of 2018. All of the

participants were active or retired SANEs. This author used PowerPoint as a presentation

tool to guide the training. All participants at the training received an emailed copy of the

PowerPoint presentation along with a copy of the short TVIT to use in practice following

the completion of the training. A copy of the PowerPoint can be found in Appendix D.

Following the presentation, there was an informal face-to-face discussion with the

audience about the perceived benefits and recommendations for improvement of the

training for future use with the New Hampshire Coalition Against Domestic and Sexual

Violence.

Measurement Instruments

The method of evaluation for this project involved a 5-point Likert scale sent out

by SurveyMonkey that was reviewed by the chairperson for this project (Appendix E).

The Likert rating system will be scored as follows: 1 strongly disagree, 2 mildly disagree,

3 neutral, 4 mildly agree, and 5 strongly agree.

DISAGREE			AGREE	
Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

The statements read:

- The training met the listed objectives.
- The content of the training was presented at an introductory level.
- The format (layout) of the modules was easy to follow.
- This training has increased my knowledge regarding how to identify and appropriately support HT victims.
- This training will help change my approach to care for potential and actual victims of human trafficking.
- This training has the potential to be applicable to my work as a SANE.
- I would recommend this training to others SANEs.

For each Likert question, there was an additional comment section for participants to expand on their 1-5 response. It was requested that if a participant responded with a "strongly disagree," "disagree," or "neutral" answer, they provide feedback for future improvements. It was designed to take under 5 minutes to complete. The goal of the survey was to evaluate the SANEs' perceptions on the quality of the presentation and applicability to their work. This goal would be deemed to have been met if the participants ranked each of the above components as a 4 or higher.

Data Collection Procedures

SurveyMonkey was the resource of choice for sending out surveys to the participants and guaranteeing anonymous responses. SurveyMonkey is free and widely used. There is also the benefit of 24/7 customer support in the case of a technical problem with the survey itself. Email was the chosen method of dissemination of the survey both due to ease of use and consistency as this is the primary mode of communication chosen by the host of the SANE overall trainings (New Hampshire Coalition Against Domestic and Sexual Violence).

<div align="center">

Cost-Benefit Analysis/Budget

</div>

This 60 minute training was completed by all 28 participants at the SANE quarterly training. There was no financial cost to completing this training as participants are not paid for attendance unless their specific hospital has decided to reimburse them for attendance. The New Hampshire Coalition Against Domestic and Sexual Violence does not reimburse attendees or presenters for their time or work specific to these quarterly trainings. Microsoft PowerPoint was used for the presentation and

SurveyMonkey for the questionnaire. Neither of these resources had a financial cost to this author for use.

Data Analysis

The post-training survey (Appendix E) was sent out via email to all 28 participants within a week of the training. Two reminder emails were sent out at one week intervals to participants who had not yet completed the training. The survey was left open for the potential of further response after the third email reminder, but no further surveys were completed after a two week period following the third email.

A total of 14 of the participants completed the survey (50% response rate). Each participant completed the entire survey except for one participant who omitted one question. No explanation was left to describe the nature of the omission.

The Likert survey data results can be classified as ordinal or interval. Participants responded to the statements ranking from 1 to 5 which correspondingly ranged from "strongly disagree" to "strongly agree." Due to the balanced nature of the responses (two in the 'disagree' category, two in the 'agree' category, and one 'neutral' response), for practical purposes of analysis the data will be analyzed as interval in nature. The analysis of Likert data as interval variables rather than ordinal in research is slightly controversial, however, commonly used in this way for analyzing results (MiniTab, 2016; Statistics Solutions, 2019; UCLA, 2019). For the purpose of this analysis, both mean (interval) and median (ordinal) will be used to confirm that the results are similar regardless of analysis choice.

Results

The goal was for every participant to "agree" or "strongly agree" with each of the seven questions. Since each response of "strongly disagree" to "strongly agree" was assigned a numerical value of 1 to 5, the goal of the survey could also be stated that the mean response would be 4 or above. This goal was achieved with an average score of 4.17. The range of the means per question spanned 4.0 to 4.43. The median result for each question were all 4 or 5, further confirming the accuracy of the ` from the mean (Appendix G, Appendix H).

One participant responded "strongly disagree" to every question and did not leave any accompanying comments to qualify these responses as was requested for any responses of "strongly disagree," "disagree," or "neutral." No other participant selected "strongly disagree" to any of the other survey questions. Based on the lack of comments and the inability to connect with this respondent due to the anonymity of the survey, the rationale behind this response will remain elusive. A re-analysis was conducted with this survey omitted due to the curiosity of this author on its impact on the overall ratings of this training. When the survey from this one outlier responder was removed and the results re-analyzed, there was only a 5% difference in the mean score. The new average score became 4.41 (previously 4.17) and the new ranges per question spanned 4.23 to 4.69 (previously 4.0 to 4.43). The results of the median were unsurprisingly unchanged with the removal of this survey. In conclusion, this outlier had minimal impact on the overall evaluation of the training.

There was only one "disagree" response out of all the surveys. This came from a response to the statement, "The content of the training was presented at an introductory

level." The respondent left a comment saying, "I feel like you tailored the talk to the audience of SANEs with a variety of experience so it was accessible and useful for all of us." Although the actual response from this participant of "disagree" did not meet the aspired goal for responses, the associated comment provided positive feedback about having a tailored presentation to the intended audience of SANEs at quarterly trainings.

There were a total of 3 "neutral" responses spread over 3 separate questions. Two of them were from the same respondent who commented that this training didn't add clinical value to their work since they had already participated in a "previous training." The third neutral response was by a participant that commented that the training wouldn't have an impact on their practice since they no longer are actively practicing as a SANE. Although these "neutral" responses did not meet the aspired goal for feedback, the comments left by the participants allows for clear understanding as to why their previous participation in trainings or retirement from clinical SANE work respectively reduced the benefit they personally and professional gained from this project.

Of the comments, the only one offering feedback for future trainings was the following: "I think it was a great presentation. I think if it was more focused in nursing actions: like documentation and medication, unique to this population it would be more specific for SANE." This was an astute observation and insightful opinion. The purpose of this training was to introduce SANEs to the potential for their role to include the recognition of and response to potential and actual human trafficking victims. Its focus was defining the problem and advocating for the expansion of the SANE practice into this overlapping area of need. Although there was review of SANE some interventions in this presentation, these focused on recognition of human trafficking victims. There is

certainly room for either extending this training or creating a new training that continues

learning toward specific interventions and associated documentation involved with caring

for a human trafficking victim.

The informal feedback session following the training also provided helpful

information. This dialogue continued for 20 minutes following the completion of the 60

minute training with consent from the host organization. Overall, the participants

reported satisfaction with the content. Several of the SANEs shared personal stories of

patients they had cared for that were human trafficking victims. Many of them expressed

feeling ill-equipped to evaluate and provide resources for this patient population.

Unexpectedly, much of the discussion involved the role of the opioid crisis in human

trafficking. Drug abuse is a commonly exploited vulnerability used by traffickers to

control their victims and a topic mentioned in this training. As New Hampshire is one of

the top affected states in the country, the SANEs reported concern over how this could

impact their patient population (National Institute on Drug Abuse, 2019). People with

preexisting or acquired drug addiction who fall prey to traffickers may not be recognized

as victims of HT in the emergency department but rather as unidimensional victims of

opioid addiction. The SANEs verbalized their new motivation to recognize this

association both in their sexual assault victims with a history of or ongoing drug use, but

also those with opioid addictions in general.

The planned time to complete the survey was less than five minutes. This goal

was met with a mean completion time of 4 minutes and 20 seconds and a median

completion time of 1 minute and 8 seconds. The disparity came from two outliers in the

completion time of 7.7 and 37.7 minutes (Appendix I). No explanation for the extended

response time was documented in the comments section of these surveys.

Outcomes

The planned goal for this project was defined as increasing NH SANEs' ability to

recognize victims of human trafficking and be able to respond appropriately to their

unique needs. This was accomplished by completing the objectives described in the

Goals, Objectives, and Expected Outcomes section listed above. These three objectives

and related actual outcomes are discussed below.

Objective 1: Complete a comprehensive and integrative literature review

The comprehensive review of the literature identified numerous educational

strategies applicable to the creation of a training of NH SANEs to respond to suspected

and actual human trafficking victims. Articles found through CINAHL and PubMed were

utilized in addition to existing trainings from the International Association of Forensic

Nursing and other respectable nursing organizations. Although there was also a paucity

of published research regarding evaluation of HT trainings for SANEs, there were

numerous articles that provided useful information that enabled the framework for the

creation of a unique HT recognition and response educational presentation for SANEs in

New Hampshire.

Objective 2: Creation and presentation of an evidence-based, comprehensive training

program on the recognition and response to HT victims at the 2018 fourth quarterly NH

SANE training

This author ultimately utilized common, critical components from the literature

review to create a unique presentation on HT recognition and response for SANEs in

New Hampshire. Forensic examination and general victimization was not reviewed since that is already a key component of SANE training. The validated Trafficking Victim Identification Tool was also integrated into this training to familiarize the participants with a high quality resource available to them in the clinical setting when caring for suspected or actual victims. Though coordination with the New Hampshire Coalition Against Domestic and Sexual Violence, this one hour training was implemented at the fourth quarterly SANE training in November 2018. 28 New Hampshire SANEs were present.

Objective 3: Request and evaluate feedback from participating SANEs on their perception on the training for further improvement.

Following the training, there was an active 20-minute informal discussion and Q&A session with this author and the participating SANEs. The online post-presentation evaluation was optional and ultimately completed half of the participants. The overall response was positive with the majority reporting that they gained clinical value from the training. Furthermore, the majority of participants agreed that the presentation had met its pre-established goals of training the SANEs to describe the role of victimization in human trafficking (including how traffickers identify potential victims and maintain control over them), differentiate between human trafficking and smuggling, identify warning signs of human trafficking, describe health problems associated with human trafficking, and to highlight resources available if the SANE has a suspected or actual victim of human trafficking. The average scores from the evaluation met the goal of creating a high-quality, value-added evidence-based training.

Ethical Considerations/Protection of Human Subjects

The University of Massachusetts, Amherst (UMass) Internal Review Board (IRB) approval was obtained prior to initiating the DNP project. It was determined that this project is exempt from IRB review since it does not meet the definition of "human subject research" under federal regulations (Appendix F). Any data gathered on the nursing participants excluded personal identifying information including name, date of birth, age, etc. All information collected as part of evaluating the impact of this project was aggregated data from the project participants and did not include any potential identifiers. There was no involvement of patient data or information. There were no identified risks to participants from this study. The benefits were an increase in researched, evidence-based knowledge that is applicable to the SANEs line of work. The surveys were anonymously completed and reviewed by SurveyMonkey.

Conclusion

Human trafficking is a public health problem. The health consequences of human trafficking on the victims is enormous and the social responsibility is high. Nurses are in an ideal position to work on an individual level as part of a larger health movement to learn to identify warning signs of human trafficking in their patients on a daily basis and respond as necessary. SANEs are on the front line for interaction with victims of human trafficking that require reactionary healthcare in the emergency department. The goal at the conclusion of this project is to have developed a HT recognition and response training for SANEs that is deemed applicable and beneficial to the participants. Ideally, this project will continue to be improved over time and ultimately included in regular

trainings for the New Hampshire Coalition Against Domestic and Sexual Violence SANE

program and others across the country to address this wide reaching global health issue.

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Appendix A

Trafficking Victim Identification Tool (TVIT) Short Version

Screening purpose. This screening tool is intended to be used as part of a regular intake process or as part of enrollment for specific programs. In order for the results to be valid, the screening should be administered according to pre-arranged protocols, *whether or not the client is believed to be a victim of human trafficking.* Please refer to the *User Guide* for directions on using this screening tool.

Screening timing. Since each agency's intake process is unique, agencies should determine how to best integrate this screening tool with their other intake forms or procedures. Whatever the timing and context of the interview, please begin and end with comfortable topics of conversation to minimize the client's discomfort.

Deferred/Suspended Screening. In some cases the intake process extends beyond the first meeting with the client. Service providers may sometimes choose to postpone sensitive screenings, judging that clients are not yet ready to disclose or discuss experiences of victimization and would prefer to continue the interview at a later date. If in the course of an interview the client shows acute signs of anxiety, ask the client if s/he would prefer to stop the interview and resume it at a later time.

Date of interview:_____ Interviewer:_____

Demographic information: The following are suggested basic demographic questions. You may wish to supplement these with your agency's routine demographic or introductory questions.

Sex of client: female _____ male _____ other_____

Age/birth date of client:_____

Number of years of schooling completed:_____

Client's preferred language:_____

Country of birth:_____

If client answers outside the U.S., please ask migration questions

Migration

1. In what year was your most recent arrival to the U.S.? _____(YYYY)
[INTERVIEWER: If client has come to the U.S. more than once, you can ask them about other entries to the U.S. if relevant.]
   → If you don't know exactly when you arrived in the U.S., about how long have you been here?
   ☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 to 10 years
   ☐ More than 10 years
   2. Did anyone arrange your travel to the U.S.?
☐ No
☐ Yes ☐ Can you tell me who?
   _____
      → What did they do?
      _____

3. Did you (or your family) borrow or owe money, or something else, to anyone who helped you come to the U.S.? *[INTERVIEWER: Probe for something owed, such as property, house, or land]*

☐   No

☐   N/A

☐   Yes Do you (or your family) still have this debt, or does anyone claim you do? No ☐ Yes ☐
        [INTERVIEWER: Record volunteered information here]

_____
_____
_____

4.   If you did borrow or owe money, have you ever been pressured to do anything you didn't want to do to pay it back?

☐   No

☐   N/A

☐   Yes If you are comfortable telling me, what kinds of things were you pressured to do that you didn't want to do?

_____
_____
            Could you describe how you were pressured?
_____
_____

Working/Living conditions

5. Have you worked for someone or done any other activities for which you thought you would be paid?
[INTERVIEWER: This could include activities like unpaid domestic work that might not be readily defined as "work" and should only detail those jobs in which the person felt unsafe or did not get paid what the person felt he/she should.]

☐   No

☐   Yes ☐ What kind(s) of work or activities were you doing?

_____
_____
            ☐How did you find out about these jobs/activities? [*INTERVIEWER:* probe for details, especially as they deal with recruitment from abroad]
_____
_____

6. Have you ever worked [or done other activities] without getting the payment you thought you would get? *[INTERVIEWER: You do not need to repeat "done other activities," if unnecessary and the client understands work does not just mean formal work.]*

    No

    Yes ☐ Was it the same work as you described above? _____
            No ☐   What kind(s) of work or activities were you doing?

_____
_____

Yes ☐ What payment did you expect and why?

_____

_____

☐ What did you receive?

_____

_____

7. Did someone ever (check all that apply):

☐ Withhold payment from you

☐ Give your payment to someone else

☐ Control the payment that you should have been paid

☐ None of the above

[INTERVIEWER: Record volunteered information here]

_____

_____

8. Have you ever worked [or done other activities] that were different from what you were promised or told?

☐ No

☐ Yes ☐ What were you promised or told that you would do?

_____

_____

☐ What did you end up doing?

_____

_____

9. Did anyone where you worked [or did other activities] ever make you feel scared or unsafe?

☐ No

☐ Yes ☐ Could you tell me what made you feel scared or unsafe?

_____

_____

10. Did anyone where you worked [or did other activities] ever hurt you or threaten to hurt you? *[INTERVIEWER: This could include any physical, sexual, or emotional harm]*

☐ No

☐ Yes ☐ Could you tell me what they did or said?

_____

_____

11. Were you allowed take breaks where you worked [or did other activities], for example, to eat, use the telephone, or use the bathroom?

☐ No ☐ What if you were sick or had some kind of emergency?

_____

_____

☐ What did you think would happen if you took a break?

_____

_____

☐ Yes ☐ Did you have to ask for permission? _____

    ☐ What did you think would happen if you took a break without getting permission?

_____

_____

12. Were you ever injured or did you ever get sick in a place where you worked [or did other activities]?

☐ No

☐ Yes   Were you ever stopped from getting medical care? No☐   Yes☐

    ☐ If you feel comfortable, could you tell me more about what happened?

_____

_____

13. Have you ever felt you could not leave the place where you worked [or did other activities]?

[INTERVIEWER: Probe for situations where someone threatened to do something bad if client tried to leave.]

☐ No

☐ Yes ☐ Could you tell me why you couldn't leave?

_____

_____

    ☐ What do you think would have happened to you if you tried to leave?

_____

_____

14. Did anyone where you worked [or did other activities] tell you to lie about your age or what you did?

☐ No

☐ Yes ☐ Could you explain why they asked you to lie?

_____

_____

15. Did anyone where you worked [or did other activities] ever trick or pressure you into doing anything you did not want to do?

☐ No

☐ Yes ☐ If you are comfortable talking about it, could you please give me some examples?

_____

_____

16. Did anyone ever pressure you to touch someone or have any unwanted physical [or sexual] contact?

☐ No

☐ Yes ☐ If you are comfortable talking about it, could you tell me what happened?

_____

_____

17. Did anyone ever take a photo of you that you were uncomfortable with?

☐ No

☐ Yes ☐ If you feel comfortable talking about this, could you tell me who took the photo?

_____

_____

    ☐ What did they plan to do with the photo, if you know?

[LAW ENFORCEMENT: If the respondent indicates that the photo was posted online, you should ask which website.]

_____

_____

☐Did you agree to this?   ☐ No   ☐ Yes

18. Did you ever have sex for things of value (for example money, housing, food, gifts, or favors)? *[INTERVIEWER: Probe for any type of sexual activity]*

☐ No

☐ Yes ☐ Were you pressured to do this?   ☐ No ☐ Yes

    ☐ Were you under the age of 18 when this occurred?   ☐ No ☐ Yes

19. Did anyone take and keep your identification, like your passport or driver's license?

☐ No

☐ Yes ☐ Could you get them back if you wanted? [*INTERVIEWER: Probe for details*]

_____

_____

20. Did anyone where you worked [or did other activities] ever take your money for things, for example, for transportation, food, or rent?

☐ No

☐ Yes ☐ Did you agree to this person taking your money? ☐ No   ☐ Yes

    ☐ Could you describe this situation?

_____

_____

Post-interview Assessment (to be completed by the interviewer)

6a. Note any nonverbal indicators of past victimization:
_____
_____
_____
_____

6b. Note any indicators that responses may have been inaccurate:
_____
_____
_____
_____

6c. Indicate the likelihood that the client is a victim of trafficking:
☐ certainly not   ☐ likely not   ☐ uncertain either way   ☐ likely   ☐ certainly

6d. Briefly state up to three reasons for your rating:
(1) _____
(2)_____
(3) _____

6e. What kind of service referrals, if any, will you make for the client?
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____

6f. Additional Notes:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Appendix B

Trafficking Victim Identification Tool (TVIT) Short Version
Adapted for SANE Use

Date of interview: _____   Interviewer:_____

Demographic information: The following are suggested basic demographic questions.
You may wish to supplement these with your agency's routine demographic or
introductory questions.

Sex of client: female _____ male _____ other _____

Age/birth date of client: _____

Number of years of schooling completed: _____

Client's preferred language: _____

Country of birth: _____

*If client answers outside the U.S., please ask migration questions*

Migration

- How long have you been in the U.S.?
- Did anyone arrange your travel to the U.S.?
- Did you (or your family) borrow or owe money, or something else, to anyone who helped you come to the U.S.? If so, is there outstanding debt? Have you or your family had to do something you didn't want to do to pay? If so, what?

Working/Living conditions

- Have you worked for someone [or done any other activities] for which you thought you would be paid? If so, what sort of work is it?
- Has any of the work you have done been different than what you expected or were promised?
- Have you ever worked [or done other activities] without getting the payment you thought you would get? What payment did you get? How did that compare to what you expected?
- Has your employer ever withheld your payment or controlled your payment?
- Has anyone you worked for/with made you feel scared or unsafe? Harmed you or threatened to harm you or loved ones?
- Have you ever felt like you can never leave your work?
- Are you allowed to take breaks (eat, drink, bathroom, phone calls)?
- Were you ever injured or gotten sick as a result of your work?
- Have you ever been stopped from seeking medical attention in the past?
- Has anyone kept or taken your identification? Phone?

Appendix C

Orlando's Nursing Process Discipline Theory
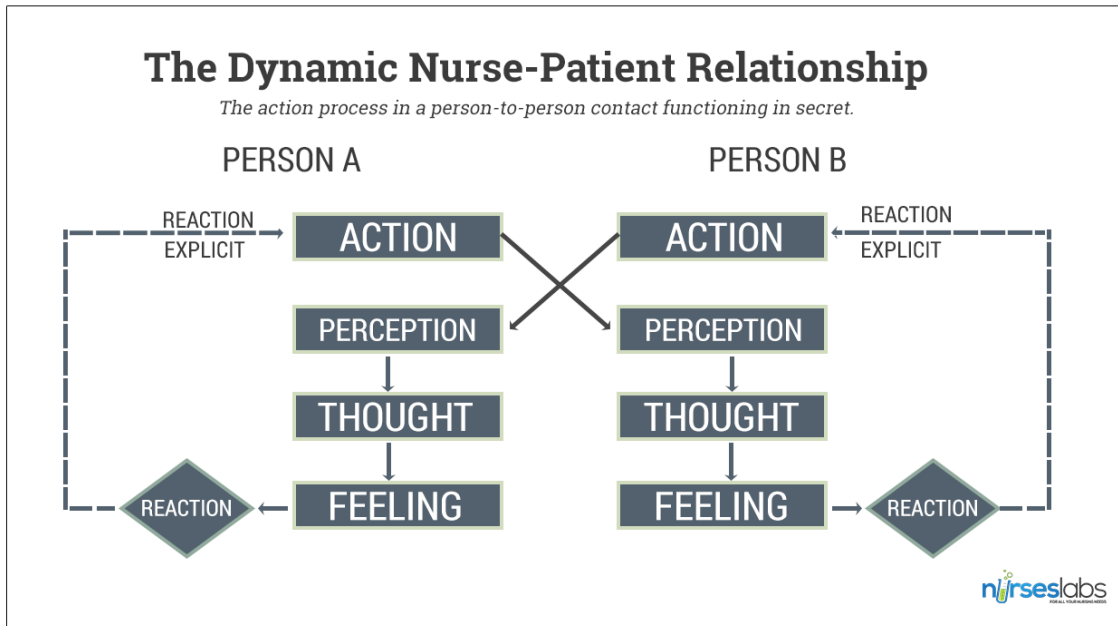
(Wayne, 2014)

Appendix D

Training PowerPoint Presentation

HUMAN TRAFFICKING
FOR THE NEW HAMPSHIRE SEXUAL ASSAULT NURSE EXAMINER
Carolyn L. Noyes, RN, SANE-trained
University of Massachusetts Amherst

How do traffickers victimize?

- Coercion
  - Threats or actual violence to victim or victim's loved ones
  - Report victim or victim's loved ones to police (immigration, drugs, prostitution)
  - Withhold food, shelter, tobacco or other drugs
- Cycle of abuse
  - Caregiver or lover role used for emotional manipulation of actions
- Desensitization
  - "It's not that bad." "It could be worse." "At least he doesn't _____."
  - Victims may not realize they are being trafficked
- Over time or immediately (Reid, 2016)
  - ↓ perceived independence, money, and/or love
  - ↑ workload, threats, and/or punishments

What is human trafficking?

- The United Nations Convention against Transnational Organized Crime (2000)
  - "The recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, fraud, or deception ...to achieve the consent of a person having control over another person, for the purpose of exploitation."
- Types of human trafficking (Ochab, 2017)
  - Sexual exploitation (79%)
  - Forced labor (18%)
    - Domestic, agricultural, construction, mining, manufacturing
  - Other (3%)
    - Child soldiers, forced begging and marriage, organ removal

Modern day slavery

Human trafficking vs. Smuggling

Human trafficking
- No transportation necessary; local, state, international transit
- Those who are trafficked do not or cannot consent freely
- Unequal power dynamic with trafficker
- Crime against the individual
- May also involve smuggling

Smuggling
- Transport across international borders otherwise preventing entry
- Those smuggled choose to be smuggled
- Smuggler is paid for transit by those requesting it
- Crime against the state
- May lead to human trafficking

Who are human trafficking victims?

- Victims
  - Predominantly women, girls, racial minorities (Skinner, 2008)
  - Other vulnerable populations: (Joint Commission, 2018)
    - Victims of violence, runaway or homeless youth, LGBTQ people, racial minorities, migrant workers, undocumented immigrants
    - People with disabilities, low incomes, history of substance abuse, history of childhood abuse or neglect, involvement with foster care or juvenile justice system

---

Lucrative business

Low risk
- Hard to prosecute
  - 14,894 prosecutions globally
  - ≈20 million victims globally
- Low sentencing

High reward
- Human bodies can be continually used and sold for services by the same trafficker
  - Unlike counterfeit bills, firearms, drugs
- Minimal expenses
  - Food, water, and shelter
  - No or limited insurance, taxes, etc

Role of nursing in human trafficking

Healthcare is ONE NEED that CANNOT typically be accommodated by an untrained person.

- Up to 87.8% of active victims of human trafficking access health care at least once during their captivity
- 63.3% are seen in the emergency setting
- Victims often require care related to their trafficking
  - Work-related injuries, diseases related to insufficient primary care, sexual and reproductive health problems, mental health concerns, and substance abuse

---

Let's get started!

Barriers to nursing advocacy

- Healthcare workers feel unable to recognize victims of human trafficking

- No mandated reporting
  - Similar to domestic violence and sexual assault
  - Exceptions
    - Suspected abuse or neglect of a minor, elder, or dependent adult

---

Screening victims of human trafficking (HT)

1. Recognizing potential victims
   - Associated health problems
2. Providing basic needs
3. Interviewing questions for potential victims
   - Trafficking Victim Identification Tool
4. Tips and tricks for interviewing
5. Resources you can use!

Nurses as best advocates

- Nurses are:
  - Perfectly situated to recognize warning signs of HT victimization and respond
  - Known advocates for their patients
  - Ranked nationally as the most trusted profession in the United States with the highest perception of honesty and ethical standards from the general population
  - Spend the most time at the bedside
  - Trained to care for the entire person rather than their individual medical needs
- SANEs are:
  - Trained to care for people who have been acutely and/or chronically victimized
  - Already in the emergency department where more HT victims present for care

---

Recognizing victims of HT

- Long- and short-term physical and psychological impact
  - Problems may become chronic and persist even after time trafficked
- Like victims of domestic violence, cause of injuries may be obfuscated
  - Don't want to attract attention
    - Including legal status
  - Fearful of reaction from their traffickers
- Some HT victims do not see themselves as such
  - Tricked into doing things for "love" (lover, parent-figure)
  - Believe their treatment is legitimate, legal, normal
  - Unaware that treatment is illegal

Recognizing victims: Health problems

- Physical trauma
- Drug and alcohol abuse
- Pregnancy and STIs
- Psychological impact

Recognizing victims: Health problems continued

- Psychological
  - Depression, suicidal ideation, PTSD
  - Sexual violence especially correlated with rates of PTSD
    - Also related to higher rates of violence experienced pre-trafficking
  - Depressive symptoms can increase challenge of assessing patient
    - Withdrawal, fatigue, agitation, psychomotor retardation
  - Trauma!
    - Inconsistencies
    - Non-linear/chronological thinking
    - Feeling "crazy"

Recognizing victims: Health problems

- Physical trauma
  - Related to work injury (unsafe working environment, insufficient initial care)
  - Purposeful physical or sexual abuse
    - Majority of sexual assault victims have no sign of injury
- Drug and alcohol abuse
  - Submission tool
    - Preexisting addiction: traffickers will control access to the drug
    - New addiction: traffickers will offer/force substances for control
  - Threaten to report their victims to the authorities for use of illicit substances
  - Decreases credibility of victims
  - Decreases likelihood for condom use and clean needles

Providing Basic Needs

- Physiological
  - Food, drink, clothing (nursing)
  - Prioritized medical needs (medical team)
  - Potential for temporary shelter (social work/ case management)
- Safety
  - Interview away from trafficker if possible
    - Or person working for trafficker
    - Remove patient ("testing") or controller
  - Observe for controlling behavior
    - Remember control can continue remotely

Recognizing victims: Health problems continued

- Pregnancy and STIs
  - Sexual exploitation plays major role in HIV transmission
  - Untreated STIs can lead to infertility, pelvic inflammatory disease, sepsis
  - Undesired pregnancy
    - Sexual assault
    - Inadequate access to contraception
  - Traffickers can dictate fate of pregnancy
    - Physical and emotional changes may limit the work the victim is able to do
  - While trafficked, 55% of female victims had at least one abortion and 30% had multiple abortions compared to the US national abortion rate of just over 1%
  - Lack of preventative care and STIs are associated with increased rates of miscarriage and birth defects

Interview questions

- Questions chosen for the screening of a patient should be used with three primary goals; to determine if they are likely a victim of human trafficking, to develop a rapport, and addressing potential and actual misconceptions that cause the patient to fear seeking assistance. The questions themselves should evaluate how much autonomy they have and if coercion, deception, or abuse of power has been used to limit her freedom (U.N. General Assembly, 2003).
- It is important to be aware that the act of the trafficker bringing a person to seek care does not indicate concern for that person's wellbeing, but rather an attempt to avoid legal or economic consequences of that person's death or loss of ability to work due to the illness or injury (Bales & Soodalter, 1804). A trafficker may not always accompany a victim seeking care either because they are unaware they have left or they believe their control over the victim will continue remotely, and they will not seek help specific to their trafficking. Victims' perception and reality may be incongruent because of the normalization of the potential abuse and trauma (Polaris Project, n.d.). Victims may not see themselves as such. Consequently, it is the role of the assessor to recognize warning signs despite the patient not asking for help.
- Nurses must also understand that the victim's priority may not be to attempt to leave. They must remain supportive even if they disagree with that choice. Victims of human trafficking have very limited autonomy. Therefore nursing must prioritize and support their independence and decision-making despite internal disagreement. Acceptance of assistance exists on a continuum and available options are often customized to the individual (Brunovskis & Surtees, 1807).

Interview framework: Trafficking Victim Identification Tool (TVIT)

- Developed by the Vera Institute of Justice in 2014
- Quick and highly reliable screening tool to use to identify victims of human trafficking when there is a high degree of suspicion
- Can be used by law enforcement, health care and shelter workers, victim service agency staff and other social service providers
- Validated in use of both U.S. and foreign-born victims
- Short and long version

Interview: Power dynamics in the living/workplace

- Do you live, or have you ever lived, in the same place where you work? (unpaid domestic work)
- Have you ever felt you could not leave the place where you worked [or did other activities]? ...what would happen if you tried to leave ... threats?
- Did anyone at the place where you lived or worked [or did other activities] monitor you or stop you from contacting your family, friends, or others? [REPHRASE: did you have to ask permission to contact your family, friends or others?]
- Did anyone ever take and keep your identification, for example, your passport or driver's license?
- Did anyone ever force you to get or use false identification or documentation, for example, a fake green card?
- Lie about age, work capacities
- Did anyone you ever worked [or did other activities] for or lived with threaten to report you to the police or other authorities?

Trafficking Victim Identification Tool: Example

Screening potential victims: Tips and tricks

- Maintain a professional and friendly attitude
  - Express sorrow without judgement or shock
- Show the patient that you care about them and can help
  - They may have been conditioned to think that no one (except the trafficker) can help them or show them love
- Be cognizant of re-traumatization
  - Potential need to repeat account to healthcare, social services, police, lawyer, etc.
- Provide interpreter as needed but must ensure confidentiality
- Be aware of cultural or gender preferences in care
- Save highly sensitive questions until later in interview
  - Physical or sexual violence, immigration fears

Interview: Power dynamics in the workplace

- Have you ever worked [or done other activities] without getting the payment you thought you would get?
- If you did borrow or owe money, have you ever been pressured to do anything you didn't want to do to pay it back?
- Did someone ever withhold payment/money from you, give your payment/money to someone else, and/or control the payment/money that you should have been paid?
- Have you ever worked [or done other activities] that were different from what you were promised or told?
- Did anyone where you worked [or did other activities] ever make you feel scared or unsafe?
- Did anyone where you worked [or did other activities] ever hurt you or threaten to hurt you?
- Did anyone where you worked [or did other activities] ever harm or threaten to harm people close to you, like family or friends?
- Were you ever injured or did you ever get sick in a place where you worked [or did other activities]? Were you ever stopped from getting medical care?

Screening potential victims: Tips and tricks continued

- Keep potential trafficker out of sight and sound
  - Nearly half of them - 47 percent - said that they were monitored in some way during their health care visits (Polaris Project, 2017).
- Helping them can further endanger them
- Keep law enforcement (especially in uniform) out of sight as much as possible
  - May have learned to be fearful or wary of law enforcement (immigration too)
  - Not all victims want law enforcement to be involved

Appendix E

Objectives of the training:

- Describe the role of victimization in human trafficking including
  - How traffickers identify potential victims
  - How traffickers maintain control over actual victims
- Differentiate between human trafficking and smuggling
- Identify warning signs of human trafficking
- Describe health problems associated with human trafficking
- Highlight resources available if the SANE has a suspected or actual victim of human trafficking

Survey questionnaire:

1. The training met the listed objectives.
2. The content of the training was presented at an introductory level.
3. The format (layout) of the modules was easy to follow.
4. This training has increased my knowledge regarding how to identify and appropriately support HT victims.
5. This training will help change my approach to care for potential and actual victims of human trafficking.
6. This training has the potential to be applicable to my work as a SANE.
7. I would recommend this training to others SANEs.

Survey response options:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
O	O	O	O	O

Appendix F

UMassAmherst

Human Research Protection Office

Mass Venture Center
100 Venture Way, Suite 116
Hadley, MA 01035
Telephone: 413-545-3428

Memorandum – Not Human Subjects Research Determination

Date: November 15, 2018

To: Carolyn L. Noyes, College of Nursing

Project Title: Human Trafficking Screening Training for Sexual Assault Nurse Examiners (SANEs) in New Hampshire

IRB Determination Number: 18-230

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination based on the information provided to our office:
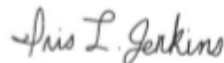
☐ The proposed project does not involve research that obtains information about living individuals
[45 CFR 46.102(f)].

☐ The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information [45 CFR 46.102(f)(1),(2)].

☒ The proposed project does not meet the definition of human subject research under federal regulations [45 CFR 46.102(d)].

Submission of an Application to UMass Amherst IRB is not required.

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO prior to initiating any changes.

A project determined as "Not Human Subjects Research," must still be conducted in accordance with the ethical principles outlined in the Belmont Report: respect for persons, beneficence, and justice. Researchers must also comply with all applicable federal, state and local regulations as well as UMass Amherst Policies and procedures which may include obtaining approval of your activities from other institutions or entities.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.

Iris L. Jenkins

Iris L. Jenkins, Assistant Director
Human Research Protection Office

Appendix F

Anonymous Survey Monkey Results

							Respondent								
Question		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
1		5	5	4	5	4	5	5	1	5	4	4	5	5	5
2		4	2	4	4	4	5	4	1	4	5	5	5	5	4
3		5	5	4	4	4	4	4	1	4	4	5	4	5	5
4		5	4	4	4	4	4	5	1	5	3	4	4	5	5
5		5	4	4	4	4	4	5	1	4	3	4	5	5	4
6	OMITTED	5	4	4	5	5	5	1	5	4	4	5	5	3	
7		5	5	3	5	4	5	5	1	5	4	4	4	5	5

Appendix G

Anonymous Survey Monkey Results Analysis

Question	Mean	Mean (no outlier)	Median	Median (no outlier)
1	4.43	4.69	5	5
2	4.00	4.23	4	4
3	4.14	4.38	4	4
4	4.07	4.31	4	4
5	4.00	4.23	4	4
6	4.23	4.50	5	5
7	4.29	4.54	5	5

Appendix I

Anonymous Survey Monkey Completion Time Data

Responder	Completion time
1	7.7
2	37.7
3	2.3
4	0.95
5	0.87
6	2.47
7	0.75
8	1.42
9	1
10	1.28
11	0.73
12	2.08
13	0.6
14	0.82
Mean time	4.33
Median time	1.14