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Abstract

Objective: The purpose of this study is to analyze the impact of trauma-informed care training on the practice of dental, optometry, and mental health providers caring for victims of human trafficking. **Methods:** A mixed method approach was used, including pre-post surveys and one focus group discussion. **Results:** The dental, optometry, and mental health provider participants reported a greater awareness of human trafficking and greater knowledge of how to approach and care for the victims in a trauma- informed way. **Conclusion:** Continued training on the provision of trauma-informed care for victims of human trafficking is necessary for dentists, optometrists, and mental health professionals serving in health clinics in a university located in the southeast United States.

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ABSTRACT

Objective: The purpose of this study is to analyze the impact of trauma-informed care training on the practice of dental, optometry, and mental health providers caring for victims of human trafficking. **Methods:** A mixed method approach was used, including pre-post surveys and one focus group discussion. **Results:** The dental, optometry, and mental health provider participants reported a greater awareness of human trafficking and greater knowledge of how to approach and care for the victims in a trauma- informed way. **Conclusion:** Continued training on the provision of trauma-informed care for victims of human trafficking is necessary for dentists, optometrists, and mental health professionals serving in health clinics in a university located in the southeast United States.

Key Words: trauma-informed care, healthcare providers, human trafficking, dental provider, trafficked victims

INTRODUCTION

The label "human trafficking" is nothing more than a synonym for modern day slavery.[1] The United Nations Office on Drugs and Crime defines human trafficking as the exploitation of persons through the "recruitment, transportation, transfer, harboring, or receipt of persons by means of threat or use of force or coercion."[2] The purpose of human trafficking is the sexual or labor exploitation of the person for the traffickers' gain.[2] It is estimated that over 40 million are trafficked worldwide.[3] Over 400,000 are trafficked in the United States.[4] This crime against human rights primarily targets women and children. The consequences of human trafficking are long lasting and devastating from mental, physical, and public health perspectives.[5] Researchers adamantly assert that human trafficking education to healthcare providers is an overlooked component of a comprehensive response.[6,7,8] While healthcare providers are trained to recognize victims of child abuse, domestic violence, and intimate partner violence, they are not routinely educated about the presentation of human trafficking victims.[8,9] Barriers to identification of trafficked victims include lack of education and training of health care providers, lack of protocols for victim identification, mistrust by victims of adults/authority figures, language barriers, and victims' shame or guilt about their situation.[10]

To provide the highest quality of care when treating trafficked survivors, providers need to demonstrate awareness and sensitivity to the impacts that past trauma may have on survivors. Trauma-informed care has been shown to reduce triggering events in the present. Trauma-informed care recognizes and understands the effects of past and current trauma on an individual. The focus of the delivery of trauma-informed care is the mutual safety of the patient and the provider, and the empowerment of the patient through control and voice.[11] In recent years, medical professions such as physicians and nurses have started to report on this issue and to educate their members to recognize signs and symptoms of trafficking. Eight-eight percent of survivors in a sex trafficking study by Lederer and Wetzel self-reported having contact with a health care professional while they were trafficked.[12] As highlighted by Daw and Tudor-Tangeman, O'Callaghan, and Nuzzolese, dentists have a key role to play in identifying and responding to the issue of human trafficking.[13, 14,15,16] Chisolm-Straker et al reported that while being trafficked, 26.5% of victims were treated by a dentist, and other health care clinicians, without the clinician recognizing the patient as a victim of trafficking.[17] There is a paucity of research on the provision of health services to survivors of human trafficking in the dental literature as awareness of this issue is only emerging.

PURPOSE

The purpose of this study was to assess the effectiveness of a human trafficking and trauma-informed care training on optometry, psychology, and dental residents, post doctorates, and interns at health clinics in a university. More specifically, the mixed method study sought to measure the gain in knowledge, awareness, and skills of health professionals exposed to the training as well as their level of preparation to care for human trafficking victims. This study stemmed from a larger project to educate the South Florida community on the human trafficking and provide trauma-informed care and resources to victims and survivors of human trafficking. The study followed a mixed method design with a pre and post-test survey and a focus group interview.

The theoretical framework chosen for the study was the Trans-Theoretical Model of Change (TTM) developed in 1983 by Prochaska & DiClemente.[18] This model postulated that people go through different stages before adopting changes, or new behaviors. In this study, the desired change was the inclusion of trauma-informed care for victims of trafficking in clinical practice. The different stages of change include precontemplation, contemplation, preparation, action, maintenance, and the risk of relapse at any stage.

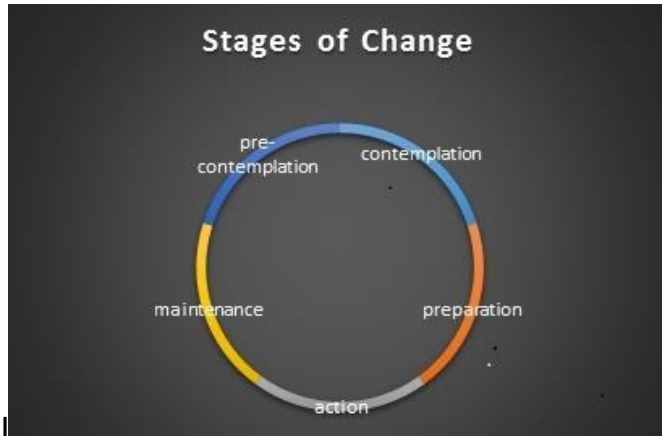

Figure . Stages of Change

METHODS

Participants

Participants (N=83) were recruited through an e-mail sent to the Dean of the College of Optometry, Dean of the College of Psychology, and Dean of the College of Dental Medicine at a private university in the southeastern United States. These three colleges were selected because they were the only colleges at the researchers' university approved to provide health services to trafficked survivors. The deans were asked to forward a mass email to the faculty, residents, and post-doctoral students involved within the optometry, dental, and psychological services clinics Thus, researchers recruited professionals and faculty members, residents, post-doctoral students, and graduate trainees to attend training sessions on the provision of trauma-informed care to human trafficking survivors. The institutional review board of the university approved the study proposal.

Measures and Procedures

After providing informed consent, participants completed demographic items and a 17-item survey measuring their knowledge of human trafficking and skills in trauma-informed care. The pre and post survey instruments were created and tested during the initial Kent, Colon and Gaillard-Kenney 2011 study and replicated by Gaillard-Kenney, Kent and Kirtley in 2013.[19,20] The instruments were revised by Gaillard-Kenney, Kent and Lyons in 2016 to include 7 questions about knowledge of trafficking and 10 questions on the delivery of trauma-informed care for victims of trafficking.[21] Items assess level of understanding of human trafficking and the adoptability of human trafficking trauma-informed care in clinical practice. The sociodemographic section provided data on personal demographics; age, gender, years of clinical practice, and previous human trafficking training. A modified version of Gibbons, Gerrard, Ouelette and Burzette's Behavioral Willingness was used to assess willingness to adopt trauma-informed care for human trafficking victims.[22] A knowledge scale on human trafficking and the health care professional's role in human trafficking prevention was developed, using a modified version of Popa's 10-item knowledge scale.[23] The Decisional Balance constructs reflected the individual's relative weighing of the pros and cons of changing. This was assessed by Velicer, DiClemente, Prochaska, and Brandenburg's short measure to address the adoption of trauma-informed clinical practice for trafficked victims.[24]

Participants endorsed their perceptions of knowledge and comfort in providing trauma-informed care using a Likert-type response scale (i.e., *nothing, not very much, some, a lot, a great deal; not important, slightly important, moderately important, very important, extremely important)*. The pretest was created with the purpose of assessing history of attending trauma-informed training, knowledge of human trafficking and providing trauma-informed care (e.g., I know how to incorporate trauma-informed care in my clinical practice), and attitudes toward providing services to trafficked survivors (e.g., I would feel good about providing trauma-informed care to survivors of human trafficking), among practicing professionals and faculty and graduate residents, post-doctoral residents, and trainees. Participants were asked to report if they had previously attended a training related to trauma-informed care or human trafficking. Immediately following the pretest, participants attended a 90-minute training which focused on the health consequences of human trafficking, survivors medical, emotional, and mental health needs, an overview of trauma and triggers of traumatic stress in the healthcare environment, and trauma-informed care principles and application.

To assess applicable post-training perceptions, questions were adapted from the pre-test. All data were analyzed using SPSS (v. 20.0). To evaluate the primary hypothesis, a bivariate correlation analysis was conducted to assess the influence of level of education, student status, and gender on self-reported knowledge of what trauma-informed care is, ability to incorporate trauma-informed care in clinical practice, and knowledge of what can trigger a survivor during a clinical exam.

Focus Group

Upon completion of the training, all participants received an email asking if the researchers could contact them regarding a focus group about the effectiveness of the trauma-informed care training for survivors of human trafficking. Five participants (N =5) responded affirmatively and researchers emailed each participant an invitation to the focus group. The focus group was scheduled 3 months after the training was completed. The length of the focus group was 90 minutes, and the conversation was audiotaped. The focus group session was semi-structured and was facilitated by the Co-PI. The second Co-PI and the research assistant took field notes. The research assistant transposed the audiotape of the focus group conversation.

The researchers analyzed the transcripts of the focus group discussion using the qualitative approach of interpretative phenomenological analysis (IPA).[25,26,27] The researchers selected IPA to analyze the focus group conversation to understand the participants' experience of the trauma-informed training from the participants' perspectives. The researchers read the focus group transcripts multiple times, individually. The researchers wrote independent notes on the content of the transcripts, the use of language, and their observations of the focus group. From their notes, the researchers autonomously identified and listed all emergent themes. Collectively, the researchers compared their notes and identified the major themes and subthemes that presented across each of the researchers' analyses.

RESULTS

Of the 83 participants sampled from the various trainings offered at the university health clinics, seven were excluded due to incomplete data. The final sample totaled 76 participants; 19 were in the field of psychology, 40 were optometry, and 17 were dental. In addition to reporting their age, gender, and race, participants were characterized according to their responses as either students or non-students (e.g., faculty, resident, post-doctoral student, and practicum student). Descriptive statistics for all demographic variables are listed in Table 2. More than three quarters of the participants (82.9%, *n* =63 and 84.2%, *n* = 64, respectively) reported they had not received any prior training on human trafficking or trauma-informed care. Prior to the training, a majority of participants reported knowing either "nothing," or "not very much," about how to incorporate trauma-informed care in their clinical practice (69.8%, *n* = 53). However, their self-reported knowledge increased as post-survey data indicated that most participants believed knowing either "a lot" (40.7%, *n* = 31), or a "great deal" (20%, *n* = 15) about incorporating trauma-informed care.

Table 1: Participants' Demographics from Pre-Post Survey Data

Characteristic	***Number***	***Percent***
Gender		
Female	44	57.9
Male	28	36.8
Missing	4	5.3
Total	76	100.0
Age		
Over 60	5	6.6
51-60	12	15.7
41-50	17	22.4
30-40	20	26.3
Under 30	17	22.4
Missing	5	6.6
Total	76	100.0
Race		
Asian	7	9.2
Black	4	5.3
Hispanic	2	2.6
Caucasian	47	61.8
Missing	16	21.1
Total	76	100.0
Highest Educational Degree		
Doctorate	60	78.9
Masters	13	17.1
Bachelors	3	4.0
Missing	0	0
Total	76	100.0
Years of Practice		
Over 16 years	25	32.9
11 to 15 years	11	14.5
5 to 10 years	16	21.0
Less than 5	17	22.4
Missing	7	9.2
Total	76	100.0
Prior Training in Human Trafficking Awareness		
No prior training	63	82.9
Some prior training	12	15.8
Missing	1	1.3
Total	76	100.0

Prior Training in Trauma-Informed Care		
No prior training	64	84.2
Some prior training	11	14.5
Missing	1	1.3
Total	76	100.0

A bivariate correlation analysis was conducted to assess the influence of level of education, student status, and gender on self-reported knowledge of what trauma-informed care is, ability to incorporate trauma-informed care in clinical practice, and knowledge of what can trigger a survivor during a clinical exam. Higher levels of education significantly correlated with reported confidence in incorporating trauma-informed care in clinical practice, p = .006, indicating that there was a positive relationship between self-reported confidence in providing trauma-informed care in clinical practice and status as a faculty, resident or post-doctoral resident. Positive correlations between knowledge of the concepts of trauma-informed care and the ability and confidence to apply that knowledge in practice were found, p=.044. Knowledge of trauma-informed care principles also positively correlated with knowledge of "what could trigger a survivor of human trafficking during a clinical exam," p = .000.

The focus group participants (N=5) related increased overall knowledge of the signs and symptoms of human trafficking. Table 2 presents the major themes, subthemes, and language illustration.

Table 2. Major Themes, Subthemes and Language Illustration from the Focus Group Data

Superordinate Themes (Su.T)	**Participants Contributing to Su.T**	**Sub-themes**	**Actual example**
Increased awareness of human trafficking	All	Sensitivity to patient's HT experience; More patient-centered Advocate for patient	"When I attended this lecture it opened my eyes about this problem and I am more aware about the patients." "I'm from Latin America…you think that this can happen in Latin America but not here (United States). After the training I said, "Oh my God this is happening here!" "Before I would usually just not intervene, but knowing what danger these people can be in, I think that we should be intervening." "We should take action; there is no way you can just close your eyes and not."
Increased knowledge of trauma-informed care for HT dental patients	All	How to communicate with patient	"Now I have more knowledge and more ideas and depended on this, know how to communicate with the patient." "…The way we are communicating with the patients and to be sensitive…"

		How to approach the patient	"It (*sic* training) opened our eyes…how to treat patients with psychological trauma. How to approach them and at the same time what accommodations can we make…even as simple as language translation."
Impact of trauma-informed care for HT patients in dental clinical setting.	All	Understanding the impact of trauma Recognition of trauma triggers Building trust with patients	"I did not realize the impact that it (*sic* trafficking) has on the people who are suffering or going through this trauma." "We have to put in mind that they are already traumatized so we have to be careful with dealing with these kinds of patients." "Given the special need of patient management in this condition (*sic,* trafficked) we need to go the extra step to make them feel comfortable." "Going above and beyond to make it a more gentle easy experience is really important." "Given the special need of patient management in this condition (*sic,* trafficked) we need to go the extra step to make them feel comfortable." "One patient only spoke Spanish… to accommodate her more we called (*sic* Spanish-speaking resident). The patient was more fluent about her problems she started actually expressing more."
Barriers to applying trauma-informed care to HT dental patients	All	University clinical environment; delayed appointments, equipment malfunctions,	"The school environment; it's not as private office would be. It is not touchy feely and cozy, so we already have on barrier that we have to sort of overcome."

		Physical layout of clinical setting; busy, noisy, open floor plan	"…we have to overcome our physical environment first. It is a big open waiting area… There are lots of people going and coming..."
			"There are multiple layers. It is not just a doctor patient relationship it is a doctor patient faculty, assistant, front desk staff relationship."
		Structure of clinical protocols; intake process, faculty supervision of resident.	"…Faculty recheck everything and go through the whole process again so it is slower for someone who have to be in a chair longer."
			"Most of the time it is not finished in one appointment; we have to go to another appointment."
			"They (victims) want you to fix it right away at the same appoint, they don't want to go for three or four appointments to fix what they have."
		Needs for continued trauma-informed training to maintain and avoid relapse	"…training is super important because I think that we have to overcome a lot of barriers."
			"I think it (sic training)…how to be more sensitive, to be more cautious about what we ask the patients and how to approach them."

DISCUSSION

The participants self-identified their increased awareness of a trafficked patient's experience of trauma, and their increased sensitivity towards the patient. Some participants described their clinical manner becoming "more patient-centered" and aware of the trafficked patient's needs. The benefit of the research identified by all the focus group participants was their increased ability to recognize potential triggers trafficked patients may experience in clinical settings. Focus group participants described progressing from awareness to action based on the Transtheoretical Model of Change and becoming "partners in addressing human trafficking."[18] Finally, the participants indicated their need for continued training on trauma-informed care for victims of human trafficking to reinforce and maintain the skills they gained through the training provided by the researchers.

Limitations

One limitation of the study was the purposive sampling method. When the study was conducted, only clinicians in the Colleges of Optometry, Dental Medicine, and Psychology were approved to provide health services to trafficked survivors at the researchers'

university. A second limitation of the study were the limited numbers of participants. While there were 76 respondents for the pre-post survey, the focus group only consisted of 5 participants from the same profession, dentistry. A third limitation of the study was the self-reported nature of the data from the focus group. The results of this study showed the effectiveness of training in trauma-informed care for the delivery of compassionate dental, optometry, and psychology services to victims and survivors of human trafficking. A future study could explore survivors' experiences of the delivery of health services from providers who were trained in trauma-informed care for human trafficking victims.

CONCLUSION

The purpose of this study was to educate and prepare dental, optometry, and psychology clinicians in the provision of trauma-informed health care services to the vulnerable, and special needs, population of survivors of human trafficking. The quantitative results showed significant increases among the providers in all three professions represented in awareness, knowledge, and skills in providing trauma-informed care to survivors of trafficking. All five participants in the focus group conversation were dental providers. Analysis of the qualitative data from the focus group showed that each focus group participant moved through the five stages change as proposed by Prochaska & DiClemente.[18] The qualitative data gave deeper meaning to the participants' experiences of the trauma-informed training for human trafficking survivors. The qualitative data also revealed the dental providers' need for ongoing training and resources to effectively support their care of human trafficking victims. To continue improving the delivery of care to this vulnerable population, future research also needs to focus on the victims' perceptions of the healthcare encounter. Obtaining victims' perspectives will inform the content and delivery of future trainings for healthcare providers and will continue to improve the delivery of services.

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