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Health Care Provider Knowledge of Human Trafficking

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Review Article

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Abstract

Human trafficking is a global public health crisis catastrophically threatening the health and well-being of those trafficked. Limited studies measure health care providers' confidence in their ability to recognize, treat, and refer those being trafficked. This integrative review synthesizes current knowledge on human trafficking and identifies gaps in research on educational interventions aimed at increasing provider knowledge and awareness as well as confidence in treating and referring those being trafficked. A systematic search of five databases identified peer-reviewed published papers between 2015 and 2021. The integrative review followed the framework of Toronto and the systemic search was guided by the Preferred Reporting Items for Systematic Revies and Meta-Analyses (PRISMA). Melnyk's Levels of Evidence framework was used for appraising the quality of evidence. Findings across studies (N = 11) reveal that providers (nurses, doctors, social workers, and hospital staff) have low knowledge and confidence in their knowledge surrounding human trafficking and their role in identification, treatment, and referrals related to an array of barriers. Further findings across studies (N = 13) reveal that providers' knowledge and confidence knowledge about human trafficking and identification, and referral of those being trafficked increased significantly with an array of educational interventions, but the transfer of this new knowledge to practice is a gap in research, as few studies reported this (n = 2).

Keywords: Healthcare; Healthcare Providers; Emergency Room/ER/Emergency Department/ED; Sex Trafficked; Human Trafficked; Labor Trafficked; Referrals; United States

Abbreviations: DOJ: Department of Justice; HT: Human Trafficking; HTVs: Human Trafficking Victim; PTSD: Post-Traumatic Stress Disorder; PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analysis; STI: Sexually transmitted infections.

Introduction

Human trafficking (HT), modern-day slavery, has reached epidemic proportions worldwide, affecting roughly 40.3 million people worldwide, a number that represents an estimation of only one percent of those trafficked. Roughly 24.9 million people are in forced labor, and 15.4 million in forced marriage [1-4]. In 2020, the National Human Trafficking Hotline received almost 51,667 calls of cases of trafficking within the United States, more than 160 calls a day, but estimates of U.S. numbers are staggeringly higher [4-6].

Human trafficking victims (HTVs) can be male or female, any age, and any income. Women and girls are disproportionately affected by modern slavery, accounting

for an estimated 71% (29 million) of the overall total, while men and boys account for 29% (10.8 million). Every country, and all 50 states of the United States hold record of people that have been trafficked in this $150-billion criminal business [7-9]. The United States defines HT as the "recruitment, harboring, transportation, provision, and obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery".

Because HTVs are so diverse in nature, they can be very difficult to recognize. Research shows that many HTVs seek emergency health care via emergency rooms, walk in-clinics, and women's clinics. They also visit primary care offices and pediatrician's offices. Research also reveals that HTVs do not disclose they are being trafficked for a host of reasons [10-14]. Therefore, it is imperative that health care providers can identify these victims in order to treat them or refer them to the support they need to recover and feel safe. At the current time, health care providers are not adequately able to do this due to lack of knowledge and training [15]. The research identifies one of the many reasons for lack of provider knowledge and confidence as the lack of evidence-based, approved education on HT for providers and a lack of approved screening tools and intervention methods for those being trafficked. Health care provider education in a variety of forms, settings, and delivery methods have been shown to increase provider confidence and knowledge [3,16-26].

The purpose of this integrative review is to identify the current state of provider knowledge of HT/HTVs case characteristics for identification, treatment or referral, and types of education that can improve on that knowledge. A review of literature and common themes surrounding victim identification, and health care provider education is presented. Gaps in the literature and future research opportunities as well as implications for health care practice and policy are also addressed.

Background

The 106th United States Congress passed the Trafficked Victims Protection Act in 2000, the first comprehensive federal law designed to protect victims of sex and labor trafficking, prosecute traffickers, and prevent HT in the United States and abroad. Prior to this law passing, it was not against the law to traffic persons. This law defines HT as "Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. The victim does not have to be transported across state/country lines for this definition to hold true." [27].

As mentioned above, HT is a global human rights problem that is ravaging victims of all ages, races, nationalities, cultures, and religions with no regard to sexual orientation.

The three main types of HT are sex, forced labor, and forced child labor. Sex and forced labor HT are the two types of HT most often seen in the U.S., and these types of HT affect children, women, and men of all ages. While abduction is the most thought-of domain of entry into trafficking, the largest domain of entry into HT worldwide is recruitment of many types both in person and online through social media. Recruitment involves seduction, isolation, and coercion over time. Individuals who are involved in HT often do not tell anyone they are being trafficked out of fear, guilt, shame, dependence on the trafficker, or a host of other reasons [3,10,28]. For this reason, and many more, it is imperative that health care providers understand the complexity of HT and HTVs and how to identify, and treat them or refer them to services needed.

Current evidence reveals health care providers have multiple knowledge gaps related to all aspects of HT, including the care of those being trafficked. Research highlights the glaring reason for lack of provider knowledge and confidence is the lack of evidence-based, approved education on HT for providers and a lack of approved screening tools and intervention methods for those being trafficked [3,5,15-26]. More troubling is the fact that HTVs encounter the health care system in multiple settings during their entrapment without detection from providers 50%-87% of the time. Eighty-seven percent of survivors report seeing a provider at least once while being trafficked without detection.

Trafficking survivors deal with a wide variety of health care issues secondary to their trauma. They are at high risk for mental health issues, substance abuse disorders, complex post-traumatic stress disorder (PTSD), and self-harm due to repeated exposure to unpredictable physical and psychological violence. Trafficking survivors also suffer from conditions of injury, untreated sexually transmitted infections (STIs), untreated chronic conditions, and undesired pregnancies [10,15].

Health care providers acknowledge their gaps in both HT understanding and, in identification, treatment, and referral arenas. Multiple studies show that education and training in these areas improve confidence and knowledge in identifying and referring HTVs (as cited above). As of 2018, only 6 of the 6,000 hospitals in the United States have a policy, procedure, or employee education initiative in place to identify and potentially rescue HTVs [16].

Defining Concepts and Variables

The central concepts that pertain to this integrative review include provider education on HT and HTVs as it relates to the confidence, identification, and treatment or referral of HTVs. To determine the relationship between these concepts, one must define them and identify how they affect one another. HT is a worldwide atrocity that is just beginning to be understood. Because of the complexity of the problem, only roughly one percent of those being trafficked have been identified, but that one percent is a staggering 40-plus million people. The U.S. law against HT defines HT as "Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. The victim does not have to be transported across state/country lines for this definition to hold true.".

The majority of those being trafficked are young people, but HT can affect individuals of any age or gender. The symptoms presented by those being trafficked can mimic a plethora of other illnesses, conditions, and issues, but research has identified that symptoms tend to clump together within the form of trafficking that is occurring (sex or labor). Because of this varying of symptoms and health-care providers' deficit of knowledge related to HT, HTVs are not being identified in the health care systems they seek out for care.

Research has illuminated the fact that introducing education in a variety of forms to health care providers surrounding the topic of HT and HTV symptomatology leads to an increase in confidence, knowledge, and dedication to improve the care of HTVs. Multiple studies highlight that the education or training does not have to be a specific type, but, in fact, every type of education or training has done the job of improving provider confidence in identification and treatment or referral of those being trafficked [25].

Rationale for Conducting the Review/Problem Statement

Research shows that HTVs go to health care systems in many settings (mostly emergency rooms), yet they are rarely identified or rescued. Providers acknowledge their lack of confidence and knowledge in the areas of background, identification, and treatment or referrals of HTV. This literature review was conducted to determine whether education or training in the above areas increases the confidence and actual identification and treatment of HTVs.

Purpose of the Project

The purpose of this literature review is to determine if education or training of health care providers increases their knowledge and ability to identify and treat or refer services to HTVs in health care settings.

Review Questions

What is the current health care provider knowledge regarding HT and ability to identify, treat, and refer HTVs?

Does education or training increase provider confidence, knowledge, ability to identify and treat or refer those individuals being trafficked?

Inclusion and Exclusion Criteria

This integrative review includes studies on health care provider education or training that improved providers' confidence and knowledge base related to identification, treatment, and referral of those persons being trafficked. It also includes research related to HT and victim accounts. There are several identified forms of education that improved provider knowledge, and none were excluded. Additionally, studies were done on providers with a variety of titles, and again, none were excluded. The selected studies were limited to peer-reviewed articles published between January 2015 and September 2021, but several outliers were also included, as they were original research sources. While studies with higher levels of evidence, such as systematic reviews and randomized control trials (RCTs), were prioritized, other studies with lower levels of evidence were included as systemic reviews and RCTs are scant.

Conceptual Framework

The conceptual framework used to complete this integrative review was developed by Whittemore, et al. [29]. Their framework provides a methodology for those who desire to secure research data to support an evidence-based practice initiative. The first step of the integrative review is to identify a problem that must be addressed with the review. The second step is the literature search. The goal of the literature search is to perform a comprehensive search of the available data on the topic of interest. To produce the most relevant data for the topic, the researcher limits their search via inclusion and exclusion criteria.

An integrative review, unlike a systematic review, honors more types of evidence, including experimental and non-experimental research. The researcher enters the data evaluation phase once all the available research has

been found on the topic. It is the data evaluation phase that the reviewer begins the laborious job of investigating data relevancy and accuracy. After appropriate research article selection has occurred, data analysis is performed to determine if the data selected answer the research question. One often-used method to analyze the data is a thematic analysis. According to Toronto, et al. [1] a thematic analysis enables the researcher to identify recurrent themes across multiple sources of literature. Theme identification aids the researcher in painting a picture of the main ideas relevant to the research question. Once the researcher compiles, evaluates, and analyzes their evidence base, the work of creating a convincing presentation of evidence for practice change can occur.

Comprehensive and Systematic Search

Search Organization and Reporting Strategies

- The process of the literature review began with the writer entering Boolean terms (pertinent key words) into appropriate databases, including CINAHL Plus with Full Text, Health Source: Nursing/Academic Edition, Medline, Cochrane, and Nursing & Allied Health Database. The keywords "healthcare," "healthcare providers," "emergency room/ER/emergency department/ED," "sex trafficked*," "human trafficked*," "labor trafficked*," "case characteristics," "methods of education" HT provider education.," and "mental health/physical health needs of those HT" were searched. Studies were excluded if they were not written between 2015 and 2021 and in English or were not focused on health care providers. Inclusion criteria were articles that were peer reviewed, full-text, published within the last five years, and focused on the identification and treatment/referral of HTVs in health care settings within the U.S. The population and demographics and location of the health care service were not defined in order to capture the full scope of potential victims and the health care settings where identification occurred.

A preliminary keyword search of the databases resulted in 300 articles. After exclusion criteria were applied, the search yielded 156 articles. Of these articles, 20 articles were excluded as duplicates. A further 100 articles were excluded based on content outside the scope of this project. Forty-four articles remained. This writer completed a thorough investigation of these studies, and in the end, 20 more articles were excluded as they did not pertain to identifying and treating/referring HTVs. In total, 24 articles were identified for this study. Appendix B contains a Preferred Reporting Items for Systemic Reviews and Meta-Analyses (PRISMA) diagram that details the process of article selection. The systematic process of this literature search was guided by the Toronto, et al. [1] review guidelines.

Toronto, et al. [1] book *"A Step-by-Step Guide to Conducting an Integrative Review"* provides a precise process for researchers to follow to when conducting an integrative review and was selected as the framework for this review. The entire research process is easily mapped out and includes the steps of identifying the purpose of the review, searching, selecting appropriate evidence, appraising, and analyzing the evidence, developing a conclusion, and disseminating findings.

Toronto, et al. [1] suggested using a specific framework to complete the literature review once the purpose is identified, and this framework is called the PRISMA method [30]. The PRISMA method allows for a comprehensive search of literature on the topic of interest. This framework was used for conducting the literature search for this review and was instrumental in determining which studies were included in the review.

Terminology

To start a literature review, the writer must select terminology to enter in the search fields in the chosen databases. Using appropriate terminology allows the most relevant literature to be identified, as it helps to narrow the data to the most beneficial for the integrative review. Once the terminology was identified for this review, the terms were entered into the search fields using Boolean logic. Boolean logic uses the operator *AND* ensures the search results will contain all the terms identified. To determine how education influences provider confidence and knowledge in the identification and treatment and referral HTVs, the following terms were identified as essential to include search database provider education: *human trafficking, identification, treatment,* and *referrals.*

Once the appropriate terminology was entered into the database search fields, all publications with those search terms populated. At times, it may be necessary for the researcher to adjust the search terms to ensure they receive the results they intend. Adjusting the search may also be needed if there are too many articles to review. It is important for the writer to narrow the results to a manageable amount in order to give appropriate investigation to the data retrieved.

Managing the Collected Data

Data Collection

A thorough systematic literature search process is key to ensure all relevant studies on the subject matter are appraised

for quality of evidence. Melnyk's levels of evidence served as the framework for appraising the quality of evidence [2]. Melnyk's, et al. [2] framework provides a tool that allows the researcher to assign a "level" to each piece of evidence being used. These levels consist of a hierarchy of evidence ranging from Level I through Level 7 and are conceptualized within a pyramid. Lower levels of evidence are on the bottom of the pyramid while the highest level is at the top. The lowest level of evidence (Level VI) is evidence from expert opinion, and the highest level (Level I) is evidence from a systematic review of RCT's. Higher levels indicate stronger evidence. Therefore, studies with higher levels of evidence are prioritized for inclusion in the review. Studies with higher levels of evidence, such as RCTs, are important, but studies with lower levels are also meaningful when limited data exist for the topic of interest.

Information Sources

The writer completed a systematic review of literature guided by PRISMA that ultimately yielded 23 pertinent publications. These publications were then placed in individual literature matrix boxes (Appendix A). The literature matrix demonstrates sufficient quality evidence from Melnyk's, et al. [2] levels of evidence, with the bulk of the evidence coming from Levels 1 through 6.

Once results are obtained from the database searches it is essential to investigate the reliability of the sources. Peer-reviewed articles are of the highest reliability. Peer reviewed means that experts on the subject have scrutinized the data to ensure their quality. Articles are scholarly work when the peer review process has occurred. This scholarly data help to build a strong case for a particular evidence-based practice.

Eligibility Criteria

Initial results of a literature search may yield excellent scholarly data, but not all data are relevant to the focus of the research. All result data are scrutinized to determine their applicability to the topic of interest. To determine eligibility for inclusion, the results are narrowed using inclusion and exclusion criteria. As aforementioned, studies included in this integrative review must include the terms *healthcare provider education, HT/HTV, identification, treatment,* and or *referral.* To ensure the most current data, only articles published in the last six years were included, and those articles needed to be in English.

Once the narrowing of articles has occurred using inclusion and exclusion criteria, the researcher briefly reviews the articles to determine their applicability in addressing the identified problem. When dealing with large volumes of article results, reading the abstracts is beneficial to begin the selection process for required material. After the initial selection of articles, the researcher reads the entire articles to determine those which are most appropriate to the research goal.

Quality Appraisal

To ensure the rigor of the integrative review, an appraisal of the evidence was conducted. All the studies included in this integrative review were analyzed according to Melnyk's, et al. [2] levels of evidence and placed on individual literature matrix charts. These literature matrix charts (Appendix A), served as tools to examine the applicability of the results.

Sources of Bias

Conducting an appraisal of the evidence allows the researcher to identify any inherent biases within the collected literature. A common source of bias unearthed during the appraisal for this literature review is that some studies that were not randomized were used or included in systematic reviews were ultimately used. These non-randomized studies may have limited applicability because the researcher determines the participants assigned to the control group versus the intervention group. This non-random allocation has the potential to cause problems with internal validity.

Internal Validity

Internal validity deals with the degree to which the study results can be attributed to the intervention. When problems arise with internal validity, the study may not be useful to the general population. For example, if a study participant has had a positive experience with a certain form of education or training in the past and partakes in the current education or training knowing that they will be assigned to a group using that form of education or training as an intervention, the results may be biased. The researcher then must ask, can the results be attributed to the educational intervention, or were they affected by the participant's bias toward the form of the education intervention itself, versus the content?.

Another concern for internal validity lies in the population of those labeled providers in some of the research. There were very few studies with just nurses and doctors (traditional provider professions) as participants, as most studies included other job entities such as security officers, transport personnel, certified nursing assistants, and unit secretaries. This factor can limit the generalizability to just "providers." Fortunately, many studies included only nurses, so these publications were given more weight.

Reporting Guidelines

The literature search process was performed using PRISMA guidelines [30]. The researcher can be confident that appropriate evidence is secured for their literature review when using PRISMA as a framework. Using the PRISMA framework allows all the published data on the topic of interest to be narrowed to manageable amounts to be analyzed. This PRISMA process can be visualized on the PRISMA flow diagram, found in Appendix B.

Quality Appraisal and Synthesis

Data Analysis

The integrative review utilized the data analysis framework from Whittemore, et al. [29]. Their framework involves performing the five steps of data reduction, data display, data comparison, and drawing conclusions. Data reduction was completed using the PRISMA guidelines. The development of a visual display was supported by the use of Melnyk's levels of evidence and involved the evaluation of each research article or report for evidence and determining strength for use. Once evaluated, the research or report was placed on visual displays known as literature matrix tables. These literature matrix tables served as tools for comparison of the data (Appendix A). Elements depicted on the literature matrix tables include study purpose, level of evidence, sample characteristics, methods, level of evidence according to Melnyk's method, and whether there is sufficient evidence for or against an evidence-based practice change. Analyzing the literature matrix for these elements ensures a thorough analysis of data.

Analysis of the Literature

The purpose of each of the studies contained in this integrative review is to examine the current level of health care provider knowledge around HT/HTVs and to identify education or training that increases knowledge and ability in how to identify and treat or refer these persons for the help they need. Despite having the same purpose, many other elements of these articles differ. These studies differ in study design, education/training delivery, population focus, sample size, outcome measures, and measurement tools. The general lack of RCTs is a glaring gap in this research topic, as is the lack of studies using a theoretical design to guide the education/training research.

Design is one of the most notable differences in the studies. A variety of study designs made it into this integrative review including, but not limited to, systematic reviews, group RCTs, non-RCTs, cohort studies, quasi-experimental pre/post design, retrospective pre/post surveys, and qualitative studies. This writer found three systematic reviews and two scoping reviews that provided significant support for the overwhelming gap in health care provider knowledge around HT treatment and the awareness that any form of education or training for providers around HT/HTV improves knowledge, confidence, and referral ability [31]. A total of 53 studies were examined; however, some were duplicates, as one or more systematic reviews may have included the same studies in their analysis.

The complete list of articles was analyzed to identify common themes pertaining to the population being trafficked and health care provider education needs and methods to improve confidence in treating those being trafficked. The three themes that emerged for the population being trafficked were (a) those at risk, (b) case characteristics for children and adults, and (c) mental and physical health needs of survivors. The two themes that emerged related to health care provider education were (a) settings for education and health care provider participants, and (b) methods for education delivery.

Population Themes

- **Those at Risk**

Being a youth and female are the biggest risk factors for being trafficked, but trafficking can occur to any vulnerable person. It does not matter where one lives (though it is easier to hide in rural areas), as trafficking happens globally and in every U.S. state. The highest population of HTVs in the U.S. for sex and forced labor trafficking are youth that are homeless, runaways, orphans, throwaways and those in the juvenile court services, poverty, or foster care. There are an estimated 1.6 million youth in these populations and their average age when entering HT is 12 to 14. The most common way that HTVs enter the HT world is recruitment. Recruitment typically occurs by victims' peers, through social media, or through the virtual gaming world.

Adults also are used for HT and are also recruited, abducted, or harbored for sex, or forced labor. Risk factors and highest populations of adult HTV are like those for youth: individuals that are marginalized, poor, drug addicted, mentally ill, or are in the U.S. illegally. Labor trafficking occurs across borders under the guise of work for hire, arranged marriage, or other false pretenses.

- **Case Characteristics for Children and Adults**

In a retroactive cohort study on 41 minor sex trafficked patients from 2013 top 2015, researchers found that patients had frequent contact with medical providers at pediatricians' offices, walk-in clinics, and emergency rooms, and 81% had been seen in the same year that their HT began.

Sexual abuse and extreme family dysfunction were identified in 57% (21 of 37) of the children. Parental substance abuse patterns were noted in 60% (22 of 41) of the families. Medical problems such as STIs were found in 32% (13 of 41) children. Psychiatric conditions such as having suicidal ideation as noted in 20% (8 of 41) of the children, and at least one psychiatric admission occurred 46% or (19 of 41) for these children. Substance use occurred in 88% (36 of 41) of the children. Runaways accounted for 42% (17 of 41) of this group, and 71% (29 of 41) lived at home. This information aligns with the report and education materials used by the Academy of Pediatrics and other studies.

A five-year analysis exploring case characteristics of 698 children in the Kentucky welfare system who were alleged to be trafficked between 2013 and 2017 found an alarming number of children were trafficked by a family member, and often the trafficking occurred in the [8]. Kentucky has some of the highest rates of child abuse and neglect, youth homelessness, and substance use in the nation, so these statistics align with the risk factors found in the studies. This report from Kentucky mirrors what is happening in states across the U.S. [32].

A systematic review of six studies looking at exit and post-exit interventions for 155 adult females and six adult male HT survivors (of all types) from four countries provides insight into the risk factors for the adult HTV. As mentioned before, being a woman, poor, marginalized, mentally ill, addicted to substances, homeless, or an illegal alien puts individuals at risk for HT. Case characteristics included physical and sexual abuse findings such as bruises, broken bones, abdominal or vaginal trauma, STI's, unwanted pregnancies, dehydration, extreme sun exposure, isolation, malnourishment, and chronic illnesses. Mental health issues included PTSD, anxiety, depression, fear, phobias, and substance use disorders. Multiple studies agree with these findings.

- **Mental and Physical Health Needs of Survivors**

Case characteristics of child, youth, and adult HTVs of all types provide a glimpse into their mental, physical, environmental and spiritual health needs. The research surrounding the vast array of needs for survivors of HT of all ages is limited, and even scarcer are studies evaluating any of the interventions applied thus far. Recommendations from professional medical groups, HT survivors, and HT experts suggest a multitude of interventions need to occur to improve current and long-term health for HTVs. Interventions such as trauma-informed care approaches, mental health services, medical services, legal services, social services, help with community reintegration, spiritual services, and employment are top priorities beyond the initial safety/rescue need.

Provider Themes

- **Methods of Healthcare Provider Education/Training**

Generally, pre-intervention surveys and tests indicated a lack of knowledge and confidence amongst all levels of emergency department staff and medical providers, regardless of hospital location or type of participants (e.g., clinical versus nonclinical) related to all areas of HT/HTVs for identification and treatment or referrals. Because there is no universal evidence-based education program for providers, and the needs differ depending on practitioner/job title, most studies created their own educational intervention. One study borrowed a validated emergency room education video from HTEmergency.com and Chisolm-Straker, et al. [17] developed a screening tool for identification of adult HTVs, implemented it across five New York City hospitals (N = 4,127), and validated the tool (RAFT) with the identification of 36 possible HTVs and 12 confirmed HTVs. Each study evaluated learning using different tools, and each study reported an increase in provider confidence and knowledge around HT identification, treatment, and referral.

In-person trainings were implemented at work sites in the forms of didactic training sessions [16] PowerPoint/case study discussions, change-of-shift in-person training with supplemental video training [5], during nurse's station huddles, and simulations. Conference education/trainings were utilized by Cole, et al. [19] and Barishaj et al. Online education was utilized by Greiner, et al. [22]. Pre- and post-testing were utilized in all these studies in the form of Likert scales, confidence scales, surveys, and exams.

- **Healthcare Settings for Education and Participants**

In the U.S., 68% to 87% of HTVs seek medical care while being trafficked at least once. Most victims seek care through the emergency department, although dentists, pediatricians, walk-in clinics and obstetrician-gynecologists also see them because they lack medical insurance, regular or legal status in the country, or access to other medical care [33]. Emergency department personnel have historically received no or inadequate training on HT, despite their settings being the most common location visited by those being trafficked. Every study in the integrative review reported that doctors, nurses, and other health care workers in every health care setting are often ill equipped to recognize trafficked persons, screen them, and treat them or refer them to appropriate services. This lack of adequate education and training contributes to the staggering negative health outcomes for this those being trafficked.

The diversity of the U.S. health care system is reflected in the review, with studies taking place all over the country, with a wide variety of emergency department staff/providers, in emergency departments small and large, and in trauma and

non-trauma emergency departments. Interventions were implemented in locations across the US, including California, Boston, Pennsylvania, Texas, New York, Chicago, and Maine. Most interventions were implemented in their respective emergency department, each of which served an annual patient census ranging from 41,000 to 173,225 [34,35].

The number of participants included in each intervention ranged from 19 to 4,127. Most of the studies included a wide variety of emergency department staff, providers, and hospital providers.

Ethical Considerations

The writer completed the Collaborative Institutional Training Initiative training prior to this integrative review, and the completion certificate can be found in Appendix C. This integrative review did not involve human subjects and therefore was exempt from Institutional Review Board approval (Appendix D).

Limitations

There are several limitations of this integrative review. The first is that it was performed by a single researcher, and there could be some internal bias from the researcher's previous work in the emergency department. A PRISMA flow chart was used in the critique of articles selected to mitigate bias. In addition to personal bias limiting the conclusions, several limitations exist with the studies selected for this review, as limited higher-level research is available on this subject.

The lack of evidence-based education programs on HT and the diversity of the education approaches, settings, and providers educated made it challenging to find studies that focused on just one technique. Due to this challenge, it is unclear whether one specific form of education or training is more beneficial than another. Future studies focusing on one education program are necessary to determine best practices. Another limitation noted is that different specialties were educated together in numerous studies, which limits the provider results. Lastly, several studies included in the review used small samples, limiting generalizability to the larger population. Due to all these limitations, future studies involving a single education program or training intervention using larger samples of specific provider populations would be beneficial to generalize the findings to the population of interest.

Implications for Practice

This integrative review revealed that the current level of health care provider awareness on HT, across the spectrum of professions is low, as is the ability to identify, treat, and refer HTVs. This review also found that educating or training health care providers (no matter the method) gives them more confidence and immediate knowledge in their ability to identify, treat and refer HTVs, but the actual transfer of knowledge to practice with HTVs identified and treated/referred was only noted in three of the studies. This gap in knowledge transfer highlights the glaring need for research to assess not only education effectiveness in the moment but also whether the education or training intervention led to a practice change and increased identification, treatment, and referral of HTVs.

Dissemination

The fact that HT has reached epidemic proportions and is a criminal-run industry highlights the urgency for health care providers and organizations to tackle this human crisis through policy, procedures, research, and education and to do so now. Being part of the solution to this crisis is important to this author and dissemination of these literature review findings is just the beginning. This literature review will be submitted to Liberty University's Scholars Crossing as well as submitted for publication to the *Emergency Nurses Journal* and the *Journal of Forensic Nursing*.

This author currently works for a holistic nursing program that has a trauma-informed approach to nursing interventions, so this integrative review content will be shared with faculty as the program continues to add to the mental health unit on abuse/trauma and sexual assault. Senior students will also benefit from this information as they learn triage skills to identify abused and trafficked persons via simulations and lab sessions.

Discussion

The purpose of this review was to ascertain the current level of provider knowledge related to HT/HTV identification in the U.S. and find out if education/training increased their level of knowledge to identify, treat and or refer those being trafficked. The integrative review clearly showed that providers across the U.S. do not hold sufficient knowledge in HT and are not currently equipped to identify, treat or refer HT in almost every setting studied. A plethora of research identifies those populations at-risk for HT in the U.S./worldwide, as well as much discussion as to their needs depending on HT experience. These literature findings also clearly identify that HTVs frequent a variety of health care settings while in captivity, with the emergency department being the most visited. Multitudes of educational interventions have been shown to increase the confidence and ability to identify HTVs as well as increase understanding of referral needs post intervention. Despite the research that

shows education is needed and indeed improves knowledge and identification/referral ability, the glaring lack of HT education in health care for providers is a key barrier to providers' ability to assist this vulnerable population. Another issue noted in this integrative review is that despite education and new knowledge, only two studies indicated that providers went on to implement practice changes and identify HTVs. The lack of standardized evidence-based education for health care providers, and the lack of validated screening tools are also barriers to the identification of HTVs.

As the research indicates that HTVs visit multiple health care settings while in captivity, it is imperative that all health care professionals be educated on HT and understand their part of the intervention/treatment/referral process. Medical and nursing licensure requirements can be adjusted to include this training as well as trauma-informed care. This knowledge can be evaluated in the professional work setting during annual competency trainings. Despite the lack of evidence-based education and screening tools, screening for HT needs to become routine with every patient, at every visit, just like suicidal ideation and safety at home is.

Future research and development of evidence-based HT education around identification, treatment and referral is imperative, as is the development of and research on screening tools. As mentioned earlier in this review, only 60 out of 6,000 U.S. hospital organizations have a policy, procedure, or employee education initiative in place to identify and potentially rescue HTVs, so it is crucial to have a national push to have all hospital organizations combat this human crisis. High-quality research, such as RCTs and control trials, is needed to give health care providers evidence-based resources. Descriptive and cohort studies are a good place to resource HTV stories to identify screening tools, treatment algorithms, and referral needs.

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