Case Report

Human Trafficking: How Nurses Can Make a Difference

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ABSTRACT

Human trafficking is a human rights violation and a global health problem. Victims of human trafficking have medical and mental health sequelae requiring specific healthcare interventions. Healthcare professionals may be the initial contact that these victims make outside the world of trafficking. Healthcare professionals are key agents in the identification of human trafficking, which is essential in eliminating this public health problem. Unfortunately, healthcare professionals are not always able to detect signs of human trafficking. Failure to detect results in missed opportunities to assist victims. This is a case report of a victim of human trafficking who presented to an emergency department with medical and mental health issues. Despite numerous encounters with different healthcare professionals, signs and symptoms of human trafficking were not identified. Skilled assessment made by a forensic nurse alerted the healthcare team to clear features of human trafficking associated with this person. Through this case report we illustrate the key role the nurse played in identifying signs of human trafficking. Improvement of human trafficking educational programs is highlighted as a key adjunct to improving detection and facilitating the proper treatment of victims.

KEY WORDS:

Case study; education; human trafficking; identification; sexual trafficking; training; violence

Background and Significance

Human trafficking (HT) is a human rights violation and a global health problem. HT is defined as "the recruitment, transportation, transfer, [and] harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, abduction, fraud, deception, the abuse of power a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation" (United Nations, 2000, p. 2). In 2014, the United Nations reported that 31,766 HT victims had been identified globally (United Nations Office on Drugs and Crime [UNDOC], 2016). Accurate data on the prevalence of HT are difficult to define due to the hidden nature of this crime. Victims are often transient and frequently made to travel to different countries, are distrustful of health and government officials, or remain hidden through forceful measures applied by traffickers (Panigabutra-Roberts, 2012; UNDOC, 2016).

HT includes a wide range of abuse, including sexual exploitation, forced labor, slavery, domestic/involuntary servitude, organ harvesting, drug sales, armed combat, begging, forced marriage, and illegal child adoption (Banks & Kyckelhahn, 2011; UNDOC, 2016). Victims may experience a single type of abuse but often endure several types of abuse concurrently (Banks & Kyckelhahn, 2011). HT victims cross all demographics. Males, females, adults, and children can be trafficked within their country of residence or trafficked to other countries. In the United States, victims are usually from the United States, Mexico, and the Philippines; the top three countries of HT victims (UNDOC,

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2016). At-risk groups for HT include vulnerable populations such as runaways, homeless youth, American and Alaskan Indigenous people, persons with disabilities, and members of the lesbian, gay, bisexual, and transgender/queer communities (U.S. Department of State, 2017).

Sex trafficking is the most common form of HT, followed by labor trafficking (UNDOC, 2016). These forms of trafficking largely affect younger women. Blacks are trafficked with a greater frequency than their White counterparts (Banks & Kyckelhahn, 2011; UNDOC, 2016). Risk factors for sex trafficking include history of sexual abuse, homelessness, financial instability, lack of social supports, exposure to domestic violence, parental substance use, and dysfunctional family dynamics (Jani & Anstadt, 2013; Kiss et al., 2012; Kiss, Yun, Pocock, & Zimmerman, 2015; Macias-Konstantopoulos et al., 2015). Victims of sex trafficking are often lured into trafficking under the guise of a romantic relationship with the trafficker. The trafficker creates a situation where trust, romantic feelings, and dependency are established. This relationship then progresses to coercion and sexual exploitation (Wilson & Dalton, 2008). Sexual exploitation can include forms of pornography, prostitution, victim involvement in illegal escort activities, strip club work, or any other sexual practice that is forced on the victim without his or her consent.

In addition to sexual exploitation, HT victims often endure significant physical and psychological abuse. Traffickers often use physical violence to maintain control of HT victims. Violence can be used to force victims into submission. Along with violence, isolation may be used as a form of punishment. Traffickers maintain control by showing that any choice other than to remain in captivity will result in severe and permanent injury. Victims of sex trafficking can experience sexually transmitted infections, unwanted pregnancies, medically unsafe abortions, miscarriages, and pelvic inflammatory disease (Macias-Konstantopoulos et al., 2015). In addition, psychological abuse is often used as a tactic to enforce submission of the HT victim. Fear can be a powerful catalyst used by traffickers to gain victim compliance. Traffickers frequently engage in tactics that negatively impact a victim's mental health, such as isolation, sleep deprivation, threats, and humiliation. The psychological tactics used on victims are so ingrained in victims' psyche that, even without the presence of the trafficker, victims are fearful, submissive, and under their control (Baldwin, Fehrenbacher, & Eisenman, 2014). The psychological sequelae of trafficking includes posttraumatic stress disorder, depression, anxiety, suicidal ideation, homicidal ideation, and self-inflicted injuries; psychosis, dissociative disorders, and panic disorders can also develop because of the psychological stress of HT (Kiss et al., 2015; Macias-Konstantopoulos et al., 2015). In addition to the traumatic experiences of HT, victims of HT who are kidnapped or detained against their will may endure despicable living conditions. Limited access to food and water and overcrowded, dangerous, and unsanitary environmental conditions may result in extreme stress for the victim. Traffickers can use deprivation to coerce victims into using illicit drugs that may result in dependency/addiction and drug-related disease processes (Kiss et al., 2015).

Victims may seek healthcare while being trafficked, making healthcare professionals, especially those who work in acute care settings where HT victims are more likely to present, critical agents in any effort to help HT victims. Current research has shown that HT remains underidentified by healthcare providers and opportunities to help victims are often missed (Grace, Ahn, & Macias-Konstantopoulos, 2014). Emergency room providers have been identified as the primary healthcare provider HT victims may encounter while still being trafficked. Only 4.8% of emergency care professionals reported confidence in their ability to identify HT victims (Chisolm-Straker et al., 2016; Chisolm-Straker, Richardson, & Cossio, 2012). This case report highlights missed opportunities for identification of HT. It also illustrates the need to improve HT education in healthcare settings.

Description of Case

Brittany, a 19-year-old woman, presented to the emergency department (ED) twice in a single day with two different complaints. Her past medical history included bipolar disorder and suicidal ideation with previous suicide attempts; her social history included homelessness with episodic foster care placement as a minor due to history of maltreatment/abuse that was undefined in her medical record. Brittany endorsed smoking cigarettes and regular marijuana use. Brittany's initial presentation to the emergency department was after a motor vehicle accident. She arrived to the ED via ambulance, lying flat on a backboard immobilized with a cervical spine collar for a trauma evaluation. On arrival, her primary concern was her presumed pregnancy; she was holding a picture of an ultrasound image of a fetus with an estimated gestational age of 8–10 weeks. Given the extent of the motor vehicle accident, concern for traumatic injury, and presumed pregnancy, a code trauma was activated. A code trauma entails a complete head-to-toe trauma assessment conducted by emergency doctors and nurses and the surgical trauma team. The result of her evaluation was negative for traumatic injuries; bedside ultrasound and laboratory blood work did not reveal evidence of a pregnancy. To confirm this finding, Brittany then received a pelvic ultrasound, which again confirmed that she was not. She was informed of this finding, became distraught, and then was seen by the ED social worker for pregnancy loss. She was discharged home and instructed to follow up with her primary obstetrician.

Several hours after discharge, Brittany returned to the ED with a complaint of depression and suicide ideation stemming from what she believed to be the loss of a pregnancy. She was placed on a suicide protocol that included the removal of all belongings and clothing, except underwear, as part of a personal safety process. Brittany was assessed by emergency doctors, emergency nurses, a psychiatrist, and a social worker. She was deemed not to have an active suicide plan, and the decision was made to transfer Brittany to a voluntary crisis stabilization unit (CSU). This process took more than 24 hours because of lack of bed availability at the CSU. Brittany continued to receive regular routine care from the emergency and psychiatric healthcare teams as she awaited placement.

While Brittany was awaiting transport to the CSU, one of the emergency nurses certified as a sexual assault nurse examiner (SANE) overheard a discussion between two staff members related to Brittany and an unusual tattoo of a man's name across her chest. The SANE recognized this finding as a possible sign of HT, alerted the emergency healthcare team to the concern for HT, and proceeded to conduct a forensic interview with the patient. During the interview, the patient opened up and reported episodes of being forced into sexual activities with strangers for money and drugs by a person she identified as her current boyfriend. Brittany also reported emotional abuse, being isolated from family and friends, and safety concerns regarding her ability to end the relationship. After the SANE evaluation, the emergency team deemed her appropriate to continue with the transfer to the CSU where she could receive follow-up care for the HT concerns. However, it was reported back to the hospital, that within a few hours of arriving at the CSU, Brittany's boyfriend arrived at the unit. He was granted access, as it was a voluntary unit, and talked her into leaving the facility with him, which she did, never receiving follow-up care for HT issues.

Summary of Key Findings

The case presented is consistent with previously known high-risk factors associated with HT. The victim had a long-standing history of reproductive health complications, psychiatric illness, unstable living situations, poor support systems, and recreational drug use. Brittany did not self-identify as a victim of HT; however, like many other victims, she may encounter multiple healthcare providers without being identified at risk or a current victim of HT. In addition, this patient had an unusual tattoo, which was seen by many healthcare professionals when she undressed for the head-to-toe trauma evaluation and a second time for the psychiatric assessment and suicide protocol. Tattooing, also known as branding, is one of the more obvious physical indicators that a person may be a victim of HT (Sabella, 2011). Despite multiple healthcare professionals conducting assessments who would have seen the unusual tattoo, it was not picked up as a red flag until the SANE happened to hear a conversation where this unusual tattoo was being discussed. This case illustrates the value of having forensic nurses and SANEs in the ED.

Although the patient was lost during follow-up, an SANE successfully engaged the patient in a meaningful dialogue that resulted in disclosure of HT. In this case, there was a delay in identifying the patient as a victim of HT, given the length of time she spent in the ED; there may have been a different outcome if these resources were implemented in the beginning of her ED visit rather than as a follow-up process. This case also highlights a need for psychiatric nurse practitioners. Psychiatric nurse practitioners who are forensically trained and knowledgeable about HT issues can evaluate patients in acute crisis and assess for HT signs early. Powerful psychological coercion and fear often result in victims returning to trafficking situations, despite the availability of resources for exiting these situations (Baldwin et al., 2014). Having early psychiatric care is necessary to address the psychological impact a trafficker has on his or her victim, which is necessary to help victims gain the necessary tools to leave the trafficking situation.

Implication for Forensic Nurses

Studies support the finding that HT education enhances healthcare professionals' ability to increase awareness, identification, and treatment and improve healthcare outcomes for victims of HT (Chisolm-Straker et al., 2012; Egyud, Stephens, Swanson-Bierman, DiCuccio, & Whiteman, 2017; Grace, Lippert, et al., 2014; Ross et al., 2015; Viergever, West, Borland, & Zimmerman, 2015). Lack of HT identification education has been noted as a primary reason for a decrease in awareness of HT warning signs and proper identification among healthcare providers (Hachey & Phillippi, 2017). For some HT victims, opportunities to exit a trafficking situation may be limited, and healthcare providers must be aware of possible signs of HT so that opportunities to help victims are not lost. Emergency department nurses who can identify at-risk patients of HT can then make necessary referrals to professionals, such as a psychiatric nurse practitioner, skilled in helping HT victims in the acute traumatic stages of being trafficked, and able to help develop a plan for a safe exit out of a trafficking situation.

HT education for healthcare providers must include the following key elements:

- Scope of the problem: global/medical/psychosocial impact and financial cost
- HT identification: forensic interviewing techniques and common physical signs and symptoms
- Medical treatment that is guided with trauma-informed care (TIC) principles

- Psychological treatment: role of forensic trained psychiatric nurse practitioners
- Safety measures: victim risk assessment to include exiting strategies and reacclimating to the nontrafficking environment
- Resources: access to both inpatient and outpatient HT-specific treatment modalities

In efforts to support patients in a comprehensive manner, it is essential that HT education have its foundation in TIC principles. TIC is patient centered, culturally respectful, gender sensitive, and inclusive of sexuality and individual history of trauma (U.S. Department of Justice, 2014). TIC helps to guide healthcare professionals in delivering healthcare that respects individual trauma history as fundamental to all current and ongoing medical, psychological, and safety needs. TIC prevents the revictimization of HT survivors by providing highly sensitive patient-centered care that is considerate of the patient's previous or current trauma history (U.S. Department of Justice, 2014). Forensic nurses can take the lead in HT education by advocating for TIC training as part of all HT education. Forensic nurses have a solid knowledge base in TIC, often work in EDs and typically have experience in caring for victims of HT. Education should focus on specific protocols but should consider that examples gained from personal experiences can enhance teaching methods and promote greater levels of understanding in terms of victim typology and presentation.

Other methods of HT education have also proven effective. Egyud and colleagues (2017) developed an educational training session for all emergency personnel, which included common HT clinical presentations and social circumstances. This educational platform was implemented as part of a screening tool designed to identify HT victims. Survey findings indicated an increase in perceived provider competence for HT identification for all personnel utilizing the tool (Eyed et al., 2017). Viergever and colleagues (2015) developed a 2-day training program and a handbook on caring for victims of HT. After surveying, providers who had participated in the program found this form of HT education useful to their practice. Unfortunately, it is not feasible for all healthcare professionals to attend extended training sessions. Methods for HT education may need to be implemented through a wide variety of educational platforms. Scannell, Lewis-O'Connor, and Barash (2015) implemented an interprofessional educational program for healthcare providers caring for sexual assault victims that included didactic HT education and simulation training in the care of HT victims. Although sexual assault education is not exclusively related to all areas of HT, it allowed for participants to learn about the most common form of HT, warning signs, and available resources, which are relevant to other forms of HT.

One area of policy implication is the need for forensic nurses to work in EDs. The availability of a forensic nurse or an SANE varies across healthcare institutions. Some healthcare institutions offer these services within the ED or hospital. Other healthcare institutions may access these services via an external agency. Some agencies do not have access to forensic or SANE nurses and utilize employed providers who may not have the clinical or educational background to care for HT victims and other forensic patients. When forensic nurses or SANEs are a part of EDs, identification of high-risk patients and access to critical services can be facilitated in a timely manner.

Mental health practitioners can also play a critical role in identifying and treating victims of HT. Researchers have recognized the serious impact HT has on mental health and the need to address the psychological well-being of survivors (Zimmerman, Hossain, & Watts, 2011). Proper support mechanisms in the setting of an acute trauma can make the difference between victim recovery and victim mental health crisis. Psychiatric nurse practitioners are skilled in interviewing patients and helpful in therapy techniques to motivate HT victims to seek help, overcome fears, and help to treat with proper medications. This case illustrates the need to screen all patients for HT, but particularly those who present with an acute mental health crisis.

HT is a global problem and crosses many different demographics. Educational efforts are underway within the public where other types of professionals may encounter HT victims. For example, cases of HT are often seen more in stagnating cities located near international borders and highway systems where encounters with federal government agents may occur (Wilson & Dalton, 2008). In 2016, the U.S. Homeland Security Department implemented training for personnel to raise awareness, collect data, and provide immigration relief for victims of HT who had illegally crossed borders (Clark, 2016). A recent U.S. Senate bill was passed to provide support services and funding to local and state government and law enforcement agencies (Office of the Senator John Cornyn, 2017). There is a growing international effort to address all forms of HT (Efra, 2016). Forensic nurses often have established relationships with other disciplines and work collaboratively with other healthcare professionals to improve awareness and increase identification of HT victims.

Conclusion

HT is a serious public health crisis that affects individuals, families, and society. Identification of HT can be challenging for healthcare professionals due to the covert nature of trafficking and the often-complex clinical presentations of these patients. Healthcare providers must have comprehensive education to identify and treat victims of HT. Nurses are usually the first caregivers to interact with patients.

Emergency departments are the primary and often sole gateway to the healthcare system for HT victims. The presence of specialty nurses such as forensic nurses, SANEs, and psychiatric nurse practitioners in the emergency department can increase the degree of HT detection through the provision of expert assessment skills (Sabella, 2011). The case study presented herein provides insight into some factors that lead to the complexity of caring for victims of HT.

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