HEALTHCARE PROVIDER EDUCATION FOR RECOGNIZING AND ASSISTING VICTIMS OF HUMAN TRAFFICKING

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The Supervisory Committee certifies that this ***disquisition*** complies with North Dakota State University's regulations and meets the accepted standards for the degree of

DOCTOR OF NURSING PRACTICE

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ABSTRACT

Human trafficking has increasing prevalence in the United States (U.S.) with an estimated 1.6 million people trafficked at any time. Healthcare systems are one of the most critical access points for identifying and recognizing victims of human trafficking. Unfortunately, a majority of healthcare providers have never received training on human trafficking. There are approximately 835 nurse practitioners (NPs) within North Dakota (ND). With increasing prevalence of human trafficking in the U.S., education for healthcare providers must be provided to aid in the fight against human trafficking.

The purpose of this practice improvement project (PIP) was to increase NP perceived knowledge and confidence regarding human trafficking prevalence, identification, and resource utilization within ND by providing online education and resources for use within the clinical setting. This PIP consisted of two, one and a half hour educational sessions that were electronically deployed to NPs throughout ND through email, the North Dakota Nurse Practitioner annual pharmacology conference, and word of mouth. Pre- and post-surveys helped evaluate if the educational sessions improved NP perceived knowledge and confidence levels regarding human trafficking. The surveys also helped determine if NPs would utilize an online toolkit in practice.

Ten NPs completed the pre- and post-surveys. The co-investigator found that nine respondents (N=10) had increased levels of perceived knowledge regarding identifying potential human trafficking victims and eight respondents showed an increase in perceived level of confidence in managing a potential or identified victim of human trafficking. Nine participants indicated that the toolkit was comprehensive and fit the needs of their practice and a majority of respondents indicated that they would use the toolkit in the clinical setting.

Although results supported the purpose of the PIP, the co-investigator would advocate for further research to determine best modalities to increase provider human trafficking education participation in ND. Developing connections with healthcare facilities and the North Dakota Human Trafficking Task Force (NDHTTF) will also allow for continued dissemination of this education for healthcare providers. Although limitations from this PIP exist, the comprehensive education and delivery method met the needs of the NPs who participated.

DEDICATION

Brandon- Thank you for continuing to push me to succeed, constantly teaching me and answering my questions, helping me to learn and grow, encouraging me to dream big, showing me what true dedication, hard work and passion look like, and for being my person every single day. I am eternally grateful for you.

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CHAPTER 1: INTRODUCTION

Background and Significance

Human trafficking is defined as the use of force, fraud, or coercion to make individuals perform commercial sexual acts or labor (Williams & Jacobson, 2017). Human trafficking, also referred to as modern day slavery, is the second largest illegal business market in the world and generates $150 billion dollars each year. An estimated 40.3 million people are victims of human trafficking worldwide (Shin et al., 2020). In the United States (U.S.), 1.6 million people are estimated to be trafficked at any given time (Conrad, 2018; Donahue et al., 2019). Notably, an estimated 88% of human trafficking victims come into contact with the healthcare system while they are being trafficked; the majority are not recognized by healthcare providers (Donahue et al., 2019). Due to the increasing awareness as well as the negative health outcomes associated with human trafficking, healthcare providers, specifically nurse practitioners (NPs), can be a vital point of contact to help victims when presenting to the healthcare setting (Shin et al., 2020).

Healthcare professionals have emerged as first-line identifiers of human trafficking victims and are in a crucial position to reduce health related consequences and provide resources to identified victims. Unfortunately, the majority of healthcare providers have not received formal education on human trafficking (Shin et al., 2020). Lack of awareness and education by the healthcare provider, as well as increased victims' fear, creates an environment of under reporting and missed opportunities for victim recognition.

Out of the 6,000 U.S. hospitals, approximately 1.0% have policies and procedures in place for treating victims of human trafficking (Donahue et al., 2019). While a majority of providers report that human trafficking education is important to their practice, fewer than 3% had ever received training in victim recognition (Lo et al., 2020). Healthcare providers lack

formal education regarding human trafficking and are not prepared to identify and interact with victims with whom they may come into contact.

Unfortunately, standardized education is not readily available to healthcare providers, making useful access to education difficult. Education regarding victims' red flags, common diagnoses, pimp identification, provider-victim rapport, mandatory reporting regulations, and resource awareness are gaps in provider education. This practice improvement project (PIP) was one resource to help address these gaps. Provider education should be condensed to pertinent information on victim assessment skills, interview strategies, giving the possible victim a sense of control to build rapport and trust, recognizing pimp involvement and control strategies, common situations where human trafficking often arises, and resources providers can lend to help a potential victim ensure a safe journey out of a potential human trafficking situation (Lo et al., 2019; Lederer & Wetzel, 2014; Miller, 2021; Polaris, 2020; Williams & Jacobson, 2017). As requested by healthcare providers and as a result of the gap in literature for education, the co-investigator of this practice improvement project (PIP) developed an educational session to increase the perceived knowledge and confidence in human trafficking victim identification and provide an online resource toolkit for healthcare providers throughout the state of North Dakota (ND).

Problem Statement

There is a gap in the literature, as well as a need identified within healthcare systems in ND, to provide human trafficking support and education for healthcare providers. Education provided will help healthcare providers to identify victims of human trafficking and link victims to available resources within the community. At any given time, 1.6 million individuals are being trafficked within the U.S. and 514 victims have been identified in ND since 2015 (North Dakota

Human Trafficking Task Force [NDHTTF], n.d.). Based off of these statistics, human trafficking is prevalent within ND. Healthcare providers have received limited to no education during their training and only one percent of U.S. hospitals have policies and procedures in place to help providers recognize, identify, and assist victims of human trafficking (Lo et al., 2020).

Although there is no current data specific to ND, Grace et al. (2014) found that 29% of emergency department (ED) personnel thought that human trafficking was a problem in their ED and only 13% of healthcare providers felt confident in victim identification. The need for increased education was further demonstrated when the principal investigator was approached by a local healthcare provider requesting education to be available. When healthcare providers "fail to rescue trafficked victims, they unintentionally perpetuate the illegal world of trafficking that robs human beings of their lives and freedom" (Raker, 2020, p. 692). Lack of healthcare provider knowledge leads to under recognition of victims of human trafficking, which leads to lifelong health consequences for the victims. "Victims of human trafficking endure significant physical injuries and psychological abuse with serious complications such as HIV/AIDS, sexually transmitted infections, broken bones, dental problems, malnutrition, depression, anxiety, and post-traumatic stress disorder" (Raker, 2020, p. 692). Healthcare provider education is necessary in order to help stop the cycle of human trafficking and protect victims from the associated health consequences.

Purpose

The purpose of this practice improvement project was to increase provider perceived knowledge and confidence regarding human trafficking prevalence, identification, and resource utilization within ND. Healthcare providers have acknowledged a gap in their education regarding human trafficking, victim identification, recognition, and best practices for assisting

victims (Lo et al., 2020). Healthcare providers' decreased knowledge can put victims at risk for not being identified and not having adequate resources available to them. Once healthcare providers become knowledgeable of the prevalence of human trafficking in the U.S. and ND, as well as victim red flags and risk factors, it was presumed that they will be more likely to identify and assist victims. To address this knowledge gap and better provide resources, an educational session and online resource toolkit were developed for healthcare providers throughout ND.

Objectives

1. Healthcare providers will indicate increased perceived knowledge regarding identifying potential human trafficking victims and available resources to assist identified victims after the education.
2. Healthcare providers will indicate increased perceived confidence in knowing how to manage a potential human trafficking situation in the practice setting by the end of the education.
3. Healthcare providers will indicate willingness to utilize the human trafficking online toolkit to help identify and manage suspected or confirmed cases of victims of human trafficking in the clinical setting when applicable.

CHAPTER 2: THEORETICAL FRAMEWORK AND LITERATURE REVIEW

Theoretical Framework

Adult Learning Theory

In the implementation of this PIP, the Adult Learning Theory (ALT) by Malcolm Knowles was selected to guide development and implementation. This theory relates well to the PIP purpose to educate adult learners who are healthcare providers. The ALT was developed in 1973 and explains the concept of andragogy, which is the art and science of adult learning (Cercone, 2008). The ALT is composed of five assumptions. Incorporating these assumptions into an educational session regarding human trafficking improved the quality of the experience for the adult learner.

Assumption One

The first assumption is that adult learners are independent and autonomous learners, in comparison to children who are dependent learners. Evolving into independent learners allows the student to become, "autonomous, independent, and self-reliant, and they are self-directed toward goals" (Cercone, 2008 p. 143). When educating adult learners under this assumption, providing short, concrete, and focused tasks as a guide to allow the learner to guide themselves through the experience is beneficial. The healthcare providers participating in this PIP have had opportunities to guide themselves through learning experiences previously. In the same manner, the human trafficking educational sessions were designed to offer short, clear, and focused information. Topic areas included potential victim identifiers, interview strategies, how to build rapport and trust, recognizing pimp involvement and control strategies, common situations where human trafficking often arises, and resources providers can lend to help a potential victim ensure a safe journey out of a potential human trafficking situation. The webinar was created in an

online format that allowed the provider flexibility to fit the education into their schedules in order for them to achieve optimal benefit. The online flexibility aided in schedule conflicts that might otherwise have been seen as barriers for busy healthcare providers.

Assumption Two

The second assumption is that increased life and work experience provide a strong foundation for learning (Cercone, 2008). The co-investigator of the PIP needed to understand and appreciate the previous experience of the healthcare providers in order to apply their past experience to new concepts. An NP aided in webinar development in order to add work experience to create a strong learning environment that is relatable and useful within the provider role. This allowed healthcare providers to build upon their knowledge base and experience to expand upon already learned concepts.

Assumption Three

The third assumption is that adult learners are receiving the education in order to meet the needs of their personal goals (Merriam & Caffarella, 1999). As requested by the healthcare providers, the education in this PIP was focused on improving the ability of healthcare providers to recognize human trafficking victims to improve the health for this vulnerable population. Providing brief, concise, and time sensitive education that is specific to the needs of the learner allowed the learner to be more engaged and find more meaning throughout the educational session. Providing an online human trafficking toolkit with known resources and best practices also met the needs of the healthcare provider when he/she is providing care to victims in healthcare settings.

Assumption Four

As people gain experience outside of education, their desire for future education is related to the need for immediate and beneficial learning. Adult learners have the desire to gain education to use in their current/immediate practice, rather than storing new information for future use (Keesee, 2011). In order to incorporate this assumption into the human trafficking education, the co-investigator provided useful and relevant information that can be easily integrated into their everyday practice.

The education in the first educational session addressed recognizing significant concerns of human trafficking in ND, awareness of state and federal human trafficking laws, mandatory reporting, identifying common terms, myths and stereotypes of human trafficking, review the elements and red flags of human trafficking, and documents that can assist in identifying high risk/at risk youth. The second educational session's topics included understanding the trauma and barriers that victims of crime experience as well as understanding that indicators are not always obvious, understanding the human trafficking victim perspective, ways to provide a person-centered/trauma informed approach to care, local/state resources for human trafficking, do's and don'ts: lessons learned and case study, and culture change. The comprehensive human trafficking toolkit included information for healthcare providers including: online educational sessions, local and national contact and reporting information, victim identification quick reference form, a comprehensive screening form for adults, prevention and screening tools for at risk youth, and victim perspective insight.

Assumption Five

The fifth assumption is that "adults are motivated to learn by internal factors rather than external ones" (Merriam & Caffarella, 1999, p. 272). Internal factors that motivate adult learners

include increased satisfaction with their work, self-esteem, improved quality of life, and satisfaction of achievement (Keesee, 2011; Cercone, 2008). Healthcare providers want to be a part of the solution in the fight against human trafficking. By educating providers on the ways in which they can be a part of the solution, the co-investigator helped to provide a sense of internal satisfaction and meaning regarding the work they are doing**.**

Iowa Model

There are several steps to follow when using the Iowa Model to guide the PIP. When using this model to guide implementation of the PIP, the following steps were used: identify triggers; state the purpose; determine if the topic is a priority for the organization; form a team; assemble, appraise, and synthesize the body of evidence to determine if sufficient evidence is available; design and pilot the practice change; determine if the change is appropriate for adoption; integrate and sustain the practice change; and disseminate the results (Buckwalter et al., 2017).

Triggers

This project was driven by a problem-focused trigger that was the result of the identification of a clinical problem. The healthcare providers determined an increased need for education regarding human trafficking, as well as a need for known and useful resources to use if a victim of human trafficking is identified. One of the healthcare providers reached out to the principal investigator with this need. This need, or trigger, helped to support the development of this PIP.

Purpose

The purpose of this PIP was to increase provider perceived knowledge and confidence regarding human trafficking prevalence within the U.S. and ND, identification of potential

victims in the clinical setting, and best practices for providing care and treatment plans in the healthcare setting.

Priority

The priority of needing formal human trafficking education is high due to the fact that healthcare providers have identified a need for human trafficking education and requested to receive the education. The education had to align with the priorities of the healthcare providers and their goals. As human trafficking continues to escalate within the U.S., proper education was necessary to assist with the identification of victims as well as to have known resources available in order to provide holistic care to victims. The goals of this PIP aligned with the values of the healthcare providers.

Team

Prior to developing and implementing the PIP, a team was formed. "Selection of team members requires attention to interprofessional involvement, as well as the skill sets needed to plan, conduct, and evaluate the project" (Buckwalter et al., 2017 p.179). Multidisciplinary team members were selected based experience, backgrounds, interests, area of expertise, and level of education. Key stakeholders from the NDHTTF were not included in the committee but close contact was maintained with them throughout PIP development and implementation.

Assemble, Appraise, and Synthesize Body of Evidence

The collection of literature must be thorough and well-rounded prior to developing the PIP. The search for literature consisted of searching multiple data bases and hand picking the literature. Critiquing the evidence was an important piece of this phase as it provided the foundation to which the PIP was based off of. The evidence was weighed according to the four criteria (quality, quantity, consistency, and risk) suggested by The Iowa Model (Buckwalter et

al., 2017). Only published scholarly articles were used in the development of this PIP. Based on the scholarly evidence obtained, there was a gap in the literature regarding healthcare provider education and training to identify and treat victims of human trafficking.

Design and Pilot

When developing the PIP, the Iowa Model suggests incorporating patient and family centered values and preferences. This is in alignment with the literature in which "training sessions led by human trafficking survivors may have a more pronounced effect on increasing levels of empathy" (Shin et al, 2020 p. 9). Including the patient's perspective in the education will increase provider knowledge, empathy, and lead to cost containment and better health outcomes (Buckwalter et al., 2017). When designing the PIP, understanding the time frame for implementation as well as time allotment was important. Healthcare providers' schedules are full of patient care activities, making pertinent education that was efficient and easy to access imperative. Per the request of the healthcare providers, a brief overview and educational session of resources and management was requested. The co-investigator was responsible for providing evidence-based education to healthcare providers while staying within the approved time frame in order to increase participation and satisfaction. In addition, the development of an online human trafficking toolkit provided additional education, support, and guidance for identification and support of human trafficking victims. Through collaboration with the NDHTTF, the co-investigator tailored the education and resources to serve the specific needs of the healthcare providers throughout the state.

Adoption

After the initial educational intervention, evaluation was necessary. The evaluation determines "if the practice change worked, if the implementation plan was effective, and if

rollout to other areas would be beneficial" (Buckwalter et al., 2017 p. 180). Through examination of the literature, only one pre- and post-knowledge test has been tested for content validity. The knowledge questionnaire was developed by Kovacic (2017) and the content validity was published in 2018. The reliability is currently being tested and the results are not yet available. This was the only tool found that has been tested for content validity, therefore it was the strongest tool to use for this PIP. The tool was tested by a panel of members who discussed each question on the tool and graded the strength of the questions. Questions that received poor grades by members of the panel were either modified or removed from the tool and questions that received high grades were kept in the tool. The tool is a 30-item questionnaire with true or false responses. The purpose of this tool is to collect data regarding pre- and post- intervention knowledge of healthcare providers regarding human trafficking. The questionnaire was to be delivered before and after the educational session in order to gauge the knowledge gained during the educational session. There are no time specifications provided by the author to suggest how long after the educational intervention that the post-test should be administered. Although this was the strongest and most reliable tool to use for this PIP, access to reproduce and modify this tool was not granted by the author and the tool was not used for this PIP.

A second tool found in the literature has not undergone testing for content validity and reliability. This tool, known as the PROTECT: Provider Responses, Treatment, and Care for Trafficked People tool is used to elicit information from healthcare providers regarding their experiences, knowledge, and opinions regarding human trafficking. This tool was available for public use and adaptation (Ross et al., 2015). The PROTECT tool aligns closely with the goals and objectives of this PIP and was the foundation from which the co-investigator developed the PIP tool. The final pre- and post-test, developed by the co-investigator, used a mix of

quantitative and qualitative questions to determine healthcare provider demographics, baseline knowledge, previous education on human trafficking, perceived knowledge and confidence changes pre- and post- intervention, as well as the usefulness of the PIP in order to create change and sustainability of the PIP.

Integrate and Sustain

The PIP was designed as a two-part webinar that could be accessed by all healthcare providers throughout the state of ND. Through the use of available technology, online dissemination made the PIP education easy to access and available for NPs. Dissemination occurred over a variety of platforms including at the ND Nurse Practitioner Association (NDNPA) conference, word of mouth, email links, the NDHTTF website, and through contacts within local healthcare facilities. To allow for continued access to the education developed for the PIP, the co-investigator made sure the education was available through many online resources such as the NDHTTF website and the NDNPA website to expand the audience. The NDHTTF website, along with its members, were key stakeholders in disseminating this information to healthcare providers throughout ND.

Dissemination

The final phase of the Iowa Model-Revised is to disseminate the results. The results were disseminated through the dissertation of the co-investigator and posters at conferences. Additionally, submission of a publication to a peer-reviewed journal will be considered.

Literature Review

Literature Review Search

A comprehensive search was conducted by the co-investigator using the Cochrane Library, PubMed, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL)

database. Key terms were searched individually and in strings. The key terms searched included: *human trafficking, child trafficking, sex trafficking, healthcare professionals, human trafficking education, and nurse practitioners.* Most articles greater than five years were excluded but some were kept if updated information was not available. Articles used in the literature review were pertinent to the U.S. and ND healthcare systems. The co-investigator also found articles by hand-searching the literature. Articles were also sent to the co-investigator through the Health, Education, Advocacy, Linkage (HEAL), an anti-human trafficking network, email listserv.

What is Human Sex Trafficking?

Human Sex Trafficking, also referred to as modern-day slavery, is defined by U.S. Congress 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" 22 U.S.C. § 7102 (2018).

Human trafficking has historically been confused with prostitution in regard to the roles, attitudes, preconceived notions, and biases about the victim and/or prostitute. Understanding and differentiating between the definition of victims of human trafficking and prostitutes is essential to healthcare providers in the clinical setting for both care and reporting purposes.

Prostitution is a "form of sex work that involves an explicit exchange of material goods, favors, and/or services in return for sexual intimacy or erotic acts with no required commitment" (Davis et al., 2020, para. 1). Prostitution is legal in some counties within the U.S. and is guided by state law. Individuals in prostitution are willingly performing their work and are over the age

of 18 years old. Victims of human trafficking are illegally bound through force, fraud, or coercion and do not have control over the work they perform. A critical distinction exists in the description for victims of human trafficking who are under the age of 18 in which force, fraud, or coercion does not have to be present. Children under the age of 18 cannot participate in any form of commercial sexual acts, whether they are willing participants or not.

Human trafficking is a crime under federal and international law. Human trafficking affects nearly every country worldwide and can be associated with worldwide human trafficking organizations, local criminal networks, and has been connected to government corruption (Grace et al., 2014; Europol, 2005; Miko & Park, 2001; Richard, 1999; U.S. Government Accountability Office, 2006). Human trafficking is used by traffickers for personal or financial gain, and is the second-largest and fastest-growing criminal industry in the world and in the U.S. (Conrad 2018; Peck & Meadows-Oliver, 2019; Roney & Villano, 2020). Human trafficking has unlimited growth potential as humans are a reusable commodity that allows recurring profits for the trafficker, unlike the drug sector in which the product (drugs) can only be sold once. Human trafficking is estimated to have a $32-billion-dollar worldwide revenue annually (Grace et al., 2014; Peck & Meadows-Oliver, 2019). A sex trafficker is estimated to make a $200,000 profit per victim (Titchen, 2017).

Prevalence

The illegal nature of human trafficking makes determining the exact number of victims that exist difficult as victims are often isolated and hidden from society (Hachey & Phillippi, 2017). Under-reporting and a lack of standardized reporting also affects the ability to determine the exact number of victims worldwide. Within the U.S., 40.3 million people are estimated to be victims of human trafficking (Shin et al., 2020). Victims are more likely to be

trafficked from a country of lower socioeconomic status to a more affluent country. More than six out of 10 victims are foreigners in another country (United Nations Office on Drugs and Crime [UNODC], 2014). Traffickers have the ability to "exploit the desire to migrate due to poverty, political strife, oppression, gender violence, social instability, human rights violations, or perceived opportunities to ensnare victims and gain cooperation and control" (Hachey & Phillippi, 2017, p. 34).

At any given time, 1.6 million people are estimated to be trafficked within the U.S. (Conrad, 2018; Donahue et al., 2019). Trafficking in the U.S. can occur in rural, urban, and suburban populations and has been reported in all 50 states. The state with the most reported victims is California (National Human Trafficking Hotline [NHTH], n.d.). Like the global trafficking trend, trafficking in the U.S. occurs more in cities or regions with fewer economic opportunities and higher levels of social disparities. Sex trafficking can occur in a variety of settings including in private homes, on the streets, brothels, strip clubs, massage parlors, and through escort services (Miller, 2021).

Human Trafficking in ND

Due to increased suspicion and reports of human labor and sex trafficking within ND, the NDHTTF was developed in 2015. Since the development of this task force, 482 victims have been identified within the state, with a majority of them being residents of ND. The NDHTTF has also investigated 75 cases of human trafficking and arrested 57 perpetrators (NDHTTF, n.d.). In 2019 alone, the NDHTTF served 114 victims of human trafficking. Of the 114 victims, 76 were adults and 38 were children. Seventy-four of the victims were ND residents. Throughout 2019, 33 cases of human trafficking were investigated, resulting in the identification of 21 victims. In addition to recognizing and identifying victims, the NDHTTF (n.d.) has also trained

15,131 professionals in ND on human trafficking since the program inception. Although this seems like a large number of professionals educated, this number includes healthcare providers, law enforcement personnel, social workers, emergency medical technician and paramedics, legal consultants, hospitality workers, and other professionals who may come into contact with victims of human trafficking. There is no data available to determine the specific amount of healthcare providers who have been trained on human trafficking in ND, but the need remains high as there is an estimated 53,030 ND healthcare employees (Kaiser Family Foundation [KFF], 2021). The task force also held 310 community-based response meetings to help prevent human trafficking. Increased education and awareness throughout the state will lead to increased victim identification and recognition by trained professionals and community members.

Victim Risk Factors

Although all genders are trafficked worldwide, 80% of victims are women and 30% are minors (Donahue et al., 2019). Prevalence and incidence can be difficult to determine as underreporting is common, as well as the hidden nature in which human trafficking occurs (Fraley et al., 2019). Females are thought to be disproportionately affected, but males and transgender youth are also targeted. Most commonly, trafficking victims are used in "street prostitution, brothels, strip clubs, massage parlors, and other underground facilities" (Donahue et al., 2019, p. 17). The average age for a female to become a victim of human trafficking is between 12-14 years of age. Half of the victims in the U.S. are children (Roney & Villano, 2020). Young victims are usually preferred by traffickers as they are easier to coerce and control. They are also less likely to recognize that they are victims of human trafficking. Traffickers often initiate contact with a vulnerable individual as they are able to offer money, goods, housing, friendships, or relationships that the individual is lacking.

Human trafficking in youth occurs more commonly on the margins of society amongst those who are less likely to have a strong support system and resources, such as homeless, runaways, “throwaways” (a child who has been rejected, ejected, or abandoned by their parents or guardians) or living in juvenile detention foster care centers (Fraley et al., 2019). Other risk factors include individuals who desire to develop romantic relationships, individuals who feel misunderstood or insecure, children who often fight with their parents/families or who feel like their families don’t care about them, teens who want more independence, and individuals who are more likely to test boundaries or take risks (Williams & Jacobson, 2017).

The top five risk factors for an individual becoming involved in human sex trafficking include substance use, runaway homeless youth, recent migration or relocation, unstable housing, and mental health concerns (Polaris, 2020). Sex traffickers prey on the emotional needs and vulnerabilities of their victim. They are able to identify those who are easily coerced, manipulated, or terrorized into doing what they ask (Hachey & Phillipi, 2017). One in six children who run away from home can become a victim of sex trafficking (Williams & Jacobson, 2017). Risk factors for children who are trafficked include mental intellectual disability; history of physical, emotional, or sexual abuse; incarcerated family members; history of personal or familial substance abuse and/or use; identification of LGBTQ; untreated mental health problems; homelessness; runaway status; past history of involvement with child protective services and/or the foster care system; undocumented migrant status; low socioeconomic status; violence within families; and unwanted migration (Greenbaum & Bodrick, 2017).

Youth are also at an increased risk due to the large amount of technology they are exposed to. Traffickers exploit youth on the internet through sites such as Facebook, Instagram, Snapchat, WhatsApp, PlayStation, and XBOX. Traffickers spend a lot of time through different

websites identifying individuals with vulnerabilities and grooming victims (Fraley et al., 2019). Women, on the other hand, are often recruited for labor or domestic services and then sold into the sex trafficking trade (Hachey & Phillippi, 2017).

After individuals become victims of human trafficking, their traffickers make it very difficult for victims to escape. Traffickers will often use sexual or physical violence to scare their victims from trying to leave. Traffickers also threaten victims' families to coerce victims to stay with the trafficker in order to keep their families safe. Undocumented victims usually have their passports and forms of identification taken so they are unable to seek assistance or return home. Traffickers also withhold money and wages so victims do not have the financial resources to support themselves even if they were able to escape.

Traffickers also threaten the victim into thinking that they will be taken to jail if they try to escape because of the sexual acts they have committed during their captivity. Victims often feel that they are not able to trust law enforcement or social workers due to the current circumstances or previous encounters with law enforcement/social workers, leading to distrust of those that might offer to provide help (Miller, 2021; Williams & Jacobson, 2017). Traffickers also get victims to develop a trauma bond with them. In order to create a trauma bond, traffickers will often "set up" victims in which the trafficker "rescues" or "saves" them. In one instance, a trafficker might secretly arrange for the victim to undergo prearranged trauma in which the victim is taken by another individual that acts as if they are going to physically or sexually abuse the victim. Before the abuse occurs, the trafficker will come to the aid of the victim and "save" them from that situation. Situations like this cause the victim to develop a trusting, loving, and deeper relationship with their trafficker, which is the formation of a trauma bond. After this relationship is established, victims will then try to please their trafficker and do anything the

traffickers asks of them, in order to show their gratitude to the trafficker for saving them. The trafficker then rewards the victim if he or she performs well, which the victim interprets as continued love and affection from their trafficker (Williams & Jacobson, 2017).

Human Traffickers

To better understand the context of human trafficking, there are several terms that should be clarified. Individuals who are involved in the sale of a human are referred to as human traffickers. There are different types of individuals involved in the sale, purchase, and recruitment of victims (Williams & Jacobson, 2017). The trafficker is the individual who is responsible for harboring victims and typically is the individual that the victim is most familiar with during captivity. Traffickers are responsible for finding buyers for the victim in order to receive revenue. Traffickers can commonly be referred to as a "pimp" or "daddy". The trafficker can also be someone close to the victim such as a family member (sibling, parent, aunt, uncle), significant other, or friend. Often, the victim has a relationship with the trafficker and was brought into the situation through their relationship. Traffickers do not have set characteristics to look out for nor do they make themselves noticeable to society which makes them difficult to identify (Leslie, 2018).

The "buyer" is the individual that pays for the victim to perform sexual acts. The buyer often engages with the trafficker for the sale of the victim for sexual acts. The trafficker and the buyer can have many different relationships. The trafficker could be the victim's boyfriend and force his girlfriend to have sex with a drug dealer to get free drugs or a trafficker can harbor several victims at once and have many buyers coming and going into the home to receive sexual acts. Any instance in which the trafficker receives money, goods, or services in exchange for sexual acts from the victim is considered human trafficking.

"Bottoms" are another individual who is involved in the recruitment and sale of human trafficking victims. Bottoms are individuals who were victims but have been "promoted" by the trafficker. The role of the bottom is to help recruit new victims into the life and to enforce rules (Williams & Jacobson, 2017). Although the concept of how victims could become bottoms can be difficult to grasp, one must understand that bottoms can be coerced into possibly having less clients/time spent working, rewarded with extra resources, or given other sought-after privileges, thus providing incentive that further perpetuates human trafficking.

Health Related Consequences

As discussed above, most individuals become victims of human trafficking during times of vulnerability. The trafficker then forms a "trauma bond" with the victim which leads the victim to believe that if they do as the trafficker says, the trafficker will love them and keep them safe (Williams & Jacobson, 2017). When the victim realizes their situation and wants to leave, the traffickers threaten them which scares them away from attempting to escape. The trafficker also takes away their ability to escape by taking their money, passports, food, clothing, shelter, cell phones, and resources that are needed to help them survive after they escape.

The average lifespan of a child victim is 7 years (Jones-Castillo, 2014; Williams & Jacobson, 2017). The seven-year average begins whenever the victim enters the human trafficking situation and leads to death as a result from sexually transmitted diseases including HIV, malnutrition, sexual and physical violence or punishment, and suicide related to the atrocities they have suffered. In other situations, victims may become ill during their time and not receive adequate healthcare leading to worsening illness or death. In some instances, victims may no longer be seen as desirable for sexual acts and perceived as knowing too much of the inside process, therefore seen as a threat and might be killed.

If a victim does escape, lifelong psychological and physical consequences can impact victims. Victims of human trafficking report increased rates of psychological disorders such as depression, post-traumatic stress disorder (PTSD), suicidal ideation, anxiety, nightmares, flashbacks, decreased self-esteem, and feelings of shame and guilt (Stevens et al., 2019). Victims also report increased physical symptoms including headaches, back pain, stomach pain, dental pain, fatigue, and dizziness. There is also an increase in HIV infections among sexually trafficked persons (Ottisova et al., 2016). According to Lo et al. (2020), victims of human trafficking have increased diagnoses of unwanted pregnancies, sexually-transmitted infections (STI's), substance use disorders, and untreated chronic illnesses.

In a study by Lederer and Wetzel (2014), out of 106 victims of human trafficking victims studied, 105 reported at least one physical health problem while they were being trafficked. The most commonly reported symptoms were neurological, including memory problems, insomnia, poor concentration, headaches, migraines, and dizziness (Lederer & Wetzel, 2014). Victims also reported poor dietary health leading to severe weight loss, malnutrition, loss of appetite, and eating disorders. Victims also had many physical injuries, with almost 70% of victims reporting physical injuries. "These include being threatened with a weapon, shot, strangled, burned, kicked, punched, beaten, stabbed, raped, or penetrated with a foreign object" (Lederer & Wetzel, 2014, p. 74). Other reported physical symptoms included cardiovascular or respiratory difficulty and gastrointestinal symptoms. Dental problems were also frequently reported which included tooth pain and tooth loss as a result of poor hygiene, lack of dental care, drug use, and physical abuse.

Gynecological problems were also prevalent amongst the victims (Lederer & Wetzel, 2014). "The most common reasons for visiting a health care provider included a general check-

up (42.6%), testing for sexually transmitted infections (34.1%); and testing for HIV (20.9%)" (Varma et al., 2015, p.100). There is an estimated prevalence for HIV in 18.1-31.9% of victims of human trafficking (Ottisova et al., 2016). Multiple and/or recurrent sexually transmitted infections should raise red flags to healthcare providers (National Human Trafficking Resource Center, n.d.). The most common diseases were chlamydia, gonorrhea, and hepatitis C. Victims of human trafficking "reported being used for sex by approximately thirteen buyers per day, with a median response of ten. Some respondents reported typical days of as many as thirty to fifty buyers" (Lederer & Wetzel, 2014, p. 72). Over half (53%) of domestic child sex trafficking/sexual exploitation victims reported high rates of STI's. Although there is no exact data regarding the amount of STI's each victim experienced due to lack of treatment for each diagnosis, healthcare providers should be suspicious of patients who present frequently due to concern for STIs (Varma et al., 2015). Due to the number of sexual encounters, pregnancy during trafficking was also common. Of the victims in the study, 71.2% reported at least one pregnancy while they were being trafficked, and 21.2% of those with at least one pregnancy reported having 5 or more pregnancies. More than one third of these victims reported miscarriages and more than half reported at least one abortion, which was often forced upon the woman by the trafficker (Lederer & Wetzel, 2014).

The study also assessed psychological symptoms. Victims most commonly reported depression, anxiety, nightmares, flashbacks, low self-esteem, and feelings of shame or guilt. These psychological issues resulted in 41.5% of victims reporting attempted suicide and 54.7% of victims reported that they suffered from PTSD. Additionally, 84.3% of the victims in this study reported substance use to include alcohol, drugs, or both during their captivity (Lederer & Wetzel, 2014). About 27.9% of the victims reported that the substances were forced upon them

during their experience as human trafficking victims. Victims reported injecting drugs as well as overdosing. The most common substances that were used included alcohol, marijuana, cocaine, heroin, ecstasy, and phenylcyclohexyl piperidine (PCP). The victims reported that they were forced to use substances as demanded by the trafficker or they were driven to substance abuse due to their grave circumstances. Often times, the trafficker will keep the victim drugged or drunk to prevent them from trying to escape and to make them more cooperative to engage in sexual acts for the buyer. Once the victim is addicted to substances, they are more willing to stay with the trafficker in order to meet the needs of their addiction as well (Miller, 2021).

Red Flags

Several red flags have been identified as indicators to help healthcare providers identify victims of human trafficking. Healthcare providers need to be knowledgeable of these red flags in order to help with victim identification. Victims often give scripted or inconsistent histories related to their diagnosis that could be secondary to PTSD or substance use. Victims are typically unwilling to give details about their injuries or diagnosis and are hesitant to answer questions from healthcare providers. Victims are typically accompanied by an individual (presumably the trafficker) who refuses to leave the patient alone, interprets for them, and answers questions for them (Miller, 2021). Victims may also avoid eye contact, appear fearful or nervous, demonstrate hostile behavior, decline to provide specific information regarding their address or housing, have limited knowledge regarding their medical history, provide no evidence of identifying documents, do not have employer information or insurance, and do not have belongings with them.

Human trafficking victims report to medical facilities for a variety of reasons. Important sex trafficking indicators are certain tattoos, unusual number of sex partners, recurrent sexually

transmitted infections (STIs), repeated abortions, inappropriate clothing for the situation, and unexplained injuries. Tattoos that should lead to sex trafficking suspicion include tattoos that represent ownership and include the words “daddy” or “property of”, multiple of the same tattoo, or tattoos that indicate that they are property, such as a barcode or identification number (Miller, 2021; Williams & Jacobson, 2017).

According to Lederer and Wetzel (2014), the most common physical symptoms are injuries related to physical violence. Any signs of forced sex, along with signs of being kicked, punched, beaten, or head/facial injuries should be immediate red flags to the healthcare provider. Providers should also be aware of patients who seek multiple abortions, frequent treatment for STIs or other serious communicable diseases, such as Hepatitis C, or reproductive health services at a young age. Other extreme forms of violence, including strangulation, stabbing, cigarette burns, or gunshot wounds, should be considered important for identifying victims.

Along with physical signs, providers should also look for specific psychological symptoms that are commonly reported amongst human trafficking victims. Signs including depression, anxiety, irritability, nightmares, low self-esteem, and feelings of shame/guilt should be evaluated further to determine if the patient may be a victim. Suicide attempts and repeated self-harm should also be reason to suspect that the patient may be a victim of human trafficking. Other red flags include repeated treatment for substance abuse for drugs and/or alcohol. According to Miller (2021), healthcare providers need to be suspicious of individuals who present with self-harm injuries, hypervigilance, dissociation and derealization of their circumstances, post-traumatic stress disorder, and attachment disorders.

Healthcare System Involvement

Approximately 88% of human trafficking victims received medical care while they were being victimized, yet most were not recognized as victims by their healthcare providers (Donahue et al., 2019). The inability to recognize victims in the healthcare setting can be related to a lack of healthcare provider education, victim unwillingness to disclose their situation, as well as injuries that are not obvious signs of abuse such as choking marks. An overwhelming majority of the victims are treated in the emergency room. Other common settings include ambulatory clinic settings, such as Planned Parenthood, urgent care, primary care providers, or women's health clinics (Lederer & Wetzel, 2014). Jails and dentist offices have also been identified as common places for victims of human trafficking to receive treatment (Havig & Mahapatra, 2020).

Common reasons for victims to seek medical care include trauma related to abuse, STD screening and treatment, abortions, and seeking birth control. Many of the victims reported that their provider knew that they were living on the streets, but they did not know that they were victims of human trafficking. Victims report that the providers did not know the full extent of their situation. In a study by Lederer and Wetzel (2014), a majority of the victims reported that they presented to the clinics to obtain birth control by themselves. This presents a unique opportunity for healthcare providers to intervene and assist the victim. Unfortunately, most healthcare providers and staff have not been formally trained on how to identify victims of human trafficking and they do not know the signs to look for (Lo et al., 2020).

Healthcare Provider Barriers

Out of the 6,000 total hospitals within the U.S., approximately 1.0% have policies and procedures in place for treating victims of human trafficking (Donahue et al., 2019). While a

majority of providers report that human trafficking education is important to their practice, fewer than 3% had ever received training in victim recognition (Lo et al., 2020). Local statistics regarding the percentage of healthcare providers who have received human trafficking education in ND is unknown, but there was a request from healthcare providers in the region requesting human trafficking education regarding victim identification and known resources available to aid identified or potential victims of human trafficking.

Along with the lack of knowledge and standardized education for providers, human traffickers are skilled in manipulating the healthcare system which further complicates the identification of human trafficking victims. Traffickers are known for being manipulative, placing an extreme degree of control on their victims; one media source noted “they know how to interact with the healthcare system to avoid being caught. [Traffickers] won’t go to a place where people are well-trained in identifying trafficking victims, so they'll go to smaller places where they won’t be questioned about it...and they won't use insurance, they will pay in cash” (RELIAS MEDIA, 2018, para. 7). Traffickers are also skilled at causing injuries that will be more inconspicuous to avoid questioning by healthcare personnel. By continually placing fear upon their victims, traffickers are able to control what their victims say and the interactions that are had among the victim and the healthcare providers.

Victims may interact with the healthcare system several times throughout the length of their captivity. In a recent study, 97% of human trafficking victims who were in contact with the healthcare system during their captivity did not receive any information or resources regarding human trafficking and were not identified as victims (Lumpkin & Taboada, 2017). Victims may seek medical care in an emergency, after an assault or workplace injury, for gynecological services, prenatal care, plastic surgery services, orthopedic injuries, routine wellness exams,

mental health services, addiction treatment, pre-existing conditions, or health issues unrelated to trafficking (NHTRC, n.d.). Although victims may be seen in every aspect of the medical community, they may not be willing to disclose their identification related to shame or guilt, fear of retaliation, fear of arrest or deportation, lack of transportation, fear of report to social services, and a lack of understanding of the U.S. healthcare system.

Healthcare Provider Role

Healthcare providers need to be well educated on the red flags of human trafficking victims in order to identify and start the conversation. “Interaction between medical care providers and victims is an extraordinarily delicate situation” (Lederer & Wetzel, 2014). Providing a safe space for the victim is important to elicit sensitive information. Building trust with the victim is an important first step and can require time and patience. Disclosure and rescue should not be the immediate goal of the healthcare provider, rather, the first priority needs to be to create a safe, nonjudgmental place in which the healthcare provider can assess potential safety risks, offer the victim the opportunity to choose the gender of their clinician, provider an interpreter, ensure the patient understands confidentiality and reporting laws, and taking time to build rapport with the victim. The healthcare provider needs to remember that not all victims are ready to accept help. The healthcare provider needs to provide immediate healthcare and provide information, referral, and resources to the victim to support them until the victim is ready to accept help (Miller, 2021).

Victims may present with their trafficker to the emergency room or office appointment. Finding a way to provide privacy and getting the victim by themselves is necessary. Lederer and Wetzel (2014) suggest to have the suspected trafficker assist with paper work, or take the victim to a designated area in order to draw lab specimens or have x-rays taken. While alone with the

victim, the healthcare provider can continue to develop the relationship with the victim and find ways to provide assistance.

Healthcare providers need to use delicate questions to elicit information, rather than asking direct questions, such as “are you being trafficked?”. Rather, the provider should inquire into the “patient’s freedom to contact family and friends, her eating and sleeping conditions (whether basic needs are being met), her ability to come and go freely, who lives with her, and whether she feels happy and cared for” (Lederer & Wetzel, 2014, p. 84). Regardless of whether or not the provider is able to build a relationship and elicit information regarding the patient’s trafficking status, if suspicion remains, the provider should contact the National Human Trafficking Hotline (NHTH) (NHTH, n.d.). The NHTH is not a local or federal government/law enforcement agency. The hotline is responsible for collecting data and information from the caller and passing the information on to the proper channels. In circumstances in which a mandatory report is necessary, the hotline will contact local law enforcement.

Reporting

Mandatory reporting varies from state to state. In all states, it is required to report suspected or identified cased of human trafficking for individuals who are 17 years of age or younger and for vulnerable adults. Most states also have mandatory reporting laws for life-threatening injuries and crimes (Miller, 2021). In cases in which mandatory reporting is necessary, the healthcare provider should contact local law enforcement as well as the NHTH to ensure timely response to the situation. When mandatory reporting is not required, the national hotline can provide assistance and information to the caller as well as keep an open record for tracking on that specific case.

Not all calls will get reported to law enforcement. Information given to the hotline may be anonymous if the provider wishes. Local taskforces and other community resources may also be contacted to aid in the investigation, recognition, and rescue of victims (NHTH, n.d.). The hotline can be reached by phone at 1888-373-7888, text at 233733, or via chat online. The hotline is available 24/7 and multiple languages are available for translation as well as interpreting services as the provider is obtaining sensitive information from the patient.

Miller (2021) stresses the importance of educating the victim on mandatory reporting laws and regulations prior to the victim disclosing information. Mandatory reporting may deter victims from confiding in healthcare professionals and may result in victims refusing to seek treatment due to fear of being reported. Victims of human trafficking have a fear of deportation, criminal prosecution, or having their children taken away from them and placed with social services if they disclose information to healthcare providers. Providers need to be upfront with victims regarding the rules and regulations prior to victim disclosure in order to protect the victim and respect his or her wishes (Miller, 2021).

Role of the Nurse Practitioner

NPs serve as a first line of defense in the fight against human trafficking. As healthcare professionals often have contact with victims while they are being trafficked, they are in the perfect position to recognize and support victims. NPs need to provide information to the victim on how to receive help once identified and they also must manage their health conditions including their spiritual, mental, and physical wellness. According to the American Association of Nurse Practitioners (AANP) (2019), NPs are able to blend clinical expertise for diagnosing and treating health conditions, as well as counsel on disease prevention and health management, which provides comprehensive and personal care to the client. As victims of human trafficking

often have increased health consequences related to their experience, NPs are in the perfect position to address the holistic needs of this patient population.

According to Peck (2018), there are three things that an NP can do to improve their ability to recognize and treat victims of human trafficking. First, the NP needs to educate themselves. Many national organizations, including the AANP, Office on Trafficking Persons, SOAR, and the National Human Trafficking Resource Center, offer evidence-based trainings for healthcare providers in which continuing education credits are available. Accessing evidence-based training will assist the NP to respond to a potential victim with an informed, comfortable, and confident approach (Peck, 2018). Miller (2021) informed that the healthcare provider must report everything that is required by law and remain sensitive to potential victim fear and safety issues. Miller also discussed the importance of advertising and posting available resources throughout the healthcare facility for victims to observe while receiving care. Legislators in Florida recently passed legislation requiring healthcare providers to post signage in a place conspicuous to employees and patients. Passing legislation to aid in victim recognition and safety needs to be a priority of healthcare providers.

Additionally, NPs can ensure that protocols are in place to assist the victim. According to Chisolm-Straker et al. (2012), only 5% of ED staff reported receiving formal education on human trafficking. Although this PIP focused on educating healthcare providers, the literature recommends that all members of the healthcare team receive education in order to be knowledgeable about human trafficking. Educating all healthcare professionals (receptionist, nursing staff, patient care technicians, dietary services, etc.) who may come into contact with potential victims will increase the likelihood of victim identification within the healthcare system.

Lastly, NPs need to be involved in advocacy. Advocating for victims, raising public awareness, and encouraging prevention at the local, state, and national levels are all ways in which an NP can combat human trafficking. New Jersey and Florida have enacted laws that require healthcare employees to receive human trafficking education prior to receiving their certification for employment. More states need to follow suit to ensure education is provided to all healthcare employees. ND has established a task force which is comprised of two social workers and a NP. These individuals aid in the investigation, identification, and aid of the victim, as well as educating healthcare providers and community members about human trafficking. National organizations such as the Heal Network, Polaris, and the Health and Human Services Office on Women's Health also provide a platform for advocacy and legislation reform on the national level.

Along with using law enforcement and national organizations, there are also available online references for providers to use when interacting with a potential victim. The Colorado High Risk Victim Identification tool is widely used by professionals who may be concerned that they are caring for a potential child/youth victim of human trafficking as well as to provide a quick reference for red flags to monitor for. The tool is to be completed by professionals who have been trained on human trafficking and is not intended to be filled out by the potential victim or family members. This tool has been recognized as a comprehensive tool for use by the NDHTTF. Although this tool is widely used, it has not been validated in the literature. Positive indicators on this tool do not confirm cases of human trafficking, but may increase a professional's suspicions. The tool is intended for use as an initial supplemental comprehensive evaluation tool and should lead to additional screenings and evaluations to confirm whether the patient is a victim of human trafficking or not (Colorado Department of Human Services, 2014).

Education

Human trafficking education lacks standardization throughout the U.S. (Shin et al., 2020). Powell et al. (2017) examined 11 healthcare professional educational sessions delivered in healthcare facilities throughout the U.S., and found 91% of them were developed by the local facilities. Although several organizations, including federal, state, local, non-governmental, academic, and professional societies have developed curricula for delivering education, most of the education delivered is created organically at the local facility. The individual development of education creates a lack of standardization throughout healthcare facilities in the U.S. Several academic institutions such as the American Academy of Pediatrics and the American Academy of Nursing have taken strong stances against human trafficking, but healthcare provider education has yet to be implemented consistently throughout the U.S. According to Donahue et al. (2019), only two states require healthcare providers to receive human trafficking education as a part of their licensing process. Incorporating human trafficking education into healthcare provider education and healthcare facilities is an important step to assist with recognition, identification, and treatment of human trafficking victims.

Several tools have been used to assist in education implementation. The development of the Jefferson Co. tool was developed to aid in the prevention and early recognition of at-risk youth (Colorado Department of Human Services, 2014). This tool was developed in Colorado to help prevent youth from becoming victims of human trafficking. Modifications of this tool have been created and are used throughout the U.S.

The "Health, Educations, Advocacy, and Linkage (HEAL) network has promoted best practice training for all types of human trafficking for healthcare providers and compiled educational resources, screening tools, and relevant literature" (Fraley et al., 2019). According

to Lutz (2013), a mixed methods delivery including case study, lectures, and multi-media was useful in increasing knowledge of human trafficking in medical and non-medical personnel. Lutz also informs that it is necessary to establish evidence-based guidelines for content development and delivery (Lutz, 2013). A systematic review by Fraley et al. (2019) determined the importance of providing educational sessions to meet the needs of the busy healthcare provider, rather than longer educational trainings.

A study by Lo et al. (2020) found that an online training module increases understanding of human trafficking from 49-93%. Lo et al. also recognized the importance of educating providers on a "trauma-informed approach" to use when identifying and aiding victims of human trafficking. A "trauma-informed approach" stresses the importance of determining the negative effects of prior trauma on the patient's thoughts, beliefs, and behaviors, and emphasizes the need for respect, trust, transparency, cultural competence, and empowerment when working with victims of traumatic experiences (Lo et al., 2020). Chisolm-Straker et al. (2012) found that educating healthcare professionals through online learning modules was successful. Before a 20-minute didactic training, which contained education relating to the identification, clinical presentation, and treatment of human trafficking victims who may present to the ED, 4.8% of participants reported confidence in the ability to identify a victim of human trafficking. After the online training 53.8% of participants stated they were confident in victim identification. Chisolm-Straker et al. recognized the limitation of utilizing only a 20-minute video for education. As the education was well received, further education was deployed to ED staff which included a web-based toolkit and an online case-based interactive program for self-direct learning. Another limitation to the study was that results were measured immediately after the

educational intervention. Without three or six-month knowledge re-assessments, knowledge retention was unable to be determined.

Educating healthcare professionals on victim red flags and health consequences is crucial to aid in the identification of a human trafficking victim, but also to inform regarding known resources and next steps to take when a victim is suspected or identified. Powell et al. (2017) reports that healthcare professionals represented only 1.7% of all calls made to the national hotline between January 2008 through May 2015. In the study by Chisolm-Straker et al. (2012), all healthcare providers reported that they provided medical care to victims of human trafficking but only 3.9% called the police, 3.3% called the hospital social worker, 2.8% asked the victim about his/her safety, and 0.6% called an intimate partner violence hotline. No connections or resources were utilized for the rest of the victims. As there is limited standardization in educating healthcare professionals on human trafficking, there is also lack of knowledge regarding the appropriate steps to take when a victim has been identified.

The NHTH has been created for standardized reporting of human trafficking. The hotline can be called anonymously if the caller desires. The national hotline is used as a national reporting system and is important to include in reporting as they are responsible for keeping national statistics of human trafficking cases. The national hotline is not a local, state, or federal governmental/law enforcement agency. If mandatory reporting is required, or the assistance of local law enforcement is desired, local law enforcement should be contacted first and the national hotline should be notified as well. In ND, mandatory reporting laws require healthcare professionals to always report special circumstances. These circumstances include:

- If a healthcare professional has knowledge of or reasonable cause to suspect that a child is abused or neglected, or has died as a result of abuse or neglect

- If a professional receives information in their professional capacity of child abuse or neglect
- If images of sexual conduct by a child is discovered on a workplace computer
- If a professional has knowledge or reasonable cause to suspect that a woman is pregnant and has used a controlled substance for a nonmedical purpose
- If a professional has reason to suspect that a child is being subjected to abuse or neglect based off of images obtained on a workplace computer
- If a vulnerable adult has been subjected to abuse or neglect
- If a vulnerable adult is witnessed being subjected to conditionals or circumstances that reasonably would result in abuse or neglect.

When the criteria above are met, local law enforcement must be contacted by the healthcare professional. Failure to report the above instances can result in suspension or termination of the medical professional's license (North Dakota Department of Human Services, 2019; ND Department of Human Services, 2020). When the above criteria are not met, the healthcare professional can contact local law enforcement if the victim desires and also report to the NHTH.

CHAPTER 3: METHODS

Overall Project Design

This PIP was disseminated by electronically delivering educational sessions to a convenience sampling of NPs throughout ND through a regional conference venue and email list. Pre- and post-survey data was collected to determine perceived knowledge and confidence levels of healthcare providers before and after the educational sessions and to determine the educational effectiveness. Quantitative numerical data was elicited and analyzed by the co-investigator using Qualtrics tools. Open-ended questions were used to elicit demographic data, educational background, work experience, prior human trafficking education, and usefulness of the online resources. The open-ended questions provided feedback to the co-investigator to recommend changes for future project implementations.

Implementation Plan

Evidence-based Practice Model

The Iowa model served as the evidence-based practice model to guide this PIP. The model has been widely used by nurses to integrate research findings into evidence-based practice changes through the processes of problem identification, research collection, implementation, revision, and sustainability (University of Iowa Hospitals and Clinics, 2020). The steps of the practice improvement project followed the Iowa Model as outlined below. Permission to use the Iowa Model was granted prior to implementation of this PIP (Appendix F).

Step 1: Selection of a Topic

This PIP was introduced to the co-investigator by the principal investigator. The principal investigator had a personal connection to human trafficking and realized a need for this project through discussions with healthcare providers throughout ND. Through further education and

research, the co-investigator became passionate about the need to educate healthcare providers throughout the state in order to aid in human trafficking victim identification and management. NPs were the target population of the PIP. Local and regional NPs had reached out and identified the lack of human trafficking education as a barrier to identifying and manage victims of human trafficking in healthcare settings. The need was further identified through the literature review and the desire to bridge the gap in education was the foundation for the development of this PIP.

Setting/Sample/Recruitment

The state of ND is 70,762 mi^2 and, according to the Centers for Rural Health (2021), ND had an estimated 47 licensed and certified general acute care hospitals, 36 critical access hospitals, two Indian Health Service Units, and three psychiatric facilities. The 2017 ND Nurse Practitioners Workforce Summer Brief indicated that there were 835 NPs practicing in the state of ND and that number has been steadily rising every year since (Zwilling & Owens, 2017). NPs with experience in all areas of healthcare in the state of ND were the targeted audience of this PIP. As victims of human trafficking can present to a variety of clinical settings, the co-investigator aimed to target all NPs within the state of ND without regard to clinical setting, experience, background, or demographics.

The principal investigator was an NP and an Associate Professor of Practice for a School of Nursing (SON) in the state of ND and the co-investigator was an NP student. NPs were chosen as the sample for this PIP due to their interest in advancing the NP profession. Inclusion criteria for this PIP included NPs in the state of ND who have completed their masters or doctoral degree and were working within the clinical setting. No minority populations were sought after for the purposes of this PIP. Educational credits through the ND Board of Nursing were offered at the completion of the educational sessions to provide incentives to complete the

education. Recruitment of participants was through email, word of mouth, and websites through North Dakota State University (NDSU), NDNPA, and the NDHTTF.

Step 2: Forming a Team

Forming a team was crucial and necessary for the successful development and implementation of this PIP. This PIP required a multidisciplinary team approach including professors within the SON and NDSU, social workers, human trafficking survivors, public health advocates, and an NP student. Team members were selected based on their backgrounds, interests, area of expertise, and level of education.

The faculty chair was a DNP faculty member at NDSU with current NP practice experience with a special interest in human trafficking and seven years in academia at NDSU. The second member of the committee was one of the DNP faculty on the committee and was a practicing NP with a specific interest in health promotion. The third member of the committee was a faculty member with a Ph.D. in nursing and health policy with extensive public health experience. The graduate appointee member was an athletic trainer who obtained her Ph.D. in Research and Evaluation and had an interest in interprofessional education.

Collaboration with the NDHTTF was chosen as they are content experts and aided in the development and dissemination of this project. The input and feedback from the NDHTTF were crucial and necessary to guide the development of this PIP as they have first-hand experience with survivors of human trafficking as well as their experience in educating healthcare providers. The NDHTTF was comprised of an NP and two licensed social workers who serve the state of ND. Their role included serving as a contact point for suspected or confirmed cases of human trafficking, aiding victims of human trafficking, providing resources for agencies to assist

victims of human trafficking, and educating communities and professionals on human trafficking.

Step 3 and 4: Retrieval and Grading the Evidence

A thorough review of the literature was completed through the NDSU library. A search in the Cochrane Review yielded no results regarding healthcare provider education on human trafficking. Only peer reviewed journal articles were used in the literature review. Most of the articles used in the development of this PIP were less than five years old in order to include the most relevant and up to date information. When updated information was unavailable and pertinent information was provided, articles older than five years were included.

As the NDHTTF contained content experts with experience in educating ND healthcare providers, a connection with them was established to ensure that the information included for healthcare providers was relevant to clinical practice in ND. The NDHTTF was provided with the literature review and resources to guide the educational session development. Feedback from the NDHTTF was elicited to strengthen and guide the implementation of the PIP.

Step 5 and 6: Developing and Implementing

The development of this PIP required collaboration from the dissertation committee as well as the NDHTTF. As found in the review of literature, healthcare provider "education should center around four key content areas: definitions and problem scope, risk factors and health implications, assessment, and response" (Raker, 2020, p. 693). In preliminary discussions with the NDHTTF, the length of each educational session should be no shorter than 1 hour in length in order to provide holistic, comprehensive, and meaningful education. Although studies have completed educational sessions in shorter time frames, the NDHTTF expertise and previous experience was important to allow guidance to ensure holistic and comprehensive educational

sessions for healthcare providers throughout ND. Additionally, each CE credit required a minimum of one hour of education.

Collaboration with the NDHTTF and evidence from the literature was used to guide the information included in the PIP. Educational session one covered topics including recognizing significant concerns of human trafficking in ND, awareness of state and federal human trafficking laws, mandatory reporting, identifying common terms, myths and stereotypes of human trafficking, review the elements and red flags of human trafficking, and documents that can assist in identifying high risk/at risk youth. The second session's topics included understanding the trauma and barriers that victims of crime experience as well as understanding that indicators are not always obvious, understanding the human trafficking victim perspective, ways to provide a person-centered/trauma informed approach to care, local/state resources for human trafficking, do's and don'ts: lessons learned and case study, and culture change. The comprehensive human trafficking online toolkit included information for healthcare providers including the educational sessions, local and national contact and reporting information, victim identification quick reference form, a comprehensive screening form for adults, prevention and screening tools for at risk youth, and victim perspective insight. The online toolkit was developed using Microsoft OneDrive. Access to Microsoft OneDrive was provided through a contract with NDSU. Using Microsoft OneDrive allowed the co-investigator the ability to create a folder containing multiple documents and links. Microsoft OneDrive also allowed for continued access to the documents in order for NPs to access the information at their convenience in their clinical settings.

To meet the needs of the CE credit requirements for healthcare providers, the educational sessions had to be a minimum of one hour in length for each session. Furthermore, to meet the

educational needs of healthcare providers and the intended objectives from the NDHTTF, two one and a half hour educational sessions were developed. Delivering the education in two sessions allowed each healthcare provider to incorporate the education as his or her schedule permitted. Three CE credits were available to healthcare providers at the conclusion of the educational sessions and were established in accordance with the NDBON.

A relationship with the NDHTTF was established to develop the educational sessions. Eliciting their knowledge and past experience in education was crucial to the development of this PIP. To aid the NDHTTF in development of the sessions, the review of literature and resources were sent to them to facilitate content development. The co-investigator was also responsible for finding a platform to record and disseminate the education. Through NDSU licensing, Zoom technology was used as a platform to record the educational sessions. The educational sessions were then uploaded to YouTube for easy access by healthcare providers. The sessions were then sent electronically through email per the NDNPA NP listserv, as well as on the NDNPA, NDSU, and NDHTTF websites. Virtual availability was chosen in order to elicit participation from a wide range of healthcare providers throughout the state and among a variety of healthcare facilities, to provide safety during the COVID-19 pandemic, as well as to allow providers to fulfill the educational requirements as their schedules permitted.

After IRB approval was received (Appendix A), the sessions were deployed to NPs throughout the state of ND. NPs had a three-month window of time available to complete the educational sessions. Pre-surveys (Appendix C) were completed prior to the start of the first session. Post-surveys (Appendix D) had to be completed after the second educational session in order for participants to receive CE credits and to enhance survey completion. Surveys were created in Qualtrics and sent as a link with the invitation e-mail along with the consent

information (Appendix C). Participant CE credits were the NP incentive for completing the surveys and education. Participation was voluntary and consent was provided by starting the pre-survey. There was no consequence for participants who chose to withdraw and stop participating at any time, though the educational sessions and surveys had to be completed in their entirety prior to receiving CE credits. No partial CE credits were granted; only those who completed the pre-survey, educational sessions, and the post-survey were eligible for the CE credits, thus also enhancing survey data collection and participation.

Step 7: Evaluation

The evaluation stage measured the effectiveness of the objectives. The pre-survey was administered prior to the participant viewing the educational sessions. The post-survey was administered immediately following the educational sessions prior to the participant receiving their CE credits for program completion and to enhance survey completion. Due to time constraints, a longer follow up (3-6 months) was not completed to assess knowledge retention.

The pre- and post-surveys were developed by modifying the original PROTECT tool (Appendix E) to fit the needs of this PIP. The surveys were administered through an online survey tool, Qualtrics. Qualtrics allowed for confidentiality and comparison between pre- and post-survey data. Collected data was stored on the co-investigators computer that was password protected and only accessible to the co-investigator. Respondents were provided a code in order to maintain their confidentiality and allowed for data comparison between the pre- and post-surveys.

The objectives were evaluated with quantitative data analysis using descriptive statistics and qualitative data analysis. The first objective was evaluated through questions #11, #12, #14, #15, 16, #17, and #18 on the pre-survey. These questions gave insight into the perceived

knowledge of healthcare providers prior to the educational assessment. Questions #3, #4, #5, #6, #11, and #12 on the post-survey gave insight into the perceived knowledge change as well as anticipated practice changes related to the perceived knowledge change.

Objective two was measured through questions #13, #19, and #20 on the pre-survey and #2, #7, and #8 on the post-survey were compared to evaluate perceived change in confidence when managing a potential or identified victim of human trafficking in the clinical setting. Objective three was analyzed through question #21 on the pre-survey and was compared to questions #9, #10, #13, and #14 on the post-test. These questions indicated if providers had preference for using the online resource tool developed by the co-investigator for the PIP when managing a potential or identified victim of human trafficking. Questions #13, #14, and #15 on the post-survey provided qualitative data to guide the co-investigator to the usefulness and recommended changes for the human trafficking toolkit, preference for choosing the human trafficking toolkit, and usefulness of the overall PIP education. After healthcare providers had a three-month window of opportunity to complete the educational sessions and review the online toolkit, the completed pre- and post-survey data that was collected through Qualtrics was analyzed by the co-investigator.

Conclusion

In conclusion, the PIP required a team approach for success. Integrating the Adult Learning Theory with the Iowa Model helped to create educational sessions and a human trafficking online toolkit for healthcare providers. Measuring the data obtained through the PIP allowed the co-investigator to determine the success of the pre-defined objectives as well as necessary changes that were needed for future educational implementations. Establishing baseline data and comparing that data to post-intervention data gave the co-investigator and the

multidisciplinary team useful information to help guide future implementations for healthcare providers throughout the state.

CHAPTER 4: RESULTS

Pre- and post-surveys were collected from NPs throughout the state of ND over a three-month time period from September 2021-December 2021. Surveys were sent via email through the NDNPA listserv, NDHTTF listserv, through the chat box during the NDNPA annual pharmacology conference, and through personal contacts. There were 42 participants who initiated the pre-survey. Twenty-five pre-surveys and 12 post-surveys were submitted. Only pre-surveys that were linked to completed post-surveys were kept for analysis. Of the 12 post-surveys analyzed, one of the surveys was eliminated due to being completed by an RN rather than an NP and one of the surveys was eliminated due to incomplete data. This allowed for 10 pre-surveys and 10 post-surveys to be analyzed. Demographic data was analyzed and can be viewed in Table 1.

Table 1

Demographics

Sex	**Frequency**	**Percent**
Male	0	0
Female	10	100%
Age		
25-35	4	40%
36-45	5	50%
56-65	1	10%
Ethnicity		
White	10	100%
Level of Education		
Masters	6	60%
Doctoral	4	40%
Care Type		
Family/Walk-in Clinic	5	50%
Specialty	4	40%
Inpatient Specialty	1	10%
Years of NP Practice		
0-1 years	3	30%
2-5 years	3	30%
6-10 years	3	30%
11-15 years	1	10%

Objective One

The first objective of the study was, "Healthcare providers will indicate increased perceived knowledge regarding identifying potential human trafficking victims and available resources to assist identified victims after the education." According to the pre-survey, 20% of respondents (N=10) had received human trafficking prior to this educational session. One of the individuals received the training through their workplace and one individual received human trafficking training through their NP education. Eighty percent of respondents had never received human trafficking training through their NP role.

Question #15 on the pre-survey and question #3 on the post-survey were identical questions and they were compared to each other to assess perceived knowledge changes. There were 9 sub-questions that all had the responses of "*none*", "*very little*", "*some*", and "*quite a bit*" (Appendix C). After comparing the pre- and post-survey responses, a majority of NPs showed perceived knowledge increases after the educational session. Ninety percent of respondents had an increased level of perceived knowledge regarding identifying potential human trafficking victims. In addition, 90% of respondents had an increased ability to identify the indicators of human trafficking.

Another finding related to perceived knowledge was that there was an 80% increase of respondents on the post-survey who were able to identify the health problems commonly experienced by victims of human trafficking. After the educational session, 70% of respondents were more confident in their ability to assess the danger affecting a patient who had been trafficked. Importantly, 90% of NPs had knowledge improvements regarding the ability to identify local and national support services for healthcare providers and victims after completing the education. Due to the information received in this educational session, 100% of respondents

indicated that they would make changes to their practice. After analyzing a subset of questions that measured NP knowledge, there was found to be an 86% overall increase in NP knowledge regarding human trafficking, which was also supported by 90% of NPs believing they had increased perceived knowledge after the educational session.

The Wilcoxon Signed Ranks nonparametric paired observations analysis was used to compare the pre- and post-survey questionnaires. All statistical testing methods used were performed using IBM SPSS Statistics software (Version 24.0.0.0; IBM), and the statistically significant relationships were defined as those with a p value less than 0.05. All of the results in Table 2 (below) were found to be significantly significant when comparing pre- and post-survey data.

Table 2

Knowledge Comparison

•	Pre-Survey (n = 10)				Post Survey (n = 10)				p value
	None	Very Little	Some	Quite a bit	None	Very Little	Some	Quite a bit	
Your role in identifying and responding to human trafficking	0%	30%	60%	10%	0%	0%	20%	80%	0.008
Indicators of human trafficking	0%	30%	70%	0%	0%	0%	10%	90%	0.006
What questions to ask to identify potential cases of human trafficking	0%	70%	30%	0%	0%	0%	30%	70%	0.006
What to say/not say to a patient who has experienced human trafficking	0%	80%	20%	0%	0%	0%	40%	60%	0.008
Health problems commonly experienced by people who have been trafficked	0%	50%	30%	20%	0%	0%	0%	100%	0.009
How to report human trafficking	10%	70%	10%	10%	0%	0%	40%	60%	0.009
Assessing danger for a patient who may have been trafficked	0%	60%	40%	0%	0%	0%	30%	70%	0.006
Local and/or national support services for people who have been trafficked	20%	60%	10%	10%	0%	0%	50%	50%	0.009
Local and/or national policies on responding to human trafficking	20%	60%	20%	0%	0%	0%	40%	60%	0.005

Respondents were also asked to select health care conditions associated with victims of human trafficking. All of the choices in the answer were correct. Eight respondents chose the correct responses on the pre-survey and the same eight respondents chose the correct responses on the post-survey.

Question #17 on the pre-survey and #5 on the post-survey also assessed perceived knowledge of NPs based on questions with true or false answers. Respondents were allowed to select from three answers indicating "*true*, "*false*", or "*not sure"* in response to each question. There were nine sub-questions that participants responded to. There was no discernable trend in improvement in perceived knowledge regarding this set of questions. Responses are reported in Table 3 below.

Table 3

Perceived Knowledge

Question	N (%) Answered correctly pre-survey N=10	N (%) Answered correctly post-survey N=10
The definition of human trafficking is restricted to women and girls who have been forced into prostitution. (False)	100%	100%
The majority of women who are trafficked for prostitution were sex workers before being trafficked. (False)	90%	80%
Children who are working for relatives in domestic situations cannot really be considered "trafficked". (False)	90%	100%
Trafficking is associated with post-traumatic symptoms. (True)	90%	100%
Trafficking is associated with chronic headaches. (True)	80%	90%
There are usually evident signs that a person in a trafficking situation. (False)	60%	60%
People who are being trafficked often have difficulty reporting these situations to outsiders, especially healthcare providers. (True)	90%	100%
Healthcare providers should NOT ask trafficked people about violence that they might have suffered, as the topic is too traumatic. (False)	90%	80%
Calling the police if I suspect a trafficking situation could put the patient in more danger. (True)	10%	20%

Two qualitative questions were used to elicit feedback regarding knowledge gain and practice change as a result of increased perceived knowledge. Question #11 was used to determine the most impactful information that was learned by participants during the educational sessions. Table 4 indicates responses from participants.

Table 4

Knowledge Improvement

What was the most impactful information that you learned from this education?	• "The different forms of trafficking that helped broaden my definition of what human trafficking is" • "I found the patient examples to be helpful to see how different scenarios present" • "The general state data regarding the numbers of victims within our communities. Contact information to be able to follow through on findings." • "There is a human traffic specific person available to see patients if needed. ND has many trafficking issues." • "Assessment findings and clues to hone in on for people who might be trafficked."

Question #12 was used to elicit feedback on the post-survey to determine if NPs plan to make changes to their practice when managing suspected or identified victims of human trafficking after viewing the educational sessions. All participants answered "*yes*" in response to this question. Common themes found through responses include the desire for NPs to ask more questions regarding human trafficking while assessing patients in the clinical setting and having increased awareness of this issue facing patients. The participants' plans for practice changes are included in Table 5.

Table 5

Practice Changes

How will you change your practice after receiving this education?	• "Can hopefully better recognize red flags and how to approach a patient" • "Ask more pertinent questions to determine if someone has is being human trafficked" • "More questions of patients" • "Be more vigilant in considering these situations when seeing patients" • "always be kind - and ASK!! give the moment they can respond to." • "I am more aware of the prevalence in my community." • "Be more aware if a patient may need help." • "awareness of clues/indications" • "Be more aware and intentional to assess and look for cues that might indicated someone is being trafficked."

Objective Two

The second objective of the PIP was, "Healthcare providers will indicate increased perceived confidence in knowing how to manage a potential human trafficking situation in the practice setting by the end of the education". Question #13 on the pre-survey and #2 on the post-survey assessed NPs perceived level of confidence regarding prior treatment of a human trafficking victim. After the educational session, 100% of respondents believed that they had been in contact with a victim in the clinical setting. Prior to the educational session, 20% of respondents did not think that they had ever had prior contact with a victim, indicating that after receiving the education, two respondents had increased suspicion that they actually had been in contact with a victim of human trafficking previously.

Question #19 on the pre-survey and #7 on the post-survey were compared for changes made in regards to NP perceived level of confidence in managing a potential or identified victim of human trafficking in the clinical setting. On the pre-survey, 70% indicated "*very little*" perceived confidence and 30% indicated "*some*". Comparatively, confidence increased on the

post-survey with 50% indicated "*some*" perceived confidence and 50% indicated "*quite a bit*" of confidence.

Objective Three

The third objective of this PIP was "Healthcare providers will indicate willingness to use the North Dakota Human Trafficking Task Force online resource tool to help identify and manage suspected or confirmed cases of victims of human trafficking in the clinical setting when applicable". The questions related to this objective were #21 on the pre-survey and #9, #10, #13, and #14 on the post-survey.

Question #21 on the pre-survey asked respondents if they "*have ever utilized a resource for researching human trafficking in the clinic setting*". All of the respondents indicated that they had never used a resource in the clinic setting. On the post-survey, question #9 was a qualitative question that asked NPs to indicate their preference for a resource that they might use in clinic setting for identifying and managing the care of a suspected human trafficking victim after receiving this education. Five of the ten participants responded to this question with resources that were provided in the online toolkit. Their responses seen in Table 6.

Table 6

Resource Preference

After completing this education, what might be a resource(s) you would use as a guide for identifying or managing the care of a suspected human trafficking victim in your clinical setting?	• "National Human Trafficking Resource Center" • "960 form National hotline, text thread - allowing for 24-hour communication Melissa Kaiser & Analena Lunde contacts " • "AAG for Medical Professionals" • "ND trafficking hotline" • "This resource kit/training."

Question #10 was used to elicit quantitative data to determine respondent preference for using the human trafficking toolkit that was created by the co-investigator for this PIP. On a

scale of 0-10, with "*0*" being not at all and "*10*" being highly likely, respondents were asked, "*What is the likelihood that you would use this human trafficking toolkit in the event of a suspected or identified victim of human trafficking?*". All of the respondents indicated a five or higher, with half of the respondents indicating that they would be highly likely (10) to use the toolkit provided. The results are shown in Table 7.

Table 7

Toolkit Use

0=Not At All; 10= Highly Likely	0	1	2	3	4	5	6	7	8	9	10
What is the likelihood that you would use this Human Trafficking Toolkit in the event of a suspected or identified victim of human trafficking?	0%	0%	0%	0%	0%	10%	0%	10%	10%	20%	50%

Respondents were also asked, in question #13 of the post-survey, if they believed that the human trafficking toolkit was a comprehensive tool that fit the needs of their practice. Ninety percent of respondents indicated "*yes*" and 10% of respondents indicated "*no*". Qualitative data was elicited to determine why respondents thought the human trafficking toolkit was useful or not. Four participants responded positively and indicated that it was: "*easy and straightforward",* "*succinct and easy to use*", "*good tool to have for reference and take with if I ever move departments*", "*has screening tools and referral information I can use*". One respondent who selected "*no*" indicated that: "*I don't typically see patients in the outpatient setting*". No participants provided qualitative feedback on #14 of the post-survey when asked if they had suggestions or changes for the human trafficking toolkit.

Qualitative data was elicited from participants at the end of the post-survey to determine if the PIP met the respondents needs for education on human trafficking. Question #15 asked, "*Did this education meet your needs regarding the topic of human trafficking*?". In response,

100% of participants indicated "*yes*". Table 8 shows their narrative feedback to this question, with three of the six narrative responses indicating the education was comprehensive.

Table 8

PIP Feedback

Did this education meet your needs regarding the topic of human trafficking?	• "Succinct and comprehensive presentation" • "Assists in ways to ask tough questions about trafficking." • "It provided comprehensive education on the topic, how to recognize, and what your next steps should be" • "very comprehensive and eye opening information. gave data, tools, examples and recommendations on how to put identify trafficking and what to do next." • "Very informative" • "I learned more on identification, how to communicate, and what to do if I suspect someone may be trafficked."

Question #16 of the post-survey asked respondents to, "*Please comment on any suggestions you have for improving this education*". Table 9 provides insight into the data provided by the respondents.

Table 9

PIP Improvement Suggestions

Please comment on any suggestions you have for improving this education.	• "I wish there would have been a little more time spent in the presentation of who to contact or the process of reporting" • "this would have been great/better as a live educational forum" • "this was extremely interesting and informative; thank you for sharing this valuable information." • "good information and helpful in understanding the topic. didn't have much awareness of knowledge of this topic working in a specialized clinic versus Family medicine" • "Perhaps some interactive questions to assess learning or application during the presentation to make the learner have to apply the information for better retention later."

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

Summary

The first finding, pertaining to objective one, was that NPs surveyed follow the national trend of not receiving education on human trafficking (Lo et al., 2020). Eighty percent of NPs indicated that they had not received human trafficking education in their role as a healthcare provider. This finding indicates the need for continued human trafficking education for healthcare providers within ND. As reported by the NDHTTF (n.d.), only 15,131 professionals (healthcare providers, community members, first responders, law enforcement, etc.) in ND have been trained prior to this educational session, which indicates a large need for additional healthcare provider training in ND as there is an estimated 53,030 ND healthcare employees as reported by Kaiser Family Foundation (2021). According to Lo et al. (2020), only 3% of healthcare workers within the U.S. have ever received human trafficking education. Although the national statistic is lower than the sample in this PIP, the data obtained in this PIP suggests to the co-investigator that significant need for healthcare provider education exists. Reasons to explain the inconsistencies of the results of this PIP versus national statistics are that this PIP was not required by healthcare providers. NPs who voluntarily participated in this PIP likely participated as they have an increased interest in human trafficking, thought the information would benefit them in their role as an NP, or are more likely to seek out education on their own for free CE credits. Requiring this education for all NPs, as well as other healthcare providers working in ND may provide a more accurate sample and have a statistical value that resembles the national average more closely.

There was also a positive increase of perceived knowledge from the pre-survey to the post-survey. Ninety percent of respondents reported an increased level of perceived knowledge

regarding identifying potential human trafficking victims. In addition, 90% of respondents reported an increased ability to identify the indicators of human trafficking.

Another positive finding related to perceived knowledge was that there was an 80% increase of respondents on the post-survey who were able to identify the health problems commonly experienced by victims of human trafficking. After the educational session, 70% of respondents were more confident in their ability to assess the danger affecting a patient who had been trafficked. Importantly, 90% of NPs had knowledge improvements regarding the ability to identify local and national support services for healthcare providers and victims after completing the education. Due to the information received in this educational session, 100% of respondents indicated that they would make changes to their practice. After analyzing a subset of questions that measured NP knowledge, there was found to be a statistically significant increase in NP knowledge regarding human trafficking, which was also supported by 90% of NPs believing they had increased perceived knowledge after the educational session. This can possibly be attributed to catering to the adult learner and allowing them to seek out comprehensive education of interest that they can fit into their busy schedules. These results are congruent with a study conducted by Lutz (2018) in which NP students demonstrated an increase in knowledge after a one-hour educational intervention. Although these studies have similar data, differing levels of participants' education (NPs versus NP students) between the studies must be acknowledged as level of education, work experience, and clinical practice are variable factors. Another study completed by Chisholm-Straker et al. (2012) demonstrated that after a brief 20-minute educational session, there was a knowledge increase in healthcare provider ability to define human trafficking (71.1% increase), identify a victim of human trafficking (49% increase), and provide treatment to a victim of human trafficking (49% increase).

In addition, the findings of this PIP are also supported by Shin et al. (2020) which demonstrated that healthcare professionals are better able to assist victims of human trafficking after receiving formal education. The co-investigator found that results of this PIP had larger perceived knowledge increases than found in the literature which may be attributed to the fact that this PIP was 3 hours in length, which allowed more time for thorough education to be deployed compared to other educational sessions that were 20 minutes to one hour in length. Qualitative feedback to support Objective One, found in Tables 4, 5, and 6 provided feedback that allowed respondents to explain the ways in which the PIP provided perceived knowledge increases.

The co-investigator found that there was an increase in perceived confidence in NP ability to manage a potential human trafficking situation in the practice setting after completing the educational session. After the educational session, 100% of respondents believed that they had been in contact with a victim in the clinical setting. Prior to the educational session, 20% of respondents did not think that they had ever had prior contact with a victim, indicating that after receiving the education, two respondents had increased suspicion that they actually had been in contact with a victim of human trafficking previously. This discovery is likely due to the increase in knowledge of human trafficking and its indicators. Increasing NP knowledge improves the ability to recognize and identify potential victims of human trafficking in the clinical setting. The post-survey indicated that 80% of respondents showed an increase in perceived level of confidence in managing a potential or identified victim of human trafficking. Eighty percent of respondents also indicated an increased level of perceived confidence to make the appropriate referrals for human trafficking victims. A similar study completed by Donahue et al. (2019) found that 96% of healthcare providers found human trafficking education to be useful in the

clinical setting and that there were increased levels of confidence in identifying, treating, and addressing human trafficking in the clinical setting after the educational session. After reviewing the results, the co-investigator was able to determine that this PIP was effective in improving perceived knowledge and confidence in NPs in regards to identifying and managing victims of human trafficking.

Based off of the results of Objective Three, the co-investigator discovered that 90% of respondents indicated that the human trafficking toolkit was a comprehensive toolkit that fit the needs of their practice. Also, a majority of respondents indicated that they would use the toolkit when identifying or managing a suspected or identified victim of human trafficking. No respondents had any changes or recommendations for the human trafficking toolkit. Some of the reasons that may have hindered this feedback is that not all participants may have had the opportunity to view the human trafficking toolkit as accessing the toolkit was not required in order to obtain CE credits. Other participants indicated that they have not treated potential or confirmed victims of human trafficking in the past, so it would be difficult to know what information would be useful in a human trafficking toolkit until they have needed to use the toolkit in the clinical setting. After participants have used the toolkit in clinical practice, they may determine that additional resources may be useful for reference when identifying victims of human trafficking.

Discussion

Upon reviewing the results, the co-investigator did not find demographic data that influenced the results of the PIP. There was no data to support level of education, previous education, or practice setting with increased perceived knowledge, confidence, or willingness to use the online toolkit. After considering the demographics, 100% of participants identified as

female and 100% of participants identified as white, which closely aligns with the national trend of 92.3% of NPs identifying as female, and 86.6% identifying as white/European non-Hispanic (Zwilling & Owens, 2017).

On the pre-survey, 20% of NPs were under the assumption that they had never cared for a victim of human trafficking in the clinical setting. After receiving the education, all providers had the belief that they may have had contact with a victim in the clinical setting in the past. This change is likely due to the fact that "healthcare providers lack appropriate knowledge of clues that would lead to victim identification" (Lutz, 2018, p. 66). After providing education to NPs, there was a 90% knowledge improvement regarding the indicators of human trafficking. By increasing the knowledge of human trafficking and the indicators of a trafficked person, NPs have heightened understanding regarding the likelihood of encounters with victims within their clinical setting.

Lo et al. (2020) reported that only 3% of healthcare providers have ever received training in human trafficking. According to this PIP, 20% of NPs had received training in human trafficking in the past. Although there was a higher reported incidence of individuals who have received training in the past, 20% still shows a need for NP education. Due to the small sample size and unknown practice location of the NPs, these statistics cannot be generalized to all NPs working within the state of ND. This data does support the lack of policies, procedures, standardization of information, and training in place in healthcare facilities throughout ND. Although 20% of respondents had received prior human trafficking education, only 10% of respondents had received training through their workplace. This statistic supports the fact that a majority of healthcare facilities do not have standardized human trafficking educational opportunities for NPs. As participants had the opportunity to self-select into this project,

participants may have chosen to participate in this PIP due to increased interest in the topic area and they may have also sought additional education on this topic area prior to this educational opportunity.

After completing the educational session, 90% of NP participants believed that they do have a responsibility to respond and provide interventions to suspected cases of human trafficking. This was similar to data presented by Chisolm-Straker et al. (2012) in which only 10.6% of respondents reported that they provided interventions to victims of human trafficking while they were in their care. Providing education through this PIP on the available resources, reasons to contact available resources, the importance of victim safety and reporting, and the anonymity of reporting likely contributed to this knowledge increase. One participant from this PIP commented that the education in this PIP informed them that "*there is a human trafficking specific person available to see patients if needed".* Another participant responded that, "*It provided comprehensive education on the topic, how to recognize, and what your next steps should be*.". One participant did request more information on who to contact in the event that the NP identified a suspected or confirmed victim of human trafficking.

As reported by Lo et al. (2020), there is an increased understanding of human trafficking from 43 to 93% after completing online training sessions. The results of this PIP support the finding that 90% of NPs who completed this education reported increased perceived knowledge, and 80% of NPs reported increased perceived confidence in identifying and managing victims of human trafficking after the educational session. After analyzing the data, the co-investigator determined that Objectives One and Two were met as a result of this PIP. The online educational sessions proved to be an effective platform for delivering this education. All respondents indicated that this education met their needs regarding human trafficking. Although there was an

increase in perceived knowledge and perceived confidence, one respondent indicated that the educational sessions would have been better if they were completed "*as a live educational forum*". The online educational sessions did not allow for participants to respond to questions posed by the presenters, ask questions, or interact with the presenters.

The educational session used a lecture format as well as an online human trafficking toolkit for participants to access. At the conclusion of the educational session, 90% of respondents indicated that the toolkit was a comprehensive toolkit that would fit the needs of their practice. As a result of the educational sessions and development of the online toolkit, 50% of respondents indicated that they would use resources from this toolkit in their clinical setting for identification and management of a human trafficking victim. None of the respondents suggested changes for improvement to the toolkit. Respondents reported that the toolkit is "*easy and straightforward*", "*succinct and easy to use*", "*a good tool to have for reference and take with if ever move departments*", and that it "*has screening tools and referral information I can use".* Although there are several online resources available for healthcare providers to use to aid in victim identification and management (HEAL, Polaris, National Human Trafficking Hotline), the co-investigator did not find any other studies which compared the usefulness and effectiveness of such resources. This prevented the co-investigator from being able to compare the success, strengths, and weaknesses of this toolkit. The implementation of this toolkit was at the suggestion of the principal investigator. The goal of this toolkit was to create a useful resource of local and national resources, contacts, and identification and management tools that NPs can use in the clinical setting to aid in the identification and management of human trafficking victims. As 50% of respondents indicated willingness to utilize the toolkit, the goal of Objective Three was partially met.

Recommendations

Based on the results of this PIP, the co-investigator recommends that the educational modules that were developed for the purpose of this PIP continue to be disseminated to NPs and other healthcare providers who may interact with victims of human trafficking. As the NDHTTF works closely with healthcare providers, the co-investigator would encourage the NDHTTF to use their website as a way to disseminate these educational modules to healthcare providers who may seek out educational opportunities as well as continuing to disseminate these modules to organizations requesting training for healthcare providers. The co-investigator would also encourage the NDHTTF to work nationally to establish standardized educational requirements for healthcare providers and implement these requirements at the state level. The co-investigator also encourages the NDNPA to partner with the NDHTTF on this important topic to further publicize and disseminate these educational modules to NPs, especially in departments such as emergency departments, urgent cares, walk-in-clinics, and primary care provider clinics.

Limitations

Although the online educational sessions did provide increased perceived knowledge, perceived confidence, and a beneficial human trafficking online toolkit for participants to use, there were limitations discovered throughout the analysis of the results of this PIP. First, the co-investigator should have completed a formal introduction at the beginning of the educational session. The formal introduction should have included the purpose of the PIP, the objectives, and additional information regarding access to and the intended use of the human trafficking toolkit. The co-investigator collaborated with the presenters on the literature review and intent of the educational sessions but the human trafficking toolkit was not included in those discussions and therefore was not included in the educational session by the presenters. Having the co-

investigator introduce the presenters and toolkit could have encouraged more participants to identify the human trafficking toolkit as a resource to use for identifying or managing the care of a suspected human trafficking victim in the clinical setting and provided more clarity.

As a result of this education, 50% of respondents identified specific instruments from the online toolkit that they would use in their clinical setting when identifying or managing a victim of human trafficking. The other 50% of respondents did not provide feedback regarding its use in the clinical setting. Future PIPs should require respondents to respond to this question, rather than leaving the response optional, to elicit more feedback and understand the usefulness of the toolkit. Providing additional information into the use and purpose of the toolkit may have increased the percentage of participants who identified specific instruments provided within the toolkit. The co-investigator should have also evaluated the human trafficking toolkit to "other online resources" on the post-survey. This data would have been helpful in identifying if the human trafficking toolkit was comprehensive in meeting the needs of NPs, or if other online resources were still preferred for use in the clinical setting. Knowing NP preference would also encourage the co-investigator to include these specific instruments into the online toolkit for future use.

Another limitation was the length of the pre- and post-surveys. There were 25 participants who completed the pre-survey and only 12 post-surveys were completed. This may be due to the length of time required to complete the surveys. Although data collection was necessary and the information was useful for analysis by the co-investigator, this may have hindered NPs from completing the PIP. The "*true*" and "*false*" questions from the PROTECT tool (Table 3) could have been eliminated from the surveys as the responses did not directly relate to the objectives of this project. The removal of this subset of questions, which included 9

total questions, would have shortened the pre- and post-surveys and may have resulted in increased completion of the PIP.

The pre-survey should have also inquired about the percentage of employment facilities that have policies and procedures in place for assisting victims of human trafficking. Data was retrieved regarding the percentage of respondents who have ever received training, but this did not correlate with the percentage of hospitals who have policies and procedures in place. As Donahue et al. (2019) reports that only 1% of U.S. hospitals have policies and procedure in place for treating victims of human trafficking, retrieving this data from the PIP would be helpful for future project implementations that could result in the integration of hospital policies and procedures for NPs to follow.

Another barrier to successful implementation of this PIP is that emails sent out via the NDNPA listserv went to some NPs' spam folders which resulted in a small sample size and prohibited the ability for NPs to receive and complete the education. For future implementations, determining a more successful method for recruitment is necessary. Presenting the education and partnering with healthcare facilities to distribute the education to specific departments such as emergency departments, urgent cares, walk-in-clinics, and primary care provider clinics, as well as using healthcare facility listserv, may allow for improved communication with NPs throughout the state of ND.

Focusing on specific units or organizations would also allow for insight into different sample sizes for comparison. A majority of the NPs who participated in this PIP work in specialty clinics in which the volume of human trafficking victims may be lower than in other settings defined by Lederer & Wetzel (2014) such as Planned Parenthood, urgent care, primary care providers, or women's health clinics. Deploying the educational sessions to specific

departments that have a high yield for potential or confirmed victims of human trafficking may increase the number of participants who complete the education.

Finally, one respondent requested interactive questions to assess learning and application throughout the educational session. Interactive questions throughout the educational session would be valuable to ensure the learner is engaged and may help to improve retention. The addition of interactive questions throughout the educational sessions should be considered for future development and implementation of this PIP.

Strengths

Although there were limitations found that should be considered to improve future PIP implementations, there were also strengths found in this PIP as well. A majority of respondents indicated that the delivery of this PIP met their educational needs. One respondent made a PIP improvement suggestion that requested a live/in-person educational session A live event would have allowed the opportunity to ask pertinent and valuable questions to improve the learning experience throughout the educational session. As the delivery format was determined to be supportive of NP work/life schedules and safety during the COVID-19 pandemic, providing contact information for the presenters was a useful alternative in order for participants to contact the presenters with additional questions, comments, or concerns.

As discovered by the co-investigator, there was increased levels of perceived knowledge and perceived confidence after completing the educational session which demonstrates that the online delivery was a useful method of educating NPs in the state of ND. The majority of respondents also indicated that the human trafficking toolkit was a comprehensive toolkit that met their needs and no requests were made for changes to the toolkit.

Partnering with the NDHTTF was very beneficial for the success of this PIP. Providing insight into human trafficking in ND directly from the task force allowed for accurate and meaningful insight that allowed participants a unique perspective into the problems affecting the state of ND. Partnering with the NDHTTF provided the foundation for local and pertinent education for ND, rather than a generic nationwide approach. The NDHTTF also provided local resources and contacts to better equip healthcare providers when working with a potential or identified victim of human trafficking.

Another strength of this PIP was the length of time and designation of CE credits. This PIP provided holistic, well rounded, and comprehensive education to the participants. Collaborating with the NDHTTF to develop succinct educational sessions that provided necessary and pertinent education allowed for increases in perceived knowledge and confidence for participants. Providing free CE credits as incentive helped to encourage participation and support NPs in practice for continuing their education.

Lastly, 90% of participants indicated that they would change their practice after viewing the educational session. This finding indicates that almost all of the participants had a knowledge deficit that was improved by the PIP. Implementing practice changes is necessary to improve the NPs ability to identify and manage victims in the clinical setting.

Dissemination

The discoveries made from this PIP will be discussed with the NDHTTF, shared with the dissertation committee through the co-investigator's final defense, sent through the NDNPA and NDHTTF email listserv, and were shared through a poster presentation in the fall of 2021 in which the methods and timeline were discussed, but the results were not available at that time for dissemination. Another poster presentation is planned for the spring of 2022 in which the entire

project, including the results, will be presented. There is an additional opportunity to disseminate these results to a larger audience through the HEAL network and journal publication through the *Journal of Human Trafficking*.

Conclusion

The purpose of this PIP was to increase NP perceived knowledge and confidence levels regarding human trafficking prevalence, identification, and resource utilization within ND and to provide a human trafficking online toolkit for reference and utilization within the clinical setting. The development of this PIP required the co-investigator to utilize the strengths of the doctoral prepared NP (DNP) role which include research, education, planning, organizing, interdisciplinary collaboration, analysis, and leadership.

The co-investigator first had to determine the problem, identify the need, and research the evidence and best practice. Next, the co-investigator had to plan for the implementation which required interdisciplinary collaboration with the dissertation committee, NDHTTF, and other members who were necessary for the development and implementation of this PIP. Creating educational sessions which were beneficial to NPs within the state was a main component of this PIP. The co-investigator wanted to be sensitive of the time constraints that NPs face, but also provide enough education that increased perceived knowledge and confidence levels.

NPs are front line defenders for being able to combat human trafficking. According to the AACN (2021), domain 2 of *The Essentials: Core Competencies for Professional Nursing Education* calls NPs to provide person-centered care by providing "holistic, individualized, just, respectful, compassionate, coordinated, evidence-based, and developmentally appropriate" care. This domain challenges NPs to aid in the identification and management of victims of human trafficking by building rapport with individuals, providing holistic evidence-based treatment

plans, collaborating with other members of the healthcare team, and ensuring that resources are available to the patient.

NPs are often highly regarded for providing thorough education. This PIP was an opportunity for the co-investigator to learn how to provide thorough, time sensitive, interactive, and pertinent education for the purpose of improving NP practice. At the completion of this PIP, the co-investigator used analytical skills to organize and report the data in an accurate and meaningful way that reflected the perceived knowledge and confidence improvements reported by participants. Finally, the co-investigator built upon leadership skills to organize, collaborate, and complete this PIP and meet the goals and deadlines of the SON. Although there were limitations, the findings from this PIP met its main objectives and provides recommendations for future research and implementations on this topic. This PIP provided the necessary foundation and building blocks for implementation into a future career as a DNP.

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APPENDIX A: IRB APPROVAL

NDSU NORTH DAKOTA STATE UNIVERSITY

07/16/2021

Dr. Heidi Lynn Saarinen
Nursing

Re: IRB Determination of Exempt Human Subjects Research:
Protocol #IRB0003758, "Healthcare Provider Education for Recognizing and Assisting Victims of Human Trafficking"

NDSU Co-investigator(s) and research team:

- Heidi Lynn Saarinen
- Haley Nicole Vangerud

Approval Date: 07/16/2021
Expiration Date: 07/15/2024
Study site(s): The modules will be recorded in YouTube and/or Zoom in an online format and will be distributed through the NDNPA listserve and website, NDHTTF website, and NDSU School of Nursing website. Participants will be able to view the modules and fill out the surveys online in their own preferred setting with internet access in a time frame that suits their needs within the three-month time frame after IRB approval. The participants will complete pre and post-survey collection through Qualtrics at the beginning and end of the educational modules.
Funding Agency:
The above referenced human subjects research project has been determined exempt (category 1) in accordance with federal regulations (Code of Federal Regulations, Title 45, Part 46, *Protection of Human Subjects*).

Please also note the following:

- The study must be conducted as described in the approved protocol.
- Changes to this protocol must be approved prior to initiating, unless the changes are necessary to eliminate an immediate hazard to subjects.
- Promptly report adverse events, unanticipated problems involving risks to subjects or others, or protocol deviations related to this project.

Thank you for your cooperation with NDSU IRB procedures. Best wishes for a successful study.

NDSU has an approved FederalWide Assurance with the Department of Health and Human Services: FWA00002439.

RESEARCH INTEGRITY AND COMPLIANCE
NDSU Dept 4000 | PO Box 6050 | Fargo ND 58108-6050 | ndsu.research@ndsu.edu
Shipping Address: Research 1, 1735 NDSU Research Park Drive, Fargo ND 58102

APPENDIX B: EXECUTIVE SUMMARY

Executive Summary

Healthcare Provider Education for Recognizing and Assisting Victims of Human Trafficking

Introduction

Human trafficking has increasing prevalence in the United States (U.S.) with an estimated 1.6 million people trafficked at any time. Healthcare systems are one of the most critical access points for identifying and recognizing victims of human trafficking. Unfortunately, a majority of healthcare providers have never received training on human trafficking. There are approximately 835 nurse practitioners (NPs) within the state of North Dakota (ND). With increasing prevalence of human trafficking in the U.S., education for healthcare providers must be provided in order to aid in the fight against human trafficking.

Project Design

The practice improvement project (PIP) used a descriptive mixed methods approach by electronically distributing surveys to (NPs) working in North Dakota (ND). This PIP consisted of providing educational sessions that were electronically deployed to NPs in ND through email, the North Dakota Nurse Practitioner annual pharmacology conference, and word of mouth. An online toolkit was developed and provided to participating NPs to use in their clinical setting when identifying or managing a victim or human trafficking. Pre- and post-surveys were used to determine if the educational sessions improved NP perceived knowledge and confidence levels regarding human trafficking victim identification and management. The surveys also helped to determine if NPs would use the online toolkit.

Main Findings

- NPs in ND lack education regarding identification and management of human trafficking victims.
- Providing education to NPs increased the ability of the NP to recognize and identify victims of human trafficking within the clinical setting.
- After receiving education, 80% of participants had increased perceived confidence levels and 90% of participants had increased levels of perceived knowledge.
- Participants had increased knowledge of local and national resources to contact in a suspected or confirmed case of human trafficking.
- Delivering electronic educational sessions was an effective method for providing educational sessions to NPs.
- A majority of participants indicated that the online toolkit met their needs.

Recommendations

- Although this PIP adds to the topic of providing education on human trafficking for NPs in ND, additional PIPs need to be implemented with larger sample sizes to increase the number of healthcare providers who receive this education and to determine if the data is synonymous across differing healthcare professions (physicians, physician assistants, nurses, etc.).
- Collaborating with healthcare facilities throughout the state of ND may increase the sample size of this PIP.
- Future PIPs should inquire about the percentage of healthcare facilities within ND that have policies and procedures in place regarding human trafficking.

Conclusion

The results of this PIP should be used as a guide to provide additional education on human trafficking for healthcare providers in ND. Although there were limitations, this PIP provided a strong foundation for providing education, assessing perceived knowledge and confidence gains, and providing an online toolkit for healthcare providers to access in the clinical setting. Human trafficking education needs to be implemented for all healthcare providers to aid in the identification and management of victims of human trafficking.

APPENDIX C: PRE-SURVEY

Human Trafficking Pre-Survey

Q1 NDSU North Dakota State University School of Nursing
1401 Albrecht BLVD, 136 Sudro Hall
Fargo, ND 58102
NDSU Dept. 2670 PO Box 6050
Fargo, ND 58108-6050
701.231.7395

Title of Research Study: Healthcare Provider Education for Recognizing and Assisting Victims of Human Trafficking

To Whom This May Concern:

My name is Haley Fisher. I am a graduate student in the School of Nursing at North Dakota State University, and I am conducting a research project regarding human trafficking in the health care setting. The goals of the education are to determine the perception of human trafficking education, determine current and changed levels of perceived confidence and knowledge regarding human trafficking identification and management in the clinical setting, and the use of known resources to aid victims of human trafficking. It is our hope, that with this research, there will be increased levels of perceived confidence and knowledge when treating potential victims of human trafficking as well as increased awareness of available resources after completing the educational modules.

Because you are a current Nurse Practitioner practicing in the state of North Dakota, you are invited to take part in this research project. Your participation is entirely your choice, and you may change your mind or quit participating at any time, with no penalty to you.

It is not possible to identify all potential risks in research procedures, but we have taken reasonable safeguards to minimize any known risks. These known risks may include: loss of confidentiality, and emotional or psychological distress.

By taking part in this research, you may benefit by increasing your perceived level of confidence and knowledge in identifying, treating, and managing patients who are potential or current victims of human trafficking, as well as improved knowledge regarding the available resources to aid in victim identification and management. However, you may not get any benefit from being in this study. Benefits to potential victims of human trafficking are likely to include improved trust and communication with the healthcare team, increased opportunity for identification and assistance, and improved health outcomes for potential victims of human trafficking.

The pre and post-surveys will take approximately 10 minutes to complete. There are two educational modules, each one and a half hours in length to complete after completing the pre-survey. The pre-survey, educational modules, and post-survey are included in the link you used to access this consent. After completion of the post-survey, three continuing education credits will be available to you.

We will keep private all research records that identify you. Your information will be combined with information from other people taking part in the study, we will write about the combined information that we have gathered. You will not be identified in these written materials. We may publish the results of the study; however, we will

keep your name and other identifying information private.

If you have any questions about this project, please contact me at 701-446-7280 or haley.fisher@ndsu.edu, or contact my advisor at 701-231-7821 or heidi.saarinen@ndsu.edu.

You have rights as a research participant. If you have questions about your rights or complaints about this research, you may talk to the researcher or contact the NDSU Human Research Protection Program at 701.231.8995, toll-free at 1-855-800-6717, by email at ndsu.irb@ndsu.edu, or by mail at: NDSU HRPP Office, NDSU Dept. 4000, P.O. Box 6050, Fargo, ND 58108-6050.

Thank you for your taking part in this research. If you wish to receive a copy of the results, please send me an email in order to receive a finalized copy of this dissertation.

Q2 Please enter a passcode prior to beginning the pre-survey. This same passcode will also be used on the post-survey. This passcode should be your first and last initials followed by the last 4 digits of your phone number. (Ex. Haley Fisher, 701-123-4567: passcode = HF4567)

_____

Q3 Gender Identity

- ○ Male (4)
- ○ Female (5)
- ○ Non-binary / third gender (6)
- ○ Prefer not to say (7)

Q4 Age

- ○ 25-35 (1)
- ○ 36-45 (2)
- ○ 46-55 (3)
- ○ 56-65 (4)
- ○ 66 and above (5)

Q5 Ethnicity

- White (1)
- Black or African American (2)
- American Indian or Alaska Native (3)
- Asian (4)
- Native Hawaiian or Pacific Islander (5)
- Other (6)

Q6 Level of Education

- MD or DO (1)
- Nurse Practitioner (2)
- Physician Assistant (3)
- Nurse (4)
- Other (5)

Q7 Level of Education

- Master Degree (1)
- Doctoral Degree (2)

Q8 Current job title?

_____

Q9 What type of clinic do you practice in and what is your specialty?

_____

Q10 How many years have you been practicing as a Nurse Practitioner?

- 0-1 (1)
- 2-5 (2)
- 6-10 (3)
- 10-15 (4)
- 16-20 (5)
- 20 years or greater (6)

Q11 Have you ever received training on human trafficking within your current role?

- Yes. If yes, please indicate how many hours of training you have received in the text box below. (1)

_____

- No (2)

Q12 If you have received human trafficking education in the past, who provided the education and how long ago did you receive the education?

Q13 Have you ever been in contact with a patient whom you knew or suspected had been trafficked?

- Yes, definitely. (1)
- I believe so, but I am not sure. (2)
- No. (3)
- I do not believe so. (4)

Q14 If yes, how did you know or suspect that the patient(s) had been trafficked?

- ○ Patient disclosure. (1)
- ○ Disclosure by another professional. (2)
- ○ Patient displayed signs that indicated they had been trafficked. (3)
- ○ Other (please specify). (4) _____
- ○ N/A (5)

Q15 Please indicate how much you feel you know about the following:

	None (1)	Very Little (2)	Some (3)	Quite a Bit (4)

Your role in identifying and responding to human trafficking (1)	○	○	○	○
Indicators of human trafficking (2)	○	○	○	○
What questions to ask to identify potential cases of human trafficking (3)	○	○	○	○
What to say/not say to a patient who has experienced human trafficking (4)	○	○	○	○
Health problems commonly experienced by people who have been trafficked (5)	○	○	○	○
How to report human trafficking (6)	○	○	○	○
Assessing danger for a patient who may have been trafficked (7)	○	○	○	○
Local and/or national support services for people who have been trafficked (8)	○	○	○	○
Local and/or national policies on responding to human trafficking (9)	○	○	○	○

Q16 Please respond to the following:

	None (1)	Very Little (2)	Some (3)	Quite a Bit (4)
What is your perceived knowledge level regarding identifying potential human trafficking victims? (1)	○	○	○	○

Q17 Please respond to the following:

	True (1)	False (2)	Not Sure (3)

The definition of human trafficking is restricted to women and girls who have been forced into prostitution. (1)	○	○	○
The majority of women who are trafficked for prostitution were sex workers before being trafficked. (2)	○	○	○
Children who are working for relatives in domestic situations cannot really be considered "trafficked". (3)	○	○	○
Trafficking is associated with post-traumatic symptoms. (4)	○	○	○
Trafficking is associated with chronic headaches. (5)	○	○	○
There are usually evident signs that a person in a trafficking situation. (6)	○	○	○
People who are being trafficked often have difficulty reporting these situations to outsiders, especially healthcare providers. (7)	○	○	○
Healthcare providers should NOT ask trafficked people about violence that they might have suffered, as the topic is too traumatic. (8)	○	○	○
Calling the police if I suspect a trafficking situation could put the patient in more danger. (9)	○	○	○

Q18 Which of the following problems in victims of human trafficking is(are) likely to be related to their trafficking situation? (Please select all that apply)

- [ ] Depression (1)
- [ ] Headaches (2)
- [ ] Post-traumatic stress (3)
- [ ] Memory Issues (4)
- [ ] Sexually Transmitted Infections (5)
- [ ] Death (6)

Q19 Please respond to the following:

	None (1)	Very Little (2)	Some (3)	Quite a Bit (4)
What is your perceived level of confidence in managing a potential or identified victim of human trafficking in the clinical setting? (1)	○	○	○	○

Q20 Please respond to the following:

	Strongly Disagree (1)	Disagree (2)	Neither (3)	Agree (4)	Strongly Agree (5)

My workplace allows me enough time to ask about trafficking if I suspected a person might have been trafficked. (1)	○	○	○	○	○
I would be comfortable asking a person if they were in a trafficking situation. (2)	○	○	○	○	○
Asking about experiences of exploitative situations is offensive to most patients. (3)	○	○	○	○	○
A patient's friend may interpret for him or her if I think that a person has been trafficked. (4)	○	○	○	○	○
Healthcare workers have a responsibility to respond to suspected cases of human trafficking. (5)	○	○	○	○	○
I have sufficient training in assist individuals in situations of human trafficking. (6)	○	○	○	○	○

I should contact the police immediately when I suspect a person has been trafficked. (7)	○	○	○	○	○
I am confident I can make the appropriate referrals for human trafficking victims. (8)	○	○	○	○	○
I know whom to contact in human trafficking situations. (9)	○	○	○	○	○

Q21 Have you ever utilized a resource for researching human trafficking in the clinical setting (either for identification, information, or managing the care of a suspected human trafficking victim)?

○ Yes. If yes, please indicate which one(s). (1) _____

○ No (2)

○ N/A (3)

APPENDIX D: POST-SURVEY

Human Trafficking Post-Survey

Q1 Please enter your passcode that was used prior to starting the pre-survey. This passcode should be your first and last initials followed by the last 4 digits of your phone number. (Ex. Haley Fisher, 701-123-4567: passcode = HF4567)

_____

Q2 After this education, do you now feel you have ever been in contact with a patient whom you knew or suspected had been trafficked?

- ○ Yes, definitely. (1)
- ○ I believe so, but am not sure. (2)
- ○ No. (3)
- ○ I do not believe so. (4)

Q3 Please indicate how much you feel you know about the following:

	None (1)	Very Little (2)	Some (3)	Quite a Bit (4)

Your role in identifying and responding to human trafficking (1)	○	○	○	○
Indicators of human trafficking (2)	○	○	○	○
What questions to ask to identify potential cases of human trafficking (3)	○	○	○	○
What to say/not say to a patient who has experienced human trafficking (4)	○	○	○	○
Health problems commonly experienced by people who have been trafficked (5)	○	○	○	○
How to report human trafficking (6)	○	○	○	○
Assessing danger for a patient who may have been trafficked (7)	○	○	○	○
Local and/or national support services for people who have been trafficked (8)	○	○	○	○
Local and/or national policies on responding to human trafficking (9)	○	○	○	○

Q4 Please respond to the following:

	None (1)	Very Little (2)	Some (3)	Quite a Bit (4)
After completing the education, what is your perceived knowledge level regarding identifying potential human trafficking victims? (1)	○	○	○	○

Q5 Please respond to the following:

	True (1)	False (2)	Not Sure (3)

The definition of human trafficking is restricted to women and girls who have been forced into prostitution. (1)	○	○	○
The majority of women who are trafficked for prostitution were sex workers before being trafficked. (2)	○	○	○
Children who are working for relatives in domestic situations cannot really be considered "trafficked". (3)	○	○	○
Trafficking is associated with post-traumatic symptoms. (4)	○	○	○
Trafficking is associated with chronic headaches. (5)	○	○	○
There are usually evident signs that a person in a trafficking situation. (6)	○	○	○
People who are being trafficked often have difficulty reporting these situations to outsiders, especially healthcare providers. (7)	○	○	○
Healthcare providers should NOT ask trafficked people about violence that they might have suffered, as the topic is too traumatic. (8)	○	○	○
Calling the police if I suspect a trafficking situation could put the patient in more danger. (9)	○	○	○

Q6 Which of the following problems in victims of human trafficking is(are) likely to be related to their trafficking situation? (Please select all that apply)

- [ ] Depression (1)
- [ ] Headaches (2)
- [ ] Post-traumatic stress (3)
- [ ] Memory Issues (4)
- [ ] Sexually Transmitted Infections (5)
- [ ] Death (6)

Q7 Please respond to the following:

	None (1)	Very Little (2)	Some (3)	Quite a bit (4)
After completing the education, what is your perceived level of confidence in managing a potential or identified victim of human trafficking in the clinical setting? (1)	○	○	○	○

Q8 Please respond to the following:

	Strongly Disagree (1)	Disagree (2)	Neither (3)	Agree (4)	Strongly Agree (5)

My workplace allows me enough time to ask about trafficking if I suspected a person might have been trafficked. (1)	○	○	○	○	○
I would be comfortable asking a person if they were in a trafficking situation. (2)	○	○	○	○	○
Asking about experiences of exploitative situations is offensive to most patients. (3)	○	○	○	○	○
A patient's friend may interpret for him or her if I think that a person has been trafficked. (4)	○	○	○	○	○
Healthcare workers have a responsibility to respond to suspected cases of human trafficking. (5)	○	○	○	○	○
I have sufficient training in assist individuals in situations of human trafficking. (6)	○	○	○	○	○
I should contact the	○	○	○	○	○

police immediately when I suspect a person has been trafficked. (7)					
I am confident I can make the appropriate referrals for human trafficking victims. (8)	○	○	○	○	○
I know whom to contact in human trafficking situations. (9)	○	○	○	○	○

Q9 After completing this education, what might be a resource(s) you would use as a guide for identifying or managing the care of a suspected human trafficking victim in your clinical setting?

Q10 Please respond to the following:

	0 (0)	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)

On a scale of 0-10 (with "0" being not at all and "10" being highly likely), what is the likelihood that you would use this Human Trafficking Toolkit in the event of a suspected or identified victim of human trafficking? (1)	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Q11 What was the most impactful information that you learned from this education?

Q12 Do you plan to change your practice as a direct result of this education?

- ○ Yes. If yes, please indicate how you plan to change your practice as a result of this education. (1) _____
- ○ No. (2)
- ○ Maybe. If maybe, please indicate how you might change your practice as a result of this education. (3) _____

Q13 After viewing the reference tool, do you feel like this is a comprehensive tool that will fit the needs of your practice?

- ○ Yes. If yes, please indicate why. (1) _____
- ○ No. If no, please indicate why not. (2) _____

Q14 Do you have suggestions or changes you would recommend for the online resource toolkit?

_____

Q15 Did this education meet your needs regarding the topic of human trafficking?

- ○ Yes. If yes, please explain how. (1) _____
- ○ No. If no, please explain what you needed that was not addressed. (2) _____

End of Block: Default Question Block

Start of Block: Block 1

Q16 Please comment on any suggestions you have for improving this education.

_____

APPENDIX E: PROTECT TOOL

PROTECT: Provider Responses, Treatment and Care for Trafficked People

We would like to know about your experiences, knowledge and opinions about human trafficking. Please answer the following questions, which will help us to understand your training needs. The survey is voluntary and should take approximately 10 minutes. This is not an exam; please record your first, instinctive answer.

Background Information	
1	**Gender:** Female ☐ Male ☐ **Age (years):** ☐☐ **Ethnicity**: White ☐ Mixed/multiple ethnic groups ☐ Asian/Asian British ☐ Black/ African/ Caribbean/ Black British ☐ Other (*please specify*) _____
2	**Current NHS role** (*e.g. clinical psychologist/receptionist*): _____ **Year of qualification** (if applicable): _____ **Clinical setting/speciality** (*e.g. community mental health team, GP surgery*): _____
Training	
3a	**Have you ever received training on human trafficking within your NHS role?** Yes ☐ (please answer below) No ☐ (*please go to Q4*) **If yes:** Approximately how much training have you received? _____(hours) or (days)_____ Who provided the training on human trafficking? _____ How long ago did you last receive this training (years)? _____
3b	**Which of the following areas were covered during the training on human trafficking?** (*Mark as many as apply*) General information: definitions and case studies ☐ Care approaches ☐ Why people are trafficked, types of trafficking ☐ Making referrals, giving information on national/local services ☐ Health problems associated with trafficking ☐ Local or international legislation on trafficking ☐ Indicators of human trafficking ☐ Other (please *specify*): _____
4	**Have you ever received training on violence against women within your NHS role?** Yes ☐ No ☐
5	**Have you ever received training on working with vulnerable migrants (e.g. asylum seekers, refugees) within your NHS role?** Yes ☐ No ☐
6	**Have you ever been in contact with a patient whom you knew or suspected had been trafficked?** Yes ☐ No ☐ (*If no, go to Q7*) **If yes, why did you know or suspect that the patient(s) had been trafficked?** Disclosure by patient ☐ Disclosure by another professional ☐ Patient displayed signs that indicated they had been trafficked ☐ Other (please specify): _____
7	**In your opinion, what are the three most important signs or indications that suggest a patient may have been trafficked?** 1) _____ 2) _____ 3) _____
8	**Do you have any data source within your NHS Trust that would allow the identification of the number of suspected cases of trafficking seen within your NHS Trust?** Yes ☐ No ☐ (*If no, go to next section*) **If yes, please name your NHS Trust and the relevant data source:** _____

Please indicate how much you feel you know about the following		Very Little	A Little	Some	Quite a bit	A Lot
9	Your role in identifying and responding to human trafficking	☐	☐	☐	☐	☐
10	Indicators of human trafficking	☐	☐	☐	☐	☐
11	What questions to ask to identify potential cases of human trafficking	☐	☐	☐	☐	☐
12	What to say/not say to a patient who has experienced human trafficking	☐	☐	☐	☐	☐
13	Health problems commonly experienced by people who have been trafficked	☐	☐	☐	☐	☐
14	How to document human trafficking in a medical record	☐	☐	☐	☐	☐
15	Assessing danger for a patient who may have been trafficked	☐	☐	☐	☐	☐
16	Local and/or national support services for people who have been trafficked	☐	☐	☐	☐	☐
17	Local and/or national policies on responding to human trafficking	☐	☐	☐	☐	☐

Please answer True or False if you think you know the answer		True	False	Don't Know
18	The definition of human trafficking is restricted to women and girls who have been forced into prostitution..	☐	☐	☐
19	More than 100,000 trafficked people were identified in the UK in 2010-2011	☐	☐	☐
20	The majority of women who are trafficked for prostitution were sex workers before being trafficked.	☐	☐	☐
21	Children who are working for relatives in domestic situations cannot really be considered "trafficked"	☐	☐	☐
22	Trafficking is associated with post-traumatic symptoms	☐	☐	☐
23	Trafficking is associated with chronic headaches.	☐	☐	☐
24	There are usually evident signs that a person is in a trafficking situation	☐	☐	☐
25	People who are being exploited often have difficulty reporting these situations to outsiders, especially professionals	☐	☐	☐
26	Health practitioners should *not* ask trafficked people about violence that they might have suffered, as it is too traumatic for them	☐	☐	☐
27	Calling the police if I suspect a patient has been trafficked could put the patient in more danger	☐	☐	☐

28 **Which of the following health problems are NOT likely be related to situations of human trafficking?** (please tick all that apply)

Depression	☐	Hypothermia or dehydration	☐
Chemical burns and pesticide poisoning	☐	Sexually Transmitted Infections	☐
Memory problems	☐	Headaches	☐
Coronary heart disease	☐	Post-traumatic stress disorder	☐
Diabetes	☐		

Please indicate how much you agree with the following		*Strongly Disagree*	*Disagree*	*Neither*	*Agree*	*Strongly Agree*
29	It is very unlikely that I will ever encounter a trafficked person in my NHS role	☐	☐	☐	☐	☐
30	My workplace allows me enough time to ask about trafficking if I suspected a person might have been trafficked	☐	☐	☐	☐	☐
31	I would be comfortable asking a person if they were in danger from an employer	☐	☐	☐	☐	☐
32	Asking about experiences of exploitative situations is offensive to most patients	☐	☐	☐	☐	☐
33	A patient's friend can interpret for him or her if I think that a person has been trafficked.	☐	☐	☐	☐	☐
34	Healthcare workers have a responsibility to respond to suspected cases of human trafficking	☐	☐	☐	☐	☐
35	I am aware of the precautions I need to take to protect my safety when caring for trafficked people	☐	☐	☐	☐	☐
36	I do not have sufficient training to assist individuals in situations of human trafficking	☐	☐	☐	☐	☐
37	I should call the police immediately if I suspect that a person has been trafficked.	☐	☐	☐	☐	☐
38	I am confident I can document human trafficking accurately and confidentially	☐	☐	☐	☐	☐
39	I am confident I can make the appropriate referrals for <u>women</u> who have been trafficked or exploited	☐	☐	☐	☐	☐
40	I am confident I can make the appropriate referrals for <u>men</u> who have been trafficked or exploited	☐	☐	☐	☐	☐
41	I am confident I can make the appropriate referrals for <u>children</u> who have been trafficked or exploited	☐	☐	☐	☐	☐
Interest						
42	On a scale of 1 to 5, where 1 is "not at all" and 5 is "very", how interested are you in learning about providing care in cases of human trafficking?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
43	Which do you think would be the most useful format for you to receive information or training on caring for people who may have been trafficked: Online information and training (live), facilitated, at set times ☐ Half-day training session ☐ Online information and training (recorded), self-directed, to watch/listen anytime ☐ Full day training session ☐ Two hour training session (facilitated) ☐					
OPTIONAL: We are very interested in learning about any experience you may have had with any trafficking cases. Please, if you are willing, can you either write about your experience here or offer your contact details so we can get in touch with you to learn about these experiences?						

APPENDIX F: PERMISSION TO USE IOWA MODEL

From: Kimberly Jordan - University of Iowa Hospitals and Clinics
To: Fisher, Haley
Subject: Permission to Use The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care
Date: Monday, December 28, 2020 10:04:34 AM

You have permission, as requested today, to review and/or reproduce *The Iowa Model Revised: Evidence-Based Practice to Promote Excellence in Health Care*. Click the link below to open.

The Iowa Model Revised (2015)

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Citation: Iowa Model Collaborative. (2017). Iowa model of evidence-based practice: Revisions and validation. *Worldviews on Evidence-Based Nursing, 14(3), 175-182. doi:10.1111/wvn.12223*

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