Human Trafficking: Clinical Assessment Guideline
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ABSTRACT
Approximately 18,000 people are trafficked into the United States each year and forced into commercial sex work. Up to 80% of victims are seen by a health care provider. In the health care setting, they rarely identify themselves as victims of human trafficking (HT), making it difficult to recognize them. Only a few health care professionals know how to identify victims of trafficking among their patients. The purpose of this article was to review the process used in health care settings to identify victims of traffickers.

The author conducted a search to locate current scholarly articles addressing HT identification in health care settings. Each article was reviewed for its significance in victim identification. To address the problem of identifying and assisting patients who are being trafficked, some hospitals developed their own protocols. However, the wide variation in what is included on these assessment protocols makes it difficult to hold up any particular protocol as a national model. The author concludes that until more effective standardized national protocols for the identification of the HT victim within the health care settings are developed, National Human Trafficking Resource Center’s method of screening should be used to help increase the degree at which patient victims are identified within the health care setting.

Key Words
ED, Emergency department, Health consequences, Healthcare assessment, Human Trafficking, Protocol, Red flags, Screening tool, Sex trafficking, Traffickers, Trauma, Victim identification, Warning signs

Human trafficking (HT) is the trade of human beings for the purposes of exploitation, typically in the form of commercial sexual exploitation or forced labor (Hodge, 2014). Traffickers prey on vulnerable individuals in some of the poorest areas in the world by deceptively recruiting and transporting them to countries such as the United States, and coercing them to serve the interests of traffickers, through physical force and mental anguish (Hodge, 2014). The United States harbors the marketing of trafficked people from around the world (Hodge, 2014). Approximately 18,000 people are trafficked into the United States each year and forced into commercial sex work or hard labor (Cheshire, 2017). These HT victims are subject to physical, sexual, and emotional violence (Cheshire, 2017), due to the brutal nature of the business frequently leaving these victims with life-threatening injuries (Stevens & Berishaj, 2016), and neglected health conditions (Cheshire, 2017). Up to 80% of victims are seen by a health care provider while under the control of their trafficker (Byrne, Parsh, & Ghilain, 2017). In the health care setting, rarely do they identify themselves as HT victims, due to fear, shame, or language barriers (Cheshire, 2017; Shandro et al., 2016). Because of this, clinicians may not be aware that the patient is a victim and may miss relevant clinical clues (Cheshire, 2017). Ultimately, many patients who receive medical care at a health care facility go unrecognized as victims of HT (Cheshire, 2017).

Traffickers tend to hide the abuse of HT victims from mainstream society (Cheshire, 2017) and do not make themselves identifiable as traffickers (Tripp & McMahon-Howard, 2016). Human traffickers do not have an overt set of characteristics to be on the look out for (Tripp & McMahon-Howard, 2016). They are perpetrators that could be friends, relatives, gang members, international smugglers, pimps or madams, massage parlor owners, labor subcontractors, and more (Tripp & McMahon-Howard, 2016). In some cases, a family member unknowingly recruits the individual into trafficking situations (Tripp & McMahon-Howard, 2016). The US Department of Health and Human Services developed educational toolkits to help service providers identify victims (Peters, 2013). Also, in 2014, President Obama enacted the Preventing Sex Trafficking and Strengthening Families Act (Orme & Ross-Sherif, 2015). This legislation requires states to enhance programs and policies that identify, document, and determine services for children at risk for sex trafficking (Orme & Ross-Sherif, 2015). Then in 2015, the “Trafficking Awareness Training Healthcare Act” was passed (Stevens & Berishaj, 2016). This federal law asked for the training of health care professionals to recognize and respond to victims of HT (Stevens & Berishaj, 2016).
STATEMENT OF THE PROBLEM
Low HT detection results from lack of training, lack of investigations, and ineffective laws (Stevens & Berishaj, 2016). Human trafficking victims come into contact with the health care system while being trafficked, with the emergency department being the most frequented setting for medical treatment (Stevens & Berishaj, 2016). Emergency room clinicians are in an advantageous position to identify these victims and intervene (Shandro et al., 2016). Nevertheless, only few clinicians know how to identify victims of HT among their patients (Stoklosa, Showalter, Melnick, & Rothman, 2017). An established protocol for victim identification can proactively facilitate health care providers' assistance with HT victims (Shandro et al., 2016). To address the problem of identifying and assisting victims of HT, some hospitals developed their own protocols (Stoklosa et al., 2017). However, the wide variation in what is included on HT health care protocols makes it difficult to hold up any particular protocol as a national model (Stoklosa et al., 2017).

Purpose of the Paper
The purpose of this article was to review the HT victim identification process for health care settings.

REVIEW OF LITERATURE
Types of Human Trafficking
There are seven forms of HT: (1) commercial sexual exploitation of children and sex trafficking of minors, (2) adult sex trafficking, (3) forced labor trafficking, (4) forced child labor, (5) child soldiering, (6) debt bondage/bonded labor, and (7) organ trafficking (Hachey & Phillippi, 2017).

(1) Commercial sexual exploitation of children and sex trafficking of minors: This is the sexual exploitation of children and youth under 18 years of age for economic purposes. Forms may include trafficking for sexual purposes, sex tourism, prostitution, pornography, strip clubs, or child marriage (Hachey & Phillippi, 2017).

(2) Adult sex trafficking: This is the recruiting, transporting, receiving, harboring, or obtaining of an adult for commercial sexual exploitation through means of physical force, threat, or fraud (Hachey & Phillippi, 2017).

(3) Forced labor trafficking: This is the recruiting, transporting, receiving, harboring, or obtaining of individuals for involuntary servitude through the use of physical or psychological force, threat, or fraud (Hachey & Phillippi, 2017).

(4) Forced child labor: This is the entrapment of children under the age of 18 years in forced, bonded labor, or slavery, without an economic benefit or the option to leave (Hachey & Phillippi, 2017).

(5) Child soldiering: This is the unlawful recruitment of children for labor, sexual exploitation, or combatants in conflict areas (Hachey & Phillippi, 2017).

(6) Debt bondage/bonded labor: This is the use of a debt or bond by a trafficker to subjugate and unlawfully exploit the worker, using an initial debt as part of the terms of employment (Hachey & Phillippi, 2017).

(7) Organ trafficking: This is the recruitment, transportation, or harboring of a person for organ removal through force, fraud, or coercive means, including the abuse of a position of vulnerability (Hachey & Phillippi, 2017).

Two of the rare lifesaving opportunities for a victim of trafficking are (1) when the victim's trafficker is being arrested by law enforcement and (2) when the victim is admitted to the hospital emergency room (“Human Trafficking,” 2016).

A Case Report
Hospital emergency departments provide one of a limited set of opportunities to interrupt the exploitation cycle that occurs with HT (Gibbons & Stoklosa, 2016). In a case report study conducted by Gibbons and Stoklosa (2016), the warning signs of emotional, physical, and sex trauma of a patient at a Boston hospital rose an emergency room physician's suspicion of sex trafficking, and the patient was rescued as a result. In that case, a 29-year-old Caucasian woman was brought to the emergency room by police officers following a sexual assault report. She has a past medical history of intravenous drug abuse, suicidal ideation, and posttraumatic stress disorder (PTSD), and was abused as a child. The patient stated that she was forced to have sexual intercourse with numerous people over a period of several days, while being held at gunpoint. She had no other medical complaints and was not taking any medications. Her physical examination was normal except for an abrasion to the forehead, which the patient reported was the result of being hit with a firearm. The patient was given prophylactic sexually transmitted infection (STI) medication as well as levonorgestrel and was then discharged. The following day, the patient returned to the emergency room with suicidal ideation and drugs withdrawal symptoms. She reported that she relapsed on heroin and was held at gunpoint in a locked room while being forced to have sex to pay off her debts to a drug dealer. The emergency room physician and social worker...
recognized that her situation was consistent with sex trafficking, and a report was made to the Human Trafficking Division of the Police Department. Later that day, her traffickers were arrested. This gave her some reassurance as she had received numerous threats from them during her captivity. Due to her suicidal ideation, she was transferred to an inpatient psychiatric unit (Gibbons & Stoklosa, 2016).

Warning Signs
Health care clinicians should be on the alert for the telltale signs of HT and know how to follow up by asking the right questions (Byrne et al., 2017). Physical warning signs of trafficking may include evidence of physical or sexual violence, discrepancy between suspected and reported age, self-inflicted injuries, addiction use disorders, chronic medical conditions, multiple or recurrent STIs (Hachey & Phillippi, 2017), and the presence of a controlling person who will not allow the patients to speak for themselves (Hachey & Phillippi, 2017). Victims have minimal opportunity for disclosure when their trafficker insists on speaking for them (Byrne et al., 2017). Victims fear for their lives and for the lives of their families if they speak up or attempt to escape (Byrne et al., 2017). Traffickers often “test” their victims to see if they are loyal to them when questioned (Byrne et al., 2017). Other warning signs are that victims have very little control over their lives, do not manage their own money or have ID documents, and have very few personal possessions (Byrne et al., 2017). Mental health warning signs may include responses of PTSD, ranging from aggression and combative behaviors or extreme fear with an exaggerated startle response to a submissive, emotionless, and withdrawn posture (Hachey & Phillippi, 2017). Hence, for any patient with discrepancy between suspected and reported age, signs of multiple or new STIs, physical, emotional, sexual trauma; or a patient who does not have access to valid identification or is unable to state a verifiable residential address, sensitive screening should be conducted (Hachey & Phillippi, 2017).

Screening Method
The health care worker must separate the patient from anyone accompanying her or him and refrain from screening for trafficking or violence if the person refuses to leave (Hachey & Phillippi, 2017; NHTRC, n.d.). Refusal of a person to leave may indicate that the patient is a victim of trafficking. Use a certified translator or translator phone service if there is a language barrier (Hachey & Phillippi, 2017; NHTRC, n.d.).

Screening Questions
Screening questions may include the following:

(a) Tell me about your living situation (Hachey & Phillippi, 2017);
(b) “Has anyone ever asked you to have sex in exchange for money, food, shelter, or other items?” (Hachey & Phillippi, 2017);
(c) “Has anyone ever threatened violence if you attempted to leave?”;
(d) “Has anyone ever threatened your family if you leave?” (Hachey & Phillippi, 2017).

Hypervigilant, hesitant, agitated, fearful, or inconsistent responses and behaviors may provide clues to the patient’s emotional state (Hachey & Phillippi, 2017).

Follow-Up Questions to Ask About Living/Work Conditions

(a) “Are you free to come and go in your home as you please?” (Byrne et al., 2017).
(b) “Have you ever worked without receiving the payment you thought you would get?” (Byrne et al., 2017).
(c) “Have you ever worked in a place that was different from what you were promised or told it would be?” (Byrne et al., 2017).
(d) “Does anyone at your work make you feel scared or unsafe?” (Byrne et al., 2017).
(e) “Did anyone at your workplace threaten to harm you?” (Byrne et al., 2017).
(f) “Have you ever felt you couldn’t leave the place you work/live?” (Byrne et al., 2017).
(g) “Do you live with your employer?” (Byrne et al., 2017).
(h) “How many hours do you work in a week?” (Byrne et al., 2017).
(i) “Do you owe your employer money?” (Byrne et al., 2017).
(j) “Does your home have bars on windows, windows you can’t see through, or security cameras?” (Byrne et al., 2017).

Physical Screening
Signs of trauma or assault may indicate a violent situation regardless of the patient’s story (Hachey & Phillippi, 2017). Physical examination should include a detailed documentation of injuries involving the genital and anal areas, mouth, and skin, with a written description of size, shape, color, location, and pattern of bruising, contusions, scars, lacerations, or other evidence of physical or psychological trauma (Hachey & Phillippi, 2017). Victims of labor trafficking may have injuries consistent with occupational hazards or neglect (Hachey & Phillippi, 2017).

Screening Tool
A validated screening tool is not yet available for physicians or nurse practitioners (Human Sex Trafficking,
Furthermore, according to Mumma et al. (2017), the effectiveness of several screening tools used in emergency rooms is unclear. As such, Mumma et al. (2017) conducted a study to determine whether identifying adult victims of sex trafficking in the Pennsylvania hospital emergency room was feasible. Mumma et al. (2017) used a 14-question survey screening tool. If a patient answered “yes” to any of the questions or there was a physician concern, the screening was considered to be positive, and the patient was offered social work consultation for sex trafficking (Mumma et al., 2017).

1. Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor? (Mumma et al., 2017).
2. Were you (or anyone you work with) ever beaten, hit, yelled at, raped, threatened or made to feel physical pain for working slowly or for trying to leave? (Mumma et al., 2017).
3. Has anyone threatened your family? (Mumma et al., 2017).
4. Is anyone forcing you to do anything that you do not want to do? (Mumma et al., 2017).
5. Do you owe your employer money? (Mumma et al., 2017).
6. Does anyone force you to have sexual intercourse for your work? (Mumma et al., 2017).
8. Are you forced to work in your current job? (Mumma et al., 2017).
9. Does someone else control whether you can leave your house or not? (Mumma et al., 2017).
10. Are you kept from contacting your friends and/or family whenever you would like? (Mumma et al., 2017).
12. Was someone else in control of arrangements for your travel to this country and your identification documents? (Mumma et al., 2017).
13. Do you owe money to someone for travel to this country? (Mumma et al., 2017).

In applying the 14-question survey, Mumma et al. (2017) found that identifying adult victims of sex trafficking in the emergency department is feasible, a screening survey appears to have greater sensitivity than physician concern, and that a single screening question may be sufficient to identify all adult victims of sex trafficking in the emergency room.

### SCREENING TOOL

#### Follow-Up Help and Resources

Victim identification and medical treatment are best followed by needs evaluation and safety planning (Gibbons & Stoklosa, 2016). Emergency department social workers independently interview patients to assess their situations and their needs and to provide relevant resources (Hachey & Phillippi, 2017). Needs may include shelter, substance abuse treatment, legal services, and law enforcement (Gibbons & Stoklosa, 2016). Health care professionals, particularly emergency room providers, may call the National Human Trafficking Hotline (n.d.) number at 1-888-373-7888, for help or guidance through the victim identification, needs evaluation, or safety planning process. This hotline number is also an excellent resource for victims, and is available 24 hr a day, 7 days a week (Gibbons & Stoklosa, 2016). The hotline has features such as texting, 200 languages, and has links to resources that include housing, law enforcement, and legal services (Gibbons & Stoklosa, 2016).

#### METHOD

A search was conducted to locate the most current scholarly articles addressing HT identification. A general review of HT victim identification within the health care settings was conducted. Each article was reviewed for its significance in victim identification. The search was then narrowed to reviewing the HT identification protocols used in hospitals.

#### RESULT

From the search conducted and the review of articles, six of the articles listed the screening and physical examination that is necessary to identify the victim. The remaining articles focused on the needed change in the behavior of clinicians, to help in the victim identification process.

Stoklosa, Dawson, Williams-Oni, and Rothman (2017) reviewed U.S. health care institution protocols for the identification and treatment of victims of HT. That evidence-based study looked at human-trafficking identification, along with treatment and referral protocols of U.S. health care service provider institutions. Thirty protocols from 19 states and two national organizations were reviewed; 70% of the protocols listed the most common assessment indicator of HT victimization as patient history of physical or sexual abuse, at least one medical symptom of physical trauma such as bruises, scars, frequent injuries; at least one indicator based on a patient’s apparent dependence on another person, such as patient not in control of personal identification; and at least one indicator related to how the patient communicates, such as inconsistencies in the patient’s story about his or her medical condition. A smaller proportion of protocols included indicators of HT that pertained to housing (60%), the patient’s appearance (47%),
the patient's mental health (63%), sexual history (63%), or technology-related indicators such as the patient possessing explicit digital photos of himself or herself with another person (20%). Stoklosa et al. (2017) propose that the ideal protocol might be one that uses an evidence-based and practice-informed comprehensive list of potential indicators, and includes information about approaches to screening, including trauma-informed care (Stoklosa et al., 2017).

Stevens and Berishaj (2016) and Peters (2013) examined the roles of clinicians, particularly emergency department clinicians, in screening and identifying those at risk of HT. Stevens and Berishaj (2016) further reviewed the clinical practice screening and identification tools and guidelines that may be used for HT victims, and outline the recommendations for the use of a specific screening tool. Stevens and Berishaj (2016) recommend that a specific screening tool be incorporated as follows: (a) within the regular assessment process during health care visits; (b) on an individual case-by-case basis; and (c) after report is established (Stevens & Berishaj, 2016).

Shandro et al. (2016) focus on HT identification in the emergency department. Shandro et al. (2016) believe that evaluation of possible trafficking victims in the emergency room is challenging for the clinician because patients who have been exploited rarely self-identify. Shandro et al. (2016) recommend that emergency clinicians maintain a high level of suspicion and assess for specific indicators of trafficking, when evaluating patients who appear to be at risk for abuse and violence, and that potential victims should be evaluated with a multidisciplinary and patient-centered technique.

Schwarz et al. (2016) focused on identification to assist victims of labor trafficking as well as sex trafficking, and offer a framework to antitrafficking efforts that address the practical challenges of HT victim identification.

According to Orme and Ross-Sherif (2015)’s research study, assessment for child victims of sex trafficking should be done at the individual, family, and community levels. At the individual level, social workers can assess for risk factors that could lead to increased vulnerability to sex trafficking (Orme & Ross-Sherif, 2015).

Nguyen, Coverdale, and Gordon (2017) focused on HT identification and treatment in the psychiatric department. In the study, Nguyen et al. (2017) note that on their own inpatient psychiatric unit, the number of patients who screened positive for HT increased substantially with routine screening. According to Nguyen et al. (2017), one primary reason why HT victims are not identified is that they may present with acute or decompensated mental health conditions that prevent them from accurately reporting their trafficking history and status. Nguyen et al. (2017) add that patients may be acutely psychotic, manic, agitated, or delirious, and suggest that health care providers go beyond the initial HT assessment point and rescreen patients when their mental status improves. Nguyen et al. (2017)’s study further recommends that in addition to educating staff about HT, a trauma-informed and patient-centered care model on a multidisciplinary unit is needed to allow for a safe, confidential, and integrated care approach therapeutic environment.

Hodge (2014) examines the role that social workers can play in identifying victims in settings such as hospital emergency rooms and health clinics. According to Hodge (2014), some physical or emotional symptoms among others are indicators that suggest the presence of trafficking, and be classified into three categories: situational, story, and demeanor. Situational indicators are HT victim markers that may include the absence of documentation (or documentation held by another person); the constant presence of another individual, such as a pimp; signs of physical abuse, such as scars, cigarette burns, HIV/AIDS, damage to vagina or anus, complications from forced or unsafe abortions; a large number of people living together in a private residence; and frequent changes of address or physical location (Hodge, 2014). Story indicators in the health setting refer to the patient’s presenting complaint or story that suggests the presence of trafficking (Hodge, 2014). For example, a patient’s story that indicates that the patient is being controlled, does not have the freedom to move or change employment, or is forced to provide sex may indicate the existence of trafficking (Hodge, 2014). A patient’s emotional demeanor such as signs of fear, depression, or a tendency to answer questions evasively, can also be an important indicator of trafficking (Hodge, 2014). If upon initial screening, situational, story, and emotional indicators are present, further exploration of the patient’s story and emotional demeanor may be justified (Hodge, 2014).

Hachey and Phillippi (2017) address the gap in knowledge barriers to HT identification and outline the above warning signs, screening, and physical examination to be applied in identifying a potential HT victim. According to Hachey and Phillippi (2017), a major barrier to HT identification is the patient’s deterrence to disclosing the situation. The reasons why patients tend not to disclose their situation include fear of further abuse by the trafficker, since traffickers often threaten and condition victims to conceal the trafficking situation; fear of being reported to immigration, inability to pay for services, shame and stigma, prior criminal record, and judgmental or discriminatory treatment by health care worker (Hachey & Phillippi, 2017). Hence, Hachey and Phillippi (2017) recommend that a patient-centered, trauma-informed approach can provide a safe environment to sensitively screen patients for HT.

Edwards and Mika (2017) examined the intersection of sex trafficking and social work and found that many social workers do not realize how often they have the opportunity to identify and help HT victims escape.
According to Edwards and Mika (2017), sex trafficking victims avoid seeking help because of the stigma, emotional and psychological manipulation that is involved, and are more likely to present with a different issue, leaving the social worker to use professional judgment to reach out to the suspected victim. Because of this, Edwards and Mika (2017) call on social workers to increase its efforts to combat sex trafficking by preparing themselves with the ability to identify and assess potential victims of sex trafficking. Edwards and Mika (2017) believe that the social work profession is mandated to serve vulnerable populations, and suggest that today’s social workers be called to the same standard as its traditional profession that fought for abolition, human rights, and equality.

The National Human Trafficking Resource Center (NHTRC, n.d.) notes that aside from the health indicators of HT, the following general indicators that medical providers may see in a victim of HT are as follows:

(a) Shares a scripted or inconsistent history;
(b) Is unwilling or hesitant to answer questions about the injury or illness;
(c) Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them;
(d) Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer);
(e) Demonstrates fearful or nervous behavior or avoids eye contact;
(f) Is resistant to assistance or demonstrates hostile behavior;
(g) Is unable to provide his/her address; Is not aware of his/her location, the current date, or time;
(h) Is not in possession of his/her identification documents; Is not in control of his or her own money.

The recognition of several indicators may point to the need for referrals and further assessment. (NHTRC, n.d.) NHTRC notes that the indicators of labor trafficking are as follows:

(a) Has been abused at work or threatened with harm by an employer or supervisor;
(b) Is not allowed to take adequate breaks, food, or water while at work;
(c) Is not provided with adequate personal protective equipment for hazardous work;
(d) Was recruited for different work than he/she is currently doing;
(e) Is required to live in housing provided by employer;
(f) Has a debt to employer or recruiter that he/she cannot pay off.

NHTRC notes the indicators of sex trafficking as follows:

(a) Patient is under the age of 18 years and is involved in the commercial sex industry;
(b) Has tattoos or other forms of branding, such as tattoos that say, “Daddy,” “Property of…,” “For sale,” etc.;
(c) Reports an unusually high number of sexual partners;
(d) Does not have appropriate clothing for the weather or venue;
(e) Uses language common in the commercial sex industry.

NHTRC’s Recommendations for Assessments are as follows: Allow the patient to decide if they would feel more comfortable speaking with a male or female practitioner; always use professional interpreters who are unrelated to the patient, if the patient requires interpretation; if the patient is accompanied by someone, find a time and place to speak with the patient privately; take time or find someone else on staff to build rapport with potential victims; ensure that the patient understands confidentiality policies and practices, including mandatory reporting laws; use multidisciplinary resources, such as social workers; refer to existing institutional protocols for victims of abuse/sexual abuse; and contact the National Human Trafficking Resource Center hotline for help with victim assessment if needed, in the absence of a protocol.

The early stage of research and practice related to HT victim identification and the wide variation in what is included on HT health care protocols make it difficult to hold up any particular protocol as a national model (Stoklosa et al., 2017).

DISCUSSION

Analysis

Although the study by Stoklosa et al. (2017) is an evidence-based study, its proposal appears to be contradictory in nature with a different study conducted by Stoklosa and three other authors. Stoklosa et al. (2017) propose that an ideal protocol would be a practice-informed comprehensive list of potential indicators. However, Stoklosa et al. (2017) conclude that the wide variation in what is included on HT health care protocols make it difficult to hold up any particular protocol as a national model. A true comprehensive list of indicators as proposed by Stoklosa et al. (2017) would be inclusive of the wide variation of indicators on HT health care protocols that, according to Stoklosa et al. (2017), would be difficult to hold up as a national model. Therefore, the proposal by Stoklosa et al.
(2017) negates the effect of what the federal HT laws are trying to achieve.

According to Hachey and Phillippi (2017), a major barrier to HT identification is the patient’s deterrence to disclose the situation, noting the patient’s fear of further abuse by the trafficker, fear of being reported to immigration, inability to pay for services, shame and stigma, prior criminal record, and judgmental or discriminatory treatment by health care worker. Hence, Hachey and Phillippi (2017) recommend that a patient-centered, trauma-informed approach can provide a safe environment to sensitively screen patients for HT. Based on Hachey and Phillippi (2017)’s above reasons for patients not disclosing relevant information, Hachey and Phillippi (2017)’s recommendation for a patient-centered, trauma-informed approach, by itself, is inadequate to provide a safe environment and avoid the deterrence because Hachey and Phillippi (2017) do not specify how to address the victim’s expected fears.

Edwards and Mika (2017) believe that the social work profession is mandated to serve vulnerable populations, and placed an analogous call to action on the profession of social work to increase its efforts to combat sex trafficking. However, Edwards and Mika (2017) do not address the interdisciplinary dynamics that must collaborate to effect this needed change.

In addition to observing for all of the HT warning signs of both sex and labor trafficking mentioned above, NHTRC (n.d.) recommends to first take the following actions: Allow the patients to decide if they would feel more comfortable speaking with a male or female practitioner, utilize professional interpreters who are unrelated to the patient or situation, find a time and place to speak with the patient privately; if the patient is accompanied by others, take time or find someone else on staff to build rapport with potential victims; ensure that the patient understands confidentiality policies and practices, including mandatory reporting laws; use multidisciplinary resources, such as social workers; refer to existing institutional protocols for victims of abuse/sexual abuse; and contact NHTRC (n.d.) hotline for assistance in conducting an assessment and determining next steps in the absence of a protocol to respond to victims of HT. This is unlike Hachey and Phillippi (2017), who note the victim’s fears as barriers to HT identification, yet the study does not specify how to address the expected fears of the victim.

**Recommendation**

As noted in Mumma et al. (2017), trafficking screening has a greater sensitivity than the concern of the emergency room physician. Hospitals have missed opportunities to save the life of a trafficking victim because health care professionals are more focused on finding out where the patient hurts and what the medical problem is (“Human Trafficking,” 2016).

Upon completing the review of research articles on the topic of HT identification for the health care setting, the author concludes that there should be an effective general guideline for the identification of the HT victim within the health care settings are developed, NHTRC’s method of screening should be used to help increase the degree at which HT victims are identified within the hospital setting.

**CONCLUSION**

Victims of HT often seek medical care. Health care professionals who care for potential victims have a duty to help save their lives and bring them to safety, by ensuring that the degree at which victims are identified within the health care setting, increases. Since 80% of victims are seen by a health care provider while under the control of their trafficker, it is significant that health care professionals know how to identify victims of sex trafficking among their patients. After reviewing the current health care protocols for HT victim identification, a list of the screening and physical examination, as well as the change in behavior of clinicians that is needed to help identify a victim, it is clear that more emphasis is needed in the delineation of a national framework for the identification of the HT victim within the health care setting.

Hachey and Phillippi (2017) note that victims’ fears are barriers to HT identification, yet do not specify how to address the fears of these victims. Furthermore, Edwards and Mika (2017) call on the profession of social work to increase its efforts to combat sex trafficking, yet do not address the interdisciplinary dynamics that must collaborate to effect this needed change. On the other hand, NHTRC’s approach is more holistic. NHTRC (n.d.) recommends that before screening for the warning signs of HT, the health care clinician should take actions that would address the patient’s comfortability, potential language barrier, privacy, rapport building and confidentiality, feeling of safety and protection, any needed resources that the victim may need, as well as expert resources that the assessor may need during the time of the screening. We conclude that until more effective standardized national protocols for the identification of the HT victim within the health care settings are developed, NHTRC’s method of screening should be used to help increase the degree at which HT victims are identified within the hospital setting.

**REFERENCES**


