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Identification and Management of Human Trafficking Victims in the Emergency Department

Lisa M. Hachey, DNP, CNM
Julia C. Phillippi, PhD, CNM

Abstract
Health care practitioners serve an important role in identification and assistance of human trafficking victims. Advanced practice registered nurses, including certified nurse midwives, clinical nurse specialists, and nurse practitioners, are in a unique position to interact with persons trafficked and seen in the clinical setting, yet they require knowledge to identify the signs of human trafficking. Lack of training and education has been identified as a barrier for health care professionals to recognize human trafficking victims and implement needed health care services (M. Chisolm-Straker, L. D. Richardson, & T. Cossio, 2012; C. Ross et al., 2015). Barriers to identification and management include gap in knowledge about the process to screen for trafficking, to assist victims, and to make referrals. A patient-centered, trauma-informed approach can provide a safe environment to sensitively screen patients for human trafficking. Advanced practice registered nurses should be able to assess for trafficking indicators, collaborate with multidisciplinary service providers, and ensure understanding and availability of federal, state, and local resources to manage the care of victims of trafficking. **Key words:** health care practitioners, health consequences, human organ trafficking, human trafficking, modern-day slavery, sex trafficking, sexual exploitation

HUMAN TRAFFICKING is a human rights violation with global public health implications (United Nations Office on Drugs and Crime [UNODC], 2014).

Author Affiliations: *Department of Nurse-Midwifery and Women's Health, University of Cincinnati, Cincinnati, Ohio (Dr Hachey); and Vanderbilt University School of Nursing, Nashville, Tennessee (Dr Phillippi).*

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Corresponding Author: *Lisa M. Hachey, DNP, CNM, Department of Nurse-Midwifery and Women's Health, University of Cincinnati, 9767 Acton Ct, Cincinnati, OH 45241 (bacheylm@ucmail.uc.edu).*

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The Victims of Trafficking and Violence Protection Act of 2000 defines human trafficking as "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 involuntary servitude, peonage, debt bondage, or slavery" (Pub. L. 106-386, §2, 103 Stat, 7 [2000]). In addition to sexual exploitation, other forms of trafficking include domestic servitude, organ harvesting, servile marriage, child soldiering, forced criminal activity, and forced labor in a broad range of industries such as construction, hospitality service, street begging, agriculture, and commercial fishing (International Labor Organization [ILO], 2014). Human trafficking has been described as "modern-day

slavery," and victims are exploited for the economic gain of traffickers, isolated from support systems, hidden from mainstream society, and often endure unpredictable physical, psychological, and sexual assaults (Dovydaitis, 2010; Logan, Walker, & Hunt, 2009; Munoz, 2012). Individuals trafficked are deprived of basic human rights, autonomy, freedom, self-esteem, ownership of their body, self-determination, and a sense of safety (Hopper, 2017). Table 1 offers further details on the various forms of human trafficking.

BACKGROUND AND INCIDENCE OF HUMAN TRAFFICKING

A challenge faced by trafficking advocates, policy makers, law enforcement, and scholars is to define the magnitude of human trafficking because the estimated number of victims varies widely (Weitzer, 2014). It is difficult to determine the exact incidence and prevalence of hidden populations due to the covert nature of the crime, ethical dilemmas, and political considerations (ILO, 2012b; Peters,

Table 1. Forms of trafficking in persons

Commercial sexual exploitation of children and sex trafficking of minors
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, and/or child marriage (bride). These crimes include survival sexual exploitation or the exchange of sex for basic necessities including food, shelter, clothing, or money. Force, deception, or other forms of coercion are not required under the TVPA.
Sex trafficking
The recruiting, transporting, receiving, harboring, or obtaining of an adult for that purpose commercial sexual exploitation through means of force, fraud, deception, or coercion through the use of physical or psychological threats.
Forced labor trafficking
The recruiting, transporting, receiving, harboring, or obtaining of individuals for the purpose of labor or involuntary servitude through the use of physical or psychological force, fraud, deception, threats, or coercion. Labor may occur in domestic labor, street begging, peddling, massage parlors, nail salons, construction, janitorial, agriculture, textile, commercial fishing, restaurants, fairs, carnivals, or circus, health or elder care, and/or hospitality industries.
Forced child labor
The entrapment of children under the age of 18 years old in forced, bonded labor, or slavery-like conditions for a third party without an economic benefit for self, family, or the option to leave.
Child soldiering
The unlawful recruitment of children for labor, sexual exploitation, or combatants in conflict areas. Children may be forced to work as cooks, porters, guards, spies, or suicide bombers for government or rebel groups. Both boys and girls may endure forced sexual abuse.
Debt bondage/bonded labor
The use of a debt or bond to hold a person in subjugation by traffickers or recruiters to unlawfully exploit an initial debt the worker assumed as part of the terms of employment. An inherited debt in traditional systems of bonded labor includes debt passed from generation to generation.
Organ trafficking
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. Cases in which a person's personal, situational, or circumstantial vulnerability is used or the person believes that submitting to the will of the abuser is the only real and acceptable option available.

Note. From U.S. Department of State (2014, 2015). Used with permission. TVPA = Trafficking Victims Protection Act of 2000.

2013; UNODC, 2014). Weitzer (2015) contends that the number of victims and the magnitude of trafficking have been overestimated (Macias-Konstantopoulos et al., 2013), whereas others believe that the conservative estimates are only the tip of the iceberg (ILO, 2012a). The wide variation of reported estimates has been the subject of debate, in part, due to the methods employed to determine the scope of the problem. Nonetheless, there is clear evidence that human trafficking affects numerous people, in many forms, and in every region of the globe (Macias-Konstantopoulos et al., 2013; U.S. Department of State, 2014; Weitzer, 2014).

To date, the ILO has conducted the most robust estimate of forced labor at the global and regional levels using a statistical model of estimation known as "capture–recapture" (ILO, 2012b). These estimates are extrapolated from data over a 10-year period of time (2002–2011) from 5,491 total reported cases of "forced labor" using algebraic formulas to calculate the number of cases (ILO 2012b). From the ILO's extrapolated data, the global incidence of trafficking is approximately three per 1,000 persons and considered to be a $150 billion a year industry (ILO, 2012b). Of the 20.9 million people estimated to be in forced labor or sex trafficking situations, 11.4 million are women and girls, of which 22% (4.5 million) are victims of forced sexual exploitation (ILO, 2012b). The highest concentrations of trafficked people are in the Asian-Pacific Rim region (56%) and Africa (18%), whereas the lowest is in the Middle Eastern countries (3%) (ILO, 2012b).

Although the actual number of trafficking victims in the United States is unknown, the U.S. Department of State (2006) estimated that between 14,500 and 17,500 foreign nationals are trafficked into the United States annually. The actual number of trafficked individuals is most likely higher because this estimate does not take into account U.S. citizens or residents, those trafficked within the United States, or those individuals trafficked in previous years (Chisolm-Straker, Richardson, & Cossio, 2012). The National Center for Missing and Exploited Children (n.d.) has estimated that between 100,000 and 300,000 children are at risk for commercial sexual exploitation annually.

With the exception of child soldiering, trafficking patterns in North America (the United States, Canada, and Mexico) mirror all forms of trafficking in other developing nations (Reid, 2012). The extremes of wealth and poverty in North America contribute to the problem of trafficking in this region. Canada and the United States are primarily considered destination countries for sex and labor trafficking (Reid, 2012; U.S. Department of State, 2016). Canada is also a transit country used to relocate foreign nationals into the United States. Large segments of the populations within Canada and the United States are economically disadvantaged and socially marginalized, placing them at risk to be trafficked into the flourishing commercial sex industry (Reid, 2012). Mexico is largely considered a source and a transit country. Cross-border migration between Mexico and the United States is associated with deceptive and/or coercive tactics, forced migration through deportation, forced sex in high-risk environments, violence, drug use, and Sexually transmitted infections (STIs; Goldenberg, 2015; National Human Trafficking Resource Center [NHTRC], 2016c).

Trafficking in the United States has been reported in rural, urban, and suburban areas in all 50 states, Washington, DC, and U.S. Territories (NHTRC, 2015), with the highest number of victims identified in California (NHTRC, 2016a). As of June 30, 2016, the NHTRC (2016a) has reported 130,485 total calls, e-mails, and online tip reports to the hotline since 2007. Of the 21,947 calls to the hotline in 2015, a total of 5,541 cases were reported for sex trafficking ($n = 4{,}136$), labor trafficking ($n = 721$), or both ($n = 178$) (NHTRC, 2016a). Although trafficked victims can be of any gender, race, ethnicity, age, or socioeconomic status, the risk of trafficking increases in cities or regions with fewer economic opportunities and the social determinants associated with poverty (e.g., homelessness, food

insecurity, and violence; Gibbons & Stoklosa, 2016; Shandro et al., 2016; Stevens & Berishaj, 2016).

In 2015, the U.S. Department of Justice (DOJ) initiated 257 human trafficking cases (248 sex trafficking) involving 377 defendants and convicted 297 traffickers (291 sex traffickers) (U.S. Department of State, 2016). Between 2008 and 2010, the U.S. DOJ reported that 83% of domestic sex trafficking victims were U.S. citizens whereas 67% of domestic labor trafficking victims were undocumented aliens (Banks & Kyckelhahn, 2011). The victims of sex trafficking were more likely to be White (26%) or Black (40%), whereas labor trafficking persons were identified as Hispanic (63%) or Asian (17%).

According to Shared Hope International (2009), age is the greatest vulnerability and risk factor for sex trafficking of girls, with risk increasing with a history of sexual abuse and an unstable home life. The average age of entry into the commercial sex trade in the United States is approximately 12–14 years for girls and 11–13 years for boys (Estes & Weiner, 2001; Gibbs, Walters, Lutnick, Miller, & Kluckman, 2014). Data support that women and girls are at greater risk for sex trafficking than men or boys, both internationally and within the United States (Macias-Konstantopoulos et al., 2013; UNODC, 2014; U.S. Department of State, 2016). The proportion of boys and men trafficked for sexual exploitation may be underestimated because of cultural norms, taboos, underreporting, and misperceptions regarding male victimization (U.S. Department of State, 2013). Rather than being viewed as victims of objectification and coercive sexual exploitation, male victims are perceived as being willing participants, gay, bisexual, or transgender, traffickers, or buyers within the commercial sex trade (Dennis, 2008; End Child Prostitution and Trafficking–United States of America, 2013).

Risk Factors for Exploitation of Victims

Human trafficking occurs in every region of the world, with victims identified from 124 different countries and 152 nationalities around the world (UNODC, 2014). Globally, victims tend to be trafficked within the same region or subregion, typically from poor to more affluent countries. More than six of 10 victims are foreigners in another country and have crossed at least one international border (UNODC, 2014). The origins of human trafficking are complex, multifaceted, and influenced by economic, social, and cultural factors from both the country of origin and the country of destination (Macias-Konstantopoulos et al., 2013; Organization for Security and Co-operation in Europe, 2005). Traffickers 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 (UNODC, 2008).

Traffickers often prey on the emotional needs and vulnerability of others, especially children and adolescents who are easily coerced, manipulated, and terrorized into compliance (De Chesnay, 2012; Greenbaum & Crawford-Jakubiak, 2015; Varma, Gillespie, McCrackenb, & Greenbaum, 2015). Childhood sexual abuse nearly doubles the odds of later entry into prostitution, and 80%–90% of trafficked youth have a history of childhood sexual abuse (Siskin & Sun Wyler, 2013; Williamson, 2009). Characteristics and inequities that predispose victims to all forms of trafficking include poverty, early childhood trauma or abuse, substance abuse or addiction disorders, and housing insecurity (Macias-Konstantopoulos et al., 2013). Family dysfunction, domestic violence (DV), mental illness, and familial substance abuse increase vulnerability to trafficking. Frequently, women are recruited into labor or domestic work and subsequently sold into the sex trafficking trade (Zimmerman, Hossain, & Watts, 2011). Sex trafficking is considered a complex form of gender-based violence, with its root cause in subordinate societal and cultural norms, objectification of women and girls, childhood sexual abuse, poverty, gender inequality, and oppression (Macias-Konstantopoulos et al., 2013).

The rapid evolution of digital technologies such as social networking sites, mobile phones, websites, anonymizing networks and applications, and the Internet has added unique opportunities to exploit victims (Latonero et al., 2012). In 2010, the estimated number of Internet users exceeded 2 billion and hundreds of millions of people use social networking sites (Latonero, Berhane, Hernandez, Mohebi, & Movius, 2011). These technologies are used to recruit, market, communicate, transact, and exploit victims across broad geographical areas (Latonero et al., 2012). Traffickers leverage social networking and online classified sites such as Craigslist, Facebook, Tinder, and Backpage to conduct illicit activities (Latonero et al., 2011). Digital technologies are also used by law enforcement, service providers, and antitrafficking agencies to monitor illicit activity, locate and rescue victims, communicate between agencies, collect data, and report suspected trafficking (Latonero et al., 2011). Table 2 provides additional examples of risk factors.

Exposure to Violence and Abuse

A large, quantitative, cross-sectional study ($N = 1{,}015$) of men, women, and children receiving posttrafficking services in Southeast Asia (Cambodia, Thailand, and Vietnam) evaluated the health effects of various forms of violence and occupational exposures on survivors' health (Kiss et al., 2015). Most children (281 of 344; 82%) were girls trafficked for sex work ($n = 201$), whereas boys ($n = 63$) were

Table 2. Social determinants and risk factors for trafficking in persons

Social determinants of health
Poverty
Gender (low societal and familial value of women and girls)
Lack of formal education (illiteracy and low levels of education reduce employment options)
Limited English proficiency
Food and housing insecurity
Responsibility for dependents
Limited support systems
Low self-esteem
Violence and trauma
Childhood sexual abuse
Childhood trauma/adverse childhood events/domestic violence
Previous physical, sexual, or emotional abuse
Substance abuse and/or addiction disorders
Parental drug abuse
Juvenile justice system exposure
Globalization
Migration, refugee displacement, and victims in conflict zones
Digital technologies and social networking sites
Marginalized populations
Runaway or homeless youth
Gay, bisexual, and transgender youth
Persons with disabilities
Rural populations
Migrant workers
American Indians/Alaskan Natives/Native Hawaiians and Pacific Islanders
Foreign national domestic workers

Note. Data obtained from Farley et al. (2011); Gibbons & Stoklosa (2016); Goldenberg et al. (2015); Latonero et al. (2012); Macias-Konstantopoulos et al. (2013); Shandro et al. (2016).

trafficked for begging, fishing, factory work, or construction (Kiss et al., 2015). Women ($n = 288$) were trafficked for sex work ($n = 127$; 44%), for factory work ($n = 40$; 13.9%), as brides ($n = 38$; 13.2%), for agriculture work ($n = 36$; 12.5%), or domestic work ($n = 26$; 9.0%); men were typically exploited for the fishing trade ($n = 262$; 68.4%) or factory work ($n = 76$; 19.8%). Nearly half of the survivors reported physical violence ($n = 388$; 38.3%), sexual violence ($n = 204$; 20.2%), or both ($n = 481$; 47.6%) while being trafficked (Kiss et al., 2015). In a qualitative, multisite (seven countries), posttrafficking European study, women trafficked for forced sex work ($N = 192$) reported high levels of physical violence ($n = 145$; 76%), sexual violence ($n = 172$; 90%), or both ($n = 182$; 95%) while being trafficked (Zimmerman et al., 2008). These data obtained from different regional and cultural studies expose the high rate of trauma and violence experienced by victims during various forms of trafficking.

Trafficked victims routinely endure extreme forms of physical and emotional trauma through systematic "seasoning" tactics involving coercion, force, fraud, and physical and sexual violence for the purpose of control and cooperation (Baldwin, Fehrenbacher, & Eisenman, 2014; Logan et al., 2009; NHTRC, n.d.). Often victims of human trafficking remain trapped through the use of physical and psychological confinement, as traffickers use methodical tactics designed to reduce the victim's resistance and increase dependence (Logan et al., 2009). Psychological confinement is associated with abuse, shame, and degradation to achieve submission (ILO, 2012a). Although victims may escape a trafficking situation, psychological entrapment will prevent some victims from leaving even if the opportunity arises (Logan et al., 2009).

HEALTH CONSEQUENCES OF HUMAN TRAFFICKING

Role of Health Care Practitioners

In a mixed-method study conducted in the United States across a broad geographical, racial, and ethnic range, 87.8% ($N = 98$) of sex-trafficked victims sought treatment within the health care system while in captivity but were neither identified nor offered assistance by health care practitioners (Lederer & Wetzel, 2014). Clinical areas accessed by victims of trafficking in the United States include the emergency department (ED), family planning clinics, urgent care, primary care clinics, community health centers, health departments, pediatrics, obstetrics and gynecology, and private offices (Lederer & Wetzel, 2014; Stevens & Berishaj, 2016). The most common health care setting reported by 63% of trafficked respondents was the ED (Lederer & Wetzel, 2014). The concealed nature of human trafficking makes identification in the clinical setting challenging (Oram, Ostrovschi, et al., 2012; Peters, 2013). Research suggests that victims present to the health care system with injuries, evidence of neglect, STIs, addiction disorders, pregnancy, and advanced disease states but are often not identified as victims of trafficking (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Lederer & Wetzel, 2014).

In a study of health care providers in England ($N = 792$), 13% ($n = 102$) of the respondents reported actual or suspected contact with persons trafficked in a variety of clinical settings. Maternity ward providers reported suspected or prior contact rate of 20.4% ($n = 28/137$) (Ross et al., 2015). While 91% of the study respondents ($n = 697$) felt they had an obligation to assist suspected victims of trafficking, 80% ($n = 613$) cited lack of training as a barrier to assist these individuals. Lack of knowledge regarding their role in identifying and appropriately responding to human trafficking is cited as the primary reason for not intervening (Ross et al., 2015). In a study of 180 ED providers in the United States, 95% ($n = 171$) reported they have not received formal training on the management of trafficking victims (Chisolm-Straker et al., 2012). Few health care professionals understand how to identify victims and appropriately manage the care of a suspected victim (Stoklosa, Grace, & Littenberg, 2015).

Health care professionals play a vital role in assisting victims in a variety of health care settings and require education and training to understand the nature of trafficking, identify the signs, and refer victims for appropriate services (Ahn et al., 2013; Chisolm-Straker et al., 2012; Grace et al., 2014; Ross et al., 2015). Ahn et al. (2013) reviewed the literature on human trafficking and did not find evidence of rigorously evaluated educational modules for health care providers. In response, the Department of Health and Human Services (HHS) began evaluating Stop Observe Ask Respond (SOAR) to Health and Wellness training program in 2013 for health care and social service providers in the United States (U.S. Department of Health and Human Services: Office on Trafficking in Persons, 2016). The SOAR National Technical Work Group included health care providers, human trafficking survivors, and other content experts to develop and evaluate the training program. Implementing evidence-based training modules and guidelines to inform health care providers in the identification and management of trafficking victims is an essential step to improve care and health outcomes for these individuals.

Physical Health Consequences

Emerging evidence supports the profound physical and psychological health consequences as a result of exposure to violence, restricted movement, and deprivation while being trafficked (Baldwin et al., 2011; Clawson & Dutch, 2008; Decker, McCauley, Phuengsamran, Janyam, & Silverman, 2011; Lederer & Wetzel, 2014; Oram, Ostrovschi, et al., 2012; Ottisova, Hemmings, Howard, Zimmerman, & Oram, 2016; Peters, 2013). For those victims who survive the hazards of a trafficking situation, many will require medical and psychological health services (Kiss et al., 2015). Health problems experienced by labor trafficking victims in Southeast Asia include loss of body parts (0.7%), head injury (3.7%), persistent cough (9%), lacerations (11.3%), skin damage (12.5%), weight loss (13.7%), exhaustion (18.3%), and dizziness (20.1%) (Kiss et al., 2015).

Findings from a systematic review on sex trafficking suggest that victims experience high levels of violence and associated physical symptoms over a prolonged duration (Oram, Stockl, Busza, Howard, & Zimmerman, 2012). In a survey of sex-trafficked women receiving posttrafficking services in Moldova ($N = 120$), physical symptoms include headaches (62%; $n = 74$), memory problems (44%; $n = 53$) with a strong association between duration of trafficking and severity of symptoms, and gynecological problems (16.5%; $n = 16$), whereas women in domestic trafficking circumstances described more back pain (38%; $n = 51$) and vision problems (22%; $n = 15$) (Oram, Ostrovschi, et al., 2012).

Reproductive Health Issues and Infectious Disease

Reproductive health issues from sex trafficking include STIs, pelvic inflammatory disease, unintended pregnancies, miscarriages, and forced or elective abortions (Baldwin et al., 2011; Doherty & Morley, 2013; Lederer & Wetzel, 2014). Studies conducted in Mexico, India, and Nepal estimated a 22.7%–45.8% range of prevalence of HIV infection in women trafficked for sex (Goldenberg et al., 2015; Wirth, Tchetgen Tchetgen, Silverman, & Murray, 2013). The risk of HIV infection increases with sexual violence, forced entry into sex trafficking (Wirth et al., 2013), and longer duration of exploitation (Goldenberg et al., 2015).

Although there is scarcity of research in the United States on the prevalence of HIV infection in sex-trafficked women, HIV infection has increased in female sex workers (FSWs) from 1% to 6% between 1999 and 2008 in Tijuana, Mexico (Collins et al., 2013; Strathdee & Magis-Rodriguez, 2008). The two largest Mexican cities along the U.S. border are Tijuana (south of U.S. metropolitan San Diego, CA) and Ciudad Juarez (south of U.S. metropolitan El Paso, TX). In a behavioral

intervention study to increase condom use among FSWs ($N = 924$), more than two thirds of interviewed FSWs ($n = 634$) from these two Mexican cities along the U.S. border reported having sex with at least one U.S. male client (Strathdee, Lozada, et al., 2008). These FSWs who reported having sex with U.S. male clients were significantly younger (median = 31 vs. 36 years, $p < 0.0001$; odds ratio [OR] = 0.95 per year), spoke English (25% vs. 7%, $p < 0.001$; OR = 4.33), were more educated (OR = 1.21), and entered sex work at a younger age (25 vs. 28 years; OR = 0.94) (Strathdee, Lozada, et al., 2008). In addition, they were more likely to have injected drugs (16% vs. 5%, $p = 0.001$; OR = 3.68), more likely to use drugs before sex with their clients (18% vs. 7%, $p = 0.001$; OR = 3.4), and more likely to report their U.S. clients used drugs (81% vs. 55%, $p < 0.001$; OR = 3.55) or injected drugs (36% vs. 21%, $p < 0.001$; OR = 2.20) (Strathdee, Lozada, et al., 2008). The FSWs were more likely to test positive for gonorrhea (8% vs. 2%, $p < 0.001$; OR = 4.38) or syphilis with titers of 1:8 or more (16% vs. 10%, $p < 0.008$; OR = 1.81), to have more than 250 clients in the past 6 months (OR = 1.54), and to be paid more for sex without a condom (OR = 1.07 per U.S. $10 increase) (Strathdee, Lozada, et al., 2008). Prevalence of HIV infection among FSWs increased to 6% (95% CI [4.5, 7.7]), whereas prevalence of HIV infection among FSWs who inject drugs increased to 12% (Strathdee, Philbin, et al., 2008). These data highlight the potential increased risk of cross-border HIV infection, blood-borne pathogens, and STI transmission for FSWs, their clients, and the general population in both countries (Strathdee, Lozada, et al., 2008).

In addition to the immediate risk of gender-based violence, women subjected to the trauma of sex trafficking experience high levels of physical symptoms that often persist for decades (Lederer & Wetzel, 2014; Oram, Ostrovschi, et al., 2012). Neurological problems frequently reported (91.5%) include headaches or migraines (53.8%) and memory problems, insomnia, and poor concentration (82.1%) (Lederer & Wetzel, 2014). Contrary to findings in previous studies, physical injuries (69.2%) described by victims while in the trafficking situation most commonly were inflicted to the head and the face (Lederer & Wetzel, 2014).

Psychological Health Consequences

Poor mental health has been identified as a persistent and severe health effect of trafficking. Traffickers use intimidation to control victims, including violence, deportation, threats against family, and death (Oram, Stockl, et al., 2012). The psychological trauma experienced by victims of trafficking is associated with the severe mental devastation noted in survivors (Hossain, Zimmerman, Abas, Light, & Watts, 2010; Lederer & Wetzel, 2014). Lederer and Wetzel (2014) explored the violence faced while being trafficked and the subsequent health consequences reported by women and girls exploited for commercial sex in the United States. In addition, these researchers analyzed the interactions within the health care system experienced by persons trafficked ($N = 106$) both during and after a trafficking situation. The most frequently reported psychological problems include depression (88.7%), anxiety (76.4%), nightmares (73.6%), flashbacks (68.0%), low self-esteem (81.1%), and feelings of shame and guilt (82.1%) (Lederer & Wetzel, 2014). The devastating extent of the psychological trauma in this U.S. study is evident in the attempted 41.5% ($N = 106$) suicide rate during trafficking and 20.5% ($N = 83$) after trafficking (Lederer & Wetzel, 2014). Formerly trafficked women continued to struggle with posttraumatic stress disorder (PTSD) following societal reintegration (Abas et al., 2013; Baldwin et al., 2014; Lederer & Wetzel, 2014; Ottisova et al., 2016).

Poor mental health and psychological comorbidities can manifest as depression, anxiety, substance abuse disorder, insomnia, eating disorders, and other severe psychological conditions following trauma (Hossain et al., 2010; Lederer & Wetzel, 2014). Psychological

disorders experienced by survivors ($N = 106$) include acute stress (38.7%), bipolar disorder (30.2%), depersonalization (19.8%), multiple personality disorder (13.2%), and borderline personality disorder (13.2%) (Lederer & Wetzel, 2014). The cumulative risks associated with repetitive traumatic events during trafficking are consistent with the extensive long-term psychological health problems noted in the literature on complex trauma and PTSD (Ottisova et al., 2016). Poor mental health outcomes appear to be associated with exposure to violence before trafficking, restricted freedom, and poor living conditions (Kiss et al., 2015; Ottisova et al., 2016).

IDENTIFICATION AND MANAGEMENT OF THE TRAFFICKING VICTIM

Often, there is an overlap between DV and trafficking in which the perpetrator and the trafficker are the same person (parents, boyfriends, or husbands). While abusers and traffickers use similar tactics, traffickers exert total control over their victims for economic exploitation. Victims of both trafficking and DV may experience traumatic bonding with the abuser or trafficker, a response to the simultaneous fear of death and relief for being allowed to live (Barasch & Kryszko, 2013, p. 84). Victims of DV and trafficking experience physical, psychological, and sexual trauma that requires similar services to escape and restore their lives (Barasch & Kryszko, 2013, p. 83). Similar to victims of DV, victims of trafficking have been groomed to conceal their abuse, with fabricated or ambiguous presentations inconsistent with the injury or illness (Baldwin et al., 2011; Gibbons & Stoklosa, 2016; Munoz, 2012; Shandro et al., 2016). Because of the extreme nature of trafficking, victims may require more comprehensive social, legal, and mental health services than victims of DV. Evidence-based guidelines from sexual abuse, intimate partner violence, and child abuse provide useful strategies to guide assessment and intervention in human trafficking situations (Alpert et al., 2014).

Clinical Indicators

Medical care is often delayed, and victims present with severe injuries or advanced illnesses. However, the clinical presentation will be unique to the individual patient (Baldwin et al., 2011). Because traffickers often threaten and condition victims to conceal the trafficking situation, fear of further abuse by the trafficker is a powerful deterrent to disclosing the situation (Peters, 2013). Additional barriers include the 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 personnel (Alpert et al., 2014; Gibbons & Stoklosa, 2016; Macias-Konstantopoulos et al., 2013; Ross et al., 2015). These challenges in victim identification reinforce the critical role advanced practice registered nurses (APRNs) have in the recognition and support of trafficking victims (Hardy, Compton, & McPhatter, 2013).

Potential warning signs and/or clinical health indicators of trafficking may include evidence of physical and/or sexual violence, discrepancy between suspected and reported age, self-inflicted injuries, addiction use disorders, chronic medical conditions, multiple or recurrent STIs, and the presence of a controlling person (partner, employer, or family member) (Alpert et al., 2014; Baldwin et al., 2011; Doherty & Morley, 2013; Dovydaitis, 2010; Gibbons & Stoklosa, 2016; Isaac, Solak, & Giardino, 2011; Lederer & Wetzel, 2014; Munoz, 2012; NHTRC, 2016b). Responses of PTSD may range from extreme fear with an exaggerated startle response to a submissive, emotionless, and withdrawn posture. Disruptive, aggressive, or combative behaviors as a protective measure may be suggestive of trauma and victimization (Peters, 2013). Although some symptoms may be subtle, any patient with multiple or new STIs or signs of physical, emotional, or sexual trauma should be screened. If an individual does not have access to valid identification or is unable to state a verifiable residential address, screening should be conducted. Any of these clinical indicators warrant sensitive verbal screening.

Trauma and the Victim Mind-Set

Although rescue and rehabilitation are the ideal outcomes of screening, the primary focus during an encounter is to establish trust, provide a safe environment, manage the presenting complaint(s), offer available options and resources, and facilitate empowerment and validation so that the patient feels safe to discuss her or his situation without judgment (Alpert et al., 2014; Borland & Zimmerman, 2009; Shandro et al., 2016). Trauma victims develop protective mechanisms and are able to sense signs of real or perceived danger that could elicit intense feelings of fear, vulnerability, and loss of control in different environments (Alpert et al., 2014; Peters, 2013). Many exploited patients do not recognize or self-identify as a victim of trafficking and may not be in a position to leave the trafficker (Gibbons & Stoklosa, 2016; Shandro et al., 2016). Given the complexity of physical and psychological trauma, a patient-centered, culturally aware, and trauma-informed approach creates a safe clinical environment sensitive to the needs of trauma victims while in a health care setting (Alpert et al., 2014; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Trauma-Informed Care

Trauma-informed care is defined by SAMHSA (2014) as a method of caring for people with a history of trauma that acknowledges the presence of trauma symptoms and its effect on lives of survivors. A trauma-informed approach emphasizes the need for health care practitioners and organizations to recognize the effects of violence and victimization on an individual's health, behavior, and development (Elliott, Bjelajac, Fallot, Markoff, & Glover-Reed, 2005). Disruptive, withdrawn, or combative behaviors often provide relevant clues indicative of trauma and victimization that may be overlooked by health care practitioners.

If a patient chooses to divulge a trafficking situation, each will disclose the information differently and may not present the details in a linear fashion. It is essential to establish rapport, remain flexible while screening, respect the person's decisions, and focus on the individual's needs and safety (Gibbons & Stoklosa, 2016; Shandro et al., 2016). Although a person's decision may be in contrast to the provider's, a trauma-informed approach empowers the individual with a sense of personal choice, control, and respect. The dynamics of exploitation are complex and multifaceted. By establishing a foundation of trust and safety, the patient may return prepared to leave the trafficking situation at some point.

Screening and Physical Examination

A thorough history focused on the presenting concern(s) and guided by the individual's responses should be conducted with consent (Lederer & Wetzel, 2014; Shandro et al., 2016). Separate the patient from anyone accompanying her or him and refrain from screening for trafficking or violence if the person refuses to leave (Shandro et al., 2016). Refusal of a person to leave may indicate that the patient is a victim of trafficking and alert the APRN. Use a certified translator or translator phone service if there is a language barrier. Ask the patient if she or he has a preference for a male or female provider.

Direct, open-ended questions with age- and culturally appropriate language are essential. The practitioner should strive to be familiar with cultural backgrounds and viewpoints that influence a person's perception of her- or himself, others, and the world (Hopper, 2017). Potential cultural differences may include avoidance of eye contact or the belief the trafficking situation is predetermined by position or status in life. These cultural differences could be interpreted as avoidance, withdrawal, helplessness, or hopelessness from a Western frame of reference. Alleviate fear of answering questions and support the patient's right for nondisclosure of information. A thorough sexual history may be uncomfortable and trigger traumatic experiences. Assess for consensual and nonconsensual sexual experiences (Coppola & Cantwell, 2016). Maintain patient privacy

during encounters. Assure the patient she or he is in a safe environment and all information is confidential; it is the patient's choice to report an incident (Coppola & Cantwell, 2016).

Screening questions may include the following: (a) Tell me about your living situation; (b) "Has anyone ever asked you to have sex in exchange for money, food, shelter, or other items?"; (c) "Has anyone ever threatened violence if you attempted to leave?"; (d) "Has anyone ever threatened your family if you leave?" Table 3 lists additional screening questions to assist practitioners with a sensitive evaluation. The provider should remain cognizant of the patient's verbal and nonverbal responses to questions. Hypervigilant, hesitant, agitated, fearful, or inconsistent responses and behaviors may provide clues to the patient's emotional state. Care approaches that provide accurate information and explain medical procedures in detail foster safety and independence during the clinical encounter (see Table 4; Borland & Zimmerman, 2009).

A complete and thorough physical examination is imperative; signs of trauma or assault may indicate an exploitive situation regardless of the presenting complaint. The physical examination should progress from the least to the most intrusive procedures, leaving the pelvic, speculum, and reproductive system examination for last (Coppola & Cantwell, 2016). Detailed documentation of injuries involving the genital, anal, oral, and cutaneous areas include a written description of size, shape, color, location, and patterning of

Table 3. Assessment questions to assist with screening for human trafficking

Safety
Is it safe for you to talk to me right now? Are there times you do not feel safe?
Do you feel like you may be in danger for speaking with me?
Is there anything that would help you feel safer?
Fraud
What were you told about the job before you started? What promises were you made?
Have you ever felt you were deceived or lied to about your work or relationship?
Has anything ever surprised you about your job/relationship?
Coercion
Have you ever felt pressured to do something you didn't want to do? Or uncomfortable?
What would happen if you didn't do what you were told?
Has anyone ever threatened or intimidated you?
Has anyone taken/kept your legal papers or identification?
Monetary
Do you have access to money? Has anyone ever taken your money?
Do you owe money to anyone? Can you spend your money the way you wanted to?
Force
Has someone controlled, supervised, or monitored your work?
Has your communication restricted? Have you ever felt you had no other options?
Are you able to access medical care?
Are you allowed to leave the place you were living/working?
Sex
Has anyone ever pressured you to engage in sexual acts against your will?
Have you ever been forced to engage in sex? Who decided if you could use a condom?
Have you ever been required to earn a certain amount of money/meet a quota?
Have you ever sexually assaulted or abused by anyone?

Note. From National Human Trafficking Resource Center (2011). Used with permission.

Table 4. Recommended management of a human trafficking situation in health care

Assisting victims
Prioritize safety of the patient, practitioner, staff, and other patients.
Trafficker may present as an intimate partner, relative, or friend.
Use certified translator or phone translation service. Do not have visitor interpret or present during the history and physical.
Speak with the person alone.
Ask a few questions related to the symptoms to ascertain the situation.
Focus on the presenting complaint and not the cause of the injury or illness.
Do not offer mental health services in the clinic.
Management
Adhere to HIPAA (Health Insurance Portability and Accountability Act) and exercise discretion with private information.
Assess safety risks with person and experts in the field (e.g., social services or shelter staff).
Offer to provide information or refer the person for shelter and services (e.g., hotline number).
Communicate clearly at eye level (appreciate cultural communication differences).
Use age- and culturally appropriate language.
Act only with informed consent unless mandated by law.
Know state-mandated reporting laws (minor, vulnerable adult, weapons-related).
Know how the first contact will be arranged.
Communicate relevant information to service providers only with patient consent.
Do not inquire about trafficking-related details.
Do not disclose your address, personal information, or attempt to shelter the patient.
Do not contact the authorities (law enforcement, immigration) without consent unless legally mandated.
Avoid making promises.
National Human Trafficking Resource Center Hotline 1-888-373-7888

Note. Data obtained from Alpert et al. (2014); Borland and Zimmerman (2012); NHTRC (2011).

bruising, contusions, scars, lacerations, or other evidence of physical or psychological trauma (Coppola & Cantwell, 2016; Greenbaum & Crawford-Jakubiak, 2015). Victims of labor trafficking may have injuries consistent with occupational hazards or neglect. Table 5 provides examples of examination findings associated with the physical and psychological trauma experienced across the various forms of human trafficking.

An important management aspect of care is the clear documentation of physical injuries and the patient's response during an examination. For patients who disclose sexual violence or assault, sexual assault nurse examiners (SANEs) are trained to conduct evidentiary examinations and appropriately document findings using sexual assault kits, photography, and written word (Williamson, Dutch, & Clawson, 2010). As an integral part of the multidisciplinary health care team, SANEs have the necessary training to assist patients who report sexual violence or assault with interviews, forensic examinations, collection of evidence, and facilitate community-based referrals (Alpert et al., 2014). Although an in-depth discussion of forensic evaluation is beyond the scope of this article, it is important to note that Sexual Assault Response Teams are available in some hospitals and provide valuable services in certain trafficking situations. The goal is to provide patient-centered support, avoid retraumatization, and describe injuries in a comprehensive, objective, and precise manner. When possible, it is advisable to use the patient's own words to describe events and document the examination findings from a medicolegal perspective (Williamson et al., 2010).

Table 5. Potential examination findings associated with the trauma of human trafficking

System	Subjective complaints and objective clinical findings	Associated physical and psychological trauma
General	Evidence of malnutrition, weight loss, anorexia, fatigue, febrile, poor skin turgor, nausea/vomiting	Poor nutritional status (starvation, malnutrition, dehydration, eating disorder), sleep deprivation, insomnia, infectious disease, anxiety, substance use/addiction, withdrawal symptoms
Cutaneous/ dermatological	Ecchymosis, burns, bites, scratches, tattoos, contusions, scars, lacerations, ligature marks, track marks/cellulitis	Physical trauma (slap, beat, kick, punch, burn, restraint), strangulation, confinement, torture, labor industrial injury/ exposure, branding
Head, ears, eyes, nose, throat (HEENT), mouth	Ecchymosis, scars, lacerations, ligature marks, petechiae of eyes and face, missing hair, nail damage, visual disturbances, broken/missing teeth, hearing loss	Physical trauma, strangulation, suffocation, hair pulled, facial and jaw trauma, malnutrition, lack of medical and dental care, untreated chronic medical conditions
Neurological	Headache, dizziness, disorientation, memory loss, vertigo, concentration difficulty	Traumatic brain injury, starvation, frequent relocation, isolation, anxiety, depression, complex trauma, PTSD
Pulmonary/ cardiovascular	Cough, SOB, arrhythmias, fever, asthma, tuberculosis, tachycardia, hypertension	Unsanitary or crowded living conditions, industrial exposure, trauma, dehydration, infectious disease, substance use/addiction, stress, untreated chronic medical conditions
Musculoskeletal	Fractures, back pain, joint pain, loss of extremities	Traumatic injuries (abuse, assault), industrial injuries, stress, repetitive injury, prolonged work hours
Gastrointestinal	Abdominal pain, trauma, irritable bowel syndrome, constipation	Abdominal trauma, substance use/addiction, nutritional deprivation/starvation, unsanitary living conditions, stress/anxiety, infectious disease
Genitourinary/ reproductive	Pelvic pain, dyspareunia, labial/vulvar/vaginal/cervical trauma, mutilations, ecchymosis or hematomas, untreated or recurrent STIs, PID, UTIs, retained vaginal sponge/cotton fibers, unintended pregnancies, purulent/foul vaginal discharge, multiple abortions	Sexual trauma, gang rape, nonconsensual sex, multiple sex partners; recent, multiple, forced, and/or unlicensed abortions, sponge or foreign body use while on menses (nonconsensual sex or heavy vaginal discharge)

(*continues*)

Table 5. Potential examination findings associated with the trauma of human trafficking (*Continued*)

System	Subjective complaints and objective clinical findings	Associated physical and psychological trauma
Endocrine/metabolic	Diabetes, asthma, anemias	Lack of preventive and routine care, unmanaged chronic medical conditions, stress, environmental exposures
Infectious disease	Malaise, febrile, HBV infection, HCV infection, HIV/AIDS	Unprotected, nonconsensual, forced sex, multiple partners, substance use disorders, intravenous drug use, high-risk behaviors
Psychiatric/ behavioral health	Depression, anxiety, hostility, depersonalization, hypervigilance, PTSD, traumatic bonding, normalized sexual violence, self-inflicted injuries, suicide attempt, shame, emotional dysregulation	Coercion, physical and psychological violence, intimidation, social isolation, deception, frequent relocation, sexual humiliation, sleep deprivation, restricted movement, unpredictable events, forced pornography, coercive or coping drug use

Note. Data obtained from Alpert et al. (2014); Baldwin et al. (2011); Doherty and Morley (2013); Gibbons and Stoklosa (2016); NHTRC (2016b); Stoklosa et al. (2015). AIDS = acquired immunodeficiency syndrome; HBV = hepatitis B virus; HCV = hepatitis C virus; HIV = human immunodeficiency virus; IBS = irritable bowel syndrome; PID = pelvic inflammatory disease; SOB = shortness of breath; PTSD = posttraumatic stress disorder; STI = sexually transmitted infection.

Safety and Referral

Once a patient is identified as a victim of trafficking, prioritize safety, health care, and psychological needs (Stevens & Berishaj, 2016). An important aspect of safety is the patient's assessment of immediate risks (Alpert et al., 2014). Law enforcement will need to be notified if imminent danger to the patient, staff, or others is a concern (Borland & Zimmerman, 2009). Safety measures may include a review of emergency protocols, restriction of access to doors in clinical areas, and an established relationship with local law enforcement (American College of Obstetricians and Gynecologists, 2011). The National Human Trafficking Hotline is available 24/7 to assist with posttrafficking placement resources and identification of law enforcement with human trafficking training.

Developing partnerships with organizations and community stakeholders is essential to access resources that meet the needs of trafficking victims. Many victims of trafficking have an array of needs that include medical and psychological care, substance abuse treatment, trauma recovery treatment, housing, transportation, legal assistance, and financial support (Alpert et al., 2014; Borland & Zimmerman, 2009; Gibbons & Stoklosa, 2016). The initial response of a health care organization is to meet the immediate basic and crisis needs of the patient, which may include medical conditions, safety, emergency psychiatric evaluation, nutrition and hydration status, rest, HIV and hepatitis screening, STI treatment, pregnancy, contraception, clothing, and shelter (Greenbaum & Crawford-Jakubiak, 2015; Macy & Graham, 2012). Enlisting additional comprehensive, multidisciplinary services such as social work, case management, and mental health services may be appropriate. Often, the needs of trafficking victims are extensive and beyond

Table 6. Human trafficking education and referral resources

Resource name	Information provided	Contact
Coalition Against Trafficking in Women	NGO to combat trafficking of women and children	http://www.catwinternational.org
DHS	Legal assistance, T-visa, and victim support	1-866-347-2423
DHS Blue Campaign	Awareness, education, shoe cards, victim-centered investigation	https://www.dhs.gov/blue-campaign/about-blue-campaign 1-866-347-2423 https://www.dhs.gov/blue-campaign/resource-catalog
Department of Health and Human Services: Rescue and Restore Campaign	Toolkits including literature and posters	http://www.acf.hhs.gov/programs/endtrafficking/trafficking
ECPAT-USA	"Leading anti-trafficking policy organization in the United States."	http://www.ecpatusa.org
HEAL Trafficking	Interdisciplinary health professionals connect to end trafficking through referral, education, advocacy, and support	https://healtrafficking.org
Local police department	Immediate assistance for safety and protection	911 or local contact number
National Human Trafficking Resource Center Hotline	Education, information, and local referral sites	1-888-3737-888
NHTRC SMS Short code for victims	Specialized Text Service Confidential crisis support, referrals, tip reporting, and general information through SMS text message	https://polarisproject.org/services-hours Text "BeFree" (233733) 3 p.m.–11 p.m. EST (provide information to victims)
Polaris Project website and Resource Center	Online reporting, education, and information	www.polarisproject.org
S.O.A.P.	Outreach and education rescue victims trafficked at hotels; educate motels on trafficking signs	https://www.traffickfree.com/soap
SafeHorizon	Victims' services agency—Antitrafficking Program only for New York	http://www.safehorizon.org/page/human-trafficking-what-we-do-346.html

Note. DHHS = Department of Health and Human Services; DHS = Department of Homeland Security; ECPAT = End Child Prostitution and Trafficking; HEAL = Health, Education, Advocacy, Linkage; NGO = nongovernmental organization; NHTRC = National Human Trafficking Resource Center; SMS = Short Message Service; S.O.A.P. = Save Our Adolescents from Prostitution.

the scope of a single provider or clinical site (Gibbons & Stoklosa, 2016; Peters, 2013). Table 6 provides resources for locating assistance.

Reporting and Documentation

The U.S. Department of Homeland Security (DHS, 2015) is responsible for providing sanctuary to noncitizen victims of human

trafficking, immigration relief in the form of a T-visa, U-visa, or Continued Presence (CP)-visa, and facilitating the prosecution of traffickers. A CP-visa allows victims to remain in the United States for 1 year, access to government benefits, and authorization for employment. The Trafficking Victims Protection Act of 2000 created a new class of visa (T-visa) that allows trafficking victims to remain in the United States for 3 years with work authorization, access to benefits, medical care, and services offered by HHS. At the end of 3 years, T-visa holders may apply for permanent residence. The U-visa is for victims with nonimmigrant status who have suffered substantial physical and/or psychological trauma from qualifying criminal activity and are willing to assist law enforcement with the investigation and prosecution of criminals (U.S. DHS, n.d.). After 3 years, these victims can apply for a permanent resident card, also known as a Green Card, and permanent status if cooperation with authorities is established. The Green Card status allows the victim to be eligible for employment in the United States. Otherwise, the U-visa is valid for a period of 4 years, with the option for an extension.

Mandated Reporting

All states have mandated reporting for suspected child abuse to appropriate state agencies such as child protective services, legal authorities, or a state child abuse reporting hotline. In this case, it is essential to clearly inform these service providers that the minor is a victim of exploitation (Child Welfare Information Gateway, 2016; Greenbaum & Crawford-Jakubiak, 2015; Todres, 2016). Mandated reporting statutes have explicit language, making suspected "sexual exploitation" or "sexual assault" of minors a reportable offense (Todres, 2016). As mandated reporters, health care providers should discuss these limits of confidentiality with the patient (Greenbaum & Crawford-Jakubiak, 2015).

Unless there is imminent danger to an adult patient or others, law enforcement should not be contacted without the patient's consent (Abas et al., 2013; Alpert et al., 2014; Borland & Zimmerman, 2009). Notifying legal authorities or other service providers without the patient's authorization is a violation of patient rights and a breach of confidentiality (Alpert et al., 2014). However, state-specific mandated reporting exceptions exist for adult victims in certain situations. Injuries from firearms, sharp weapons, substantial burns, death threats, or threat to a child or adult caretaker of a child and disabled or incompetent adults are examples of these reporting exceptions (Alpert et al., 2014). Practitioners should be familiar with the specific circumstances of state-mandated reporting laws for both children and adults. Consultation with administrators or risk management personnel may provide organization-specific guidance for management and referrals (Greenbaum & Crawford-Jakubiak, 2015).

While being trafficked, individuals lose control over every aspect of their life. Each instance that fosters a sense of inclusion, predictability, and choice provides an opportunity to regain control and empowerment (Borland & Zimmerman, 2009; Gibbons & Stoklosa, 2016; Stevens & Berishaj, 2016). If a suspected victim of trafficking declines assistance, provide contact information for the National Human Trafficking Hotline or the Polaris text line "BeFree" (233733). Both services offer information on local resources and recommendations for trafficking victims. Contact information can be discretely provided on a concealed shoe card from the DHS *Blue Campaign* (U.S. DHS, 2015). Other informational resources are available from both NHTRC and DHS. When referring to service organizations, indicate the patient is a victim of trafficking and avoid disclosing protected health information.

CONCLUSION

Many individuals in captivity do not self-identify as "human trafficking victims." Up to 87% of trafficked victims seek health care while in captivity but are not identified or offered assistance by APRNs or other health care practitioners (Lederer & Wetzel, 2014).

The first point of contact in the health care system is critical. Each health care encounter provides a window of opportunity for an exploited individual to disclose her or his trafficking situation. A compassionate and respectful environment fosters a sense of safety, empowerment, and control over an individual's life. This approach is especially critical for those with a history of trauma from trafficking. The clinical presentation and comorbidities of people who are trafficked are complex and varied; however, health care providers can identify victims needing assistance through appropriate assessment and screening tools (Baldwin et al., 2011; Gibbons & Stoklosa, 2016; Peters, 2013). Understanding potential clinical presentations of sex and labor trafficking can assist health care providers in recognizing and responding to the needs of these often marginalized and exploited individuals (Alpert et al., 2014). Advanced practice registered nurses can increase their awareness and ability to identify, treat, and refer victims of human trafficking through continuing education and community outreach programs. When a victim has the courage to disclose her or his trafficking situation, APRNs and other health care providers must have the requisite foundation of education, training, and clinical judgment to act as her or his advocate.

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