

## Multidisciplinary Human Trafficking Education: Inpatient and Outpatient Healthcare Settings

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# Multidisciplinary Human Trafficking Education: Inpatient and Outpatient Healthcare Settings

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## ABSTRACT

**Background:** While it is common for trafficked persons (TPs) to access healthcare, few health professionals have had training and lack confidence in their ability to respond effectively. Additionally, healthcare does not have evidenced-based education or policy for responding to TP. This study evaluated knowledge and confidence in responding to TPs among multidisciplinary participants from outpatient and inpatient settings. **Methods:** A revised version of the Provider, Responses, Treatment, and Care for Trafficked People (PROTECT) instrument was used. An additional question was added to record previous contact with trafficked persons. The first phase of data collection ( $n = 237$ ) occurred pre and post education. The second phase of data collection ( $n = 106$ ) was completed three months after implementation of a response policy and procedure. **Results:** Phase one results are statistically significant with a sharp increase in the number of participants who reported caring for a TP. Knowledge and confidence levels were also significantly impacted. The second phase did not show a significant change in confidence. However, six knowledge questions related to identifying potential cases of HT were significantly different, showing a decrease in knowledge over time. **Discussion:** This study documents the benefits of education based on Health, Education, Advocacy, Linkage (HEAL) Trafficking's recommendations. Follow-up survey shows that without ongoing education or awareness activity, key knowledge areas decline. Therefore, while policy and awareness education are important, health professionals need ongoing education as well as incentive to utilize the response policy and procedure.

## KEYWORDS

Human trafficking; healthcare; health care; education; HEAL Trafficking; sex trafficking; labor trafficking; protect; policy; protocol

## Introduction

Human trafficking (HT) is not only a 150 billion USD industry, it is a public health issue that globally affects an estimated 21 to 40 million men, women, and children (Polaris, 2017). The United States Department of State (2017) defines HT in the Trafficking Victims Protection Act of 2000 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 commercial sex acts, involuntary servitude, peonage, debt bondage, or slavery” (p. 3). However, if a trafficked person (TP) is under the age of 18 years and is used for commercial sex acts, the use of force, fraud, or coercion does not need to be proven (U.S. Department of State, 2017). This means that anyone under 18 years of age and participating in commercial sex acts is considered a victim of sex trafficking. While the U.S. definition separates HT into two categories, sex and labor, the United Nations employs a more inclusive definition. The United Nations definition of HT includes abduction as a means and states that “exploitation shall include, at a minimum, the exploitation or the prostitution of others or other

forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs” (United Nations Office on Drugs and Crime, 2004, p. 42).

Recent studies have shown that many traffickers, who profit significantly from their exploitative business, allow their victims to seek medical treatment when necessary. Surveys of trafficking survivors indicate that up to 88% sought healthcare services during their time of exploitation (Chisolm-Straker et al., 2016; Grace et al., 2014; Lederer & Wetzel, 2014; Stoklosa et al., 2019). This suggests that if TPs are identified while seeking healthcare, they can be educated about their situation and options can be presented if appropriate for the situation. It is essential that health professionals understand that the goal of any encounter with TPs should not be to “save” adult victims. The objective is to identify potential TPs while providing medical care using a trauma-informed approach. Education and options to leave a harmful situation cannot be forced upon any patient and may not be appropriate in some circumstances. Forcing self-identification upon TPs may be psychologically harmful and create a physically dangerous situation. However, when appropriate, health professionals can provide education and offer options allowing TPs to seek freedom from exploitation. Then these victims can receive treatment for the multitude of mental and physical effects that often result from being trafficked.

While education of health professionals has occurred for more than a decade, most report they are unfamiliar with how to identify or respond to a TP effectively (Powell et al., 2017; Stoklosa et al., 2017, 2019). For this reason, change is needed in the form of standardized education and protocol related to the care of TPs (Ross et al., 2015; Stoklosa et al., 2017, 2016). Health professionals want to provide compassionate assistance to TPs. However, they are unable to do so effectively without a standardized system in place. With the recognition of the intersection between healthcare and HT comes an increase in educational opportunities for health professionals. In addition to basic HT education, the U.S. Department of State’s Trafficking in Person Report (2017) also states that non-government organizations report a “need for increased availability of trauma-informed services for trafficking victims” (p. 415). Therefore, HT education should also include information on how to use a trauma-informed approach.

## **Methods**

### ***Study Design***

This mixed method, quasi-experimental study accompanied a quality improvement (QI) project. A pretest-posttest design was incorporated using a revised version of the Provider, Responses, Treatment, and Care for Trafficked People (PROTECT) instrument (Ross et al., 2015). The revisions included the addition of questions to record previous contact with TPs and, as the tool was developed in the United Kingdom, some wording was changed to be reflective of a participant pool from the United States. A policy and procedure for responding to HT was developed for a Midwestern health system. Prior to the implementation of the policy and procedure an educational module was developed to educate employees of the health system. The module was created following the recommended essential education components for healthcare training published by HEAL Trafficking (HEAL Trafficking Education and Training Committee, 2018).

The initial data collection occurred throughout a seven-month period starting July 2018. The policy and procedure were implemented January 2019. The final data collection period occurred during April and May 2019, three months after the implementation of the policy and procedure.

### ***Setting and Population***

The Midwestern health system consists of three hospital campuses in two counties and multiple outpatient services. While all hospital campuses and outpatient services will be utilizing the HT response policy and procedure, only two campuses and a select group of outpatient clinics and physician offices accepted the educational offering and were then invited to participate in the study.

During the months of July and August 2018, 15 educational sessions were provided to multiple outpatient clinics and physician offices, including ancillary staff. Those in attendance were from primary care physician (PCP) offices, urgent care clinics, obstetrics and gynecology (OB) offices, pelvic medicine/urogynecology, and geriatric medicine. The education occurred either before office hours, after office hours, or during the lunch hour and was usually conducted in the empty waiting room or the office conference room.

The 31 educational sessions for the two hospital campuses occurred during a five-month period. The sessions were divided between both hospital campuses and the staff training center and were provided at a variety of times to incorporate all shifts, including nights and weekends. Seventeen of the sessions were conducted as part of the annual Medical/Surgical Department's Nursing Skills Fair, for which attendance was mandatory for nurses. In addition to the Medical/Surgical department, education was also provided to the Behavioral Health, OB, Case Management, Emergency, and Spiritual Care Departments; the Professional Nursing Practice Council; and provider groups which included medical residents, physician assistants, nurse practitioners, and hospitalists. Attendance for the education sessions outside of the nursing skills fair was not mandatory.

### **Data Collection**

Attendees of the education sessions were approached to participate in the study and those who agreed completed the survey and supplied an e-mail address. The initial survey (pre- and post-education) was delivered in a packet to allow for comparison with paired *t*-tests without requiring identifiers on the surveys. The final survey of participants occurred three months after the implementation of the policy and procedure. Participants were sent a link via e-mail to an electronic version of the survey on SurveyMonkey®.

Participants completed the first half of the survey packet which included demographic questions, questions about any previous HT education, and an adapted version of the PROTECT tool pre-education. The PROTECT tool was used to measure the participants' knowledge about HT and level of confidence in their ability to respond effectively prior to the education session. Post-education, participants completed the second half of the survey packet which omitted the demographics and prior education questions. The post-education survey included an added question, "Now that you have attended this training, do you suspect that you may have had a patient in the past three-months who could have been a human trafficking victim?"

The final phase of data collection occurred three months after the implementation of the policy and procedure. Participants were sent the same survey with an additional question asking if they had provided services to a TP in the healthcare setting within the previous three months. Survey respondents were also asked to complete the demographic questions again, identically to the initial survey, with an added question asking which month they attended the HT education session.

### **Intervention**

An educational module was developed and delivered in person to employees of the health system following the recommended essential education components for healthcare training published by HEAL Trafficking (HEAL Trafficking Education and Training Committee, 2018). A policy and procedure were also developed utilizing the *Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings* as a guideline (Baldwin, Barrows & Stoklosa, 2017). Official collaboration between the health system and the regional HT task force was initiated as part of the policy and procedure.

HEAL (Health, Education, Advocacy, Linkage) Trafficking is an international group comprised of multidisciplinary professionals who view human trafficking as a public health issue. HEAL's mission is to shift the anti-trafficking paradigm toward approaches established in public health principles and trauma-informed care. In part, this will be accomplished through expanding the evidence base,

educating healthcare communities, and advocating for policies that enhance the public health response to trafficking while supporting survivors (HEAL Trafficking, n.d.). Therefore, HEAL Trafficking's recommended essential education components for healthcare training along with their protocol toolkit provided an appropriate framework for this QI project.

## Analysis

Statistics were estimated using Statistical Package for the Social Sciences (SPSS)<sup>®</sup> for Windows. Counts and proportions were used for categorical measures. A paired *t*-test was used to compare the mean pre-education scores to the mean post-education scores of the knowledge and confidence level questions. For the three-month post policy and procedure implementation follow-up survey, Levene's test for equality of variances and the *t*-test for equality of means were used. A one-way analysis of variance (ANOVA) was used to compare the knowledge and confidence of participants before education, immediately after education, and several months post-education. Tukey's honestly significant difference (HSD) was used to determine the nature of differences between the participants' knowledge. *P* values less than .05 with a 95% confidence interval were statistically significant.

## Results

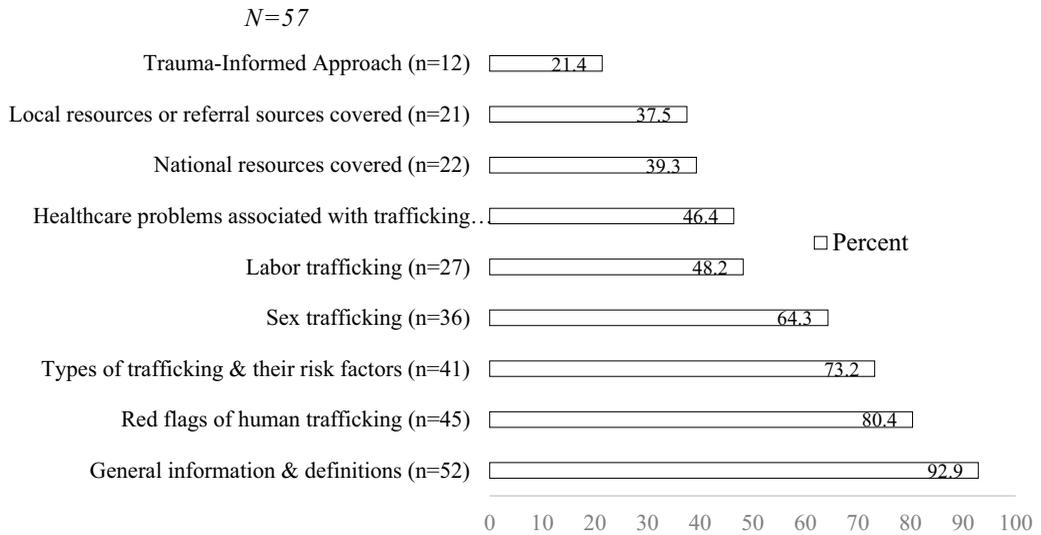
### Phase One

Phase one data collection occurred pre- and post-education. A total of 768 personnel attended the HT education sessions and provided a convenience sampling for the accompanying study. Of those who attended the education sessions, 347 agreed to participate in the study. However, 110 surveys were incomplete and determined to be ineligible for analysis, leaving 237 fully complete surveys to be included in the study. Participants were primarily nurses (66.7%), followed by medical assistants (14.8%), and providers (10.5%). The classification of provider included physicians, physician assistants, and nurse practitioners. Other participant disciplines included chaplains, educators, registrars, practice managers, a community health worker, an administrative assistant, and a radiology technician.

Most of the participants identified as female (84.0%) with the remaining 16.0% identifying as male. Seventy-eight (32.9%) of the participants stated they were between 25–34 years of age with the next largest group of 62 (26.2%) participants being between 35–44 years of age. When reviewing the highest level of education, 15 (6.4%) reported either graduating from high school or obtaining a GED, 107 (45.3%) had obtained an associate degree, 78 (33.1%) had a bachelor's degree, 26 (11.0%) had a master's degree, and 10 (4.8%) had obtained a doctorate.

Of the phase one participants, 150 (63.3%) worked in the inpatient setting, 73 (30.8%) worked in the outpatient setting, 10 reported working in both the inpatient and outpatient setting, and 11 (4.6%) worked in an urgent care clinic. Those who worked in the inpatient setting were almost evenly split between the two hospital campuses, 84 (35.1%) and 79 (33.3%) respectively. Within the inpatient setting, 41 (17.3%) participants reported they worked in the Medical/Surgical Department, 10 (4.2%) worked in the OB Department, 16 (6.7%) in Behavioral Health, and 7 (3.0%) worked in the Emergency Department. Within the outpatient setting, 35 (14.8%) participants worked in PCP offices, 8 (3.4%) in the Pelvic Medicine/Urogynecology Clinic, and 9 (3.8%) in an OB office. As the question regarding work location was a "select all that apply," of the 10 (4.22%) who indicated they worked in both the inpatient and the outpatient setting, five were from OB.

The phase one study asked participants about prior HT education. The survey results report 180 (75.9%) participants had not received prior education on HT. The 57 (24.1%) who did have prior education reported the top three topics explored were general information and definitions, red flag indicators of HT, and types of trafficking and their risk factors. The least explored topics in prior education were trauma-informed approach, local resources or referral sources, national resources, and



**Figure 1.** Education topics covered in previous training. Frequency of topics covered in previous education sessions on human trafficking in the healthcare setting. As participants were to select all that applied the frequency total is >100%.

health problems associated with HT. Information specific to sex trafficking was covered more frequently than labor trafficking (see [Figure 1](#)).

The education provided as part of this study made a significant impact on all but two questions. Question 17 asked if healthcare workers believe HT is women and girls being forced into prostitution. Upon further review, the wording of this question is unclear and does not reflect the intent of the question. Question 30 asked if healthcare professionals (HPC) believe they have a responsibility to respond to suspected cases of HT. As question 30 was scored on a 1 (strongly disagree) to 5 (strongly agree) Likert Scale and the mean scores were 4.43 and 4.38 respectively, respondents acknowledged responsibility prior to education.

Question 7 of the pre-survey asked respondents if in the previous three months they had provided care for a known or suspected TP. Of the 237 participants, 16 (6.8%) responded “Yes.” Immediately after the education, participants repeated the survey with question 7 being changed to: if they had originally answered “No” to previously caring for a TP, did they now suspect they may have had a patient in the past three months who could have been a TP? (see [Table 1](#)). An additional 77 (32.8%)

**Table 1.** Survey question 7.

<b>Pre-education</b>
In the past 3-months have you been in contact with a patient whom you knew or suspected was being trafficked?
If yes, how did you know or suspect that the patient(s) had been trafficked?
Patient disclosure?
Patient displayed “red flags”?
Disclosure by another professional?
<b>Immediate post-education</b>
On the first section of the survey, if you answered “NO” to previously caring for a trafficked person, now that you have attended this training, do you suspect that you may have had a patient in the past 3-months who could have been a human trafficking victim?
<b>3-months post policy/procedure implementation</b>
Since attending the training on how to respond to a human trafficking victim in the healthcare setting, have you cared for a trafficked person?
If yes, how many?
Did they agree to leave their trafficker?
Was the policy & algorithm used?

respondents answered “Yes” with a total of 93 (39.6%) stating that they either knew or suspected they had cared for a TP in the previous three months. All locations and departments saw significant impact except the Emergency Department (ED). While the ED location was impacted, it was not significant due to the small number of responses.

Of the 16 participants who answered “Yes” to question 7 on the pre-survey, 12 were nurses, two were medical assistants, and two were providers. Immediately post-education, the groups who indicated they either knew or suspected they had cared for a TP in the previous three months was comprised of a much broader job or discipline classification. Sixty-five (69.9%) were nurses, 10 (10.8%) were medical assistants, six (6.5%) were providers, three (3.2%) were chaplains, and two (2.2%) were radiology technicians. Others who answered “Yes” to question 7 on the immediate post-education survey were an administrative assistant, an aesthetician for breast cancer patients, a registrar, a community health worker, an educator, and one who worked in a clerical role. Most staff who reported they believed they had cared for a TP came from the Medical/Surgical Department.

To analyze question 7 (all disciplines), a paired samples *t*-test was calculated to compare the mean pre-education score to the mean post-education score. The pre-education mean was 1.93 (sd = .252) and the post-education mean was 1.60 (sd = .490). A significant difference from the pre-education to the post-education was found ( $t(235) = 10.679, p < .05$ ). More participants identified caring for a TP post-education.

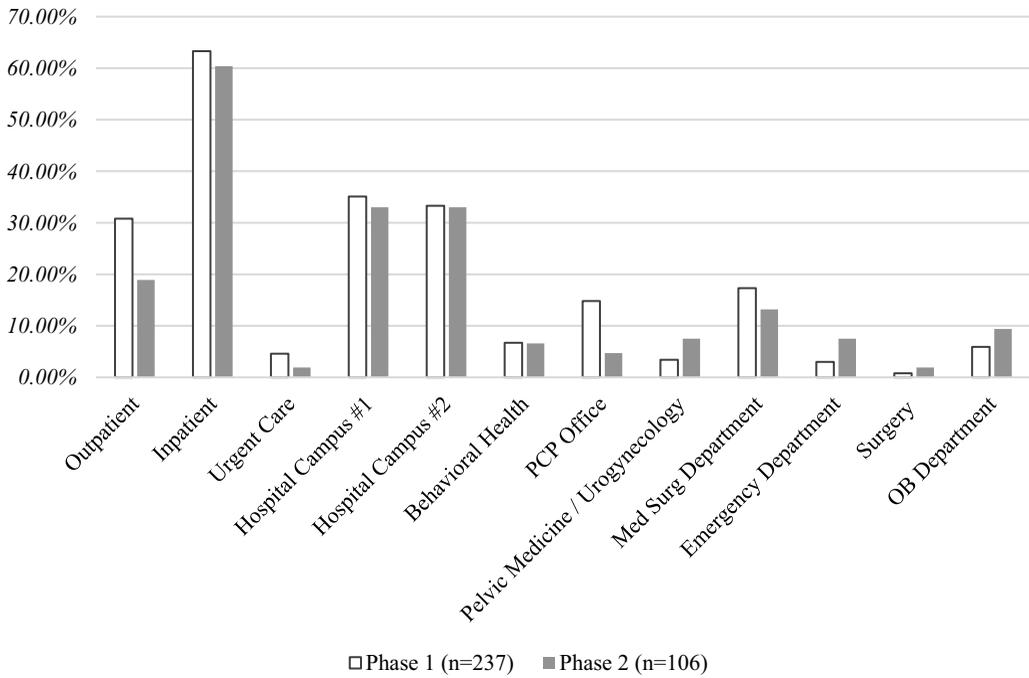
Of those who reported either a confirmation or a suspicion that they had cared for a TP, 25 (26.9%) worked in the outpatient setting, 63 (67.7%) worked in the inpatient setting, and 5 (5.4%) worked in an urgent care clinic. When analyzing those who worked in the inpatient setting, 38 (40.9%) worked at hospital #1 and 27 (29.0%) worked at hospital #2. It should be noted that the Behavioral Health Unit is located at hospital #1 and of the 16 participants from this unit, 14 reported caring for a TP. In the outpatient setting, four of the eight participants from the Pelvic Medicine/Urogynecology Clinic reported they had cared for either a confirmed or a suspected TP. In addition, 10 of the 35 from the PCP offices and five of the nine who worked in an OB office also answered “Yes” to question 7.

## **Phase Two**

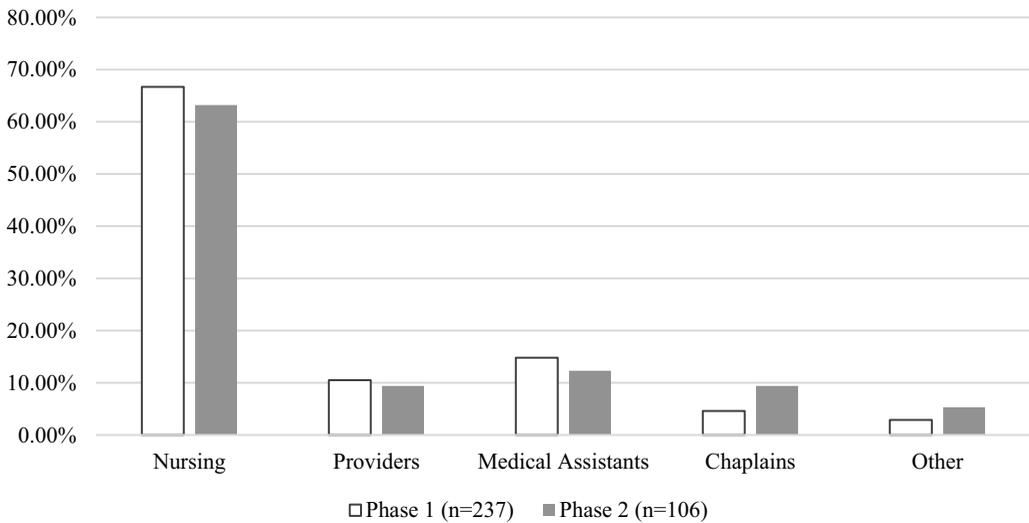
The second phase of data collection utilized an online version of the survey that was completed by 106 (44.7%) of the initial participants. The work locations and disciplines of the second phase participants closely reflect the first phase data except for the percentage of participants who worked in the PCP offices within the outpatient setting (see [Figures 2 and 3](#)). Twenty-five (26.6%) of the participants worked in the outpatient setting, 61 (64.9%) worked in the inpatient setting, and five (5.3%) worked in an urgent care clinic. Nurses again made up much of the population with 67 (63.2%) completing the survey.

The same survey was used with the exception of question 7, which was changed to ask if they had cared for a TP since attending the education (see [Table 1](#)). Five respondents reported they had cared for a TP. Three stated they had cared for a single TP, one reported caring for two victims, and one reported caring for more than five. All were from the inpatient setting with three being nurses, and two were chaplains. One of the nurses was from Behavioral Health and the other two declined to report in which department they worked. The chaplains reported working with a TP in the ED as well as OB. Anecdotally, one chaplain reported intermittently interacting with suspected sex trafficked women, outside of the study timeframe, who used the chapel of hospital #1 for shelter and a place to rest. Only one of the five respondents reported using the policy and procedure with the accompanying algorithm when caring for a TP.

For the knowledge and confidence questions, a one-way ANOVA was conducted comparing the knowledge and confidence of participants before education, immediately after education, and several months post-education. The knowledge and confidence of participants before the education session, immediately after education, and several months post-education was not significant for two questions. Question 17 was a true/false question asking if HT is women and girls being forced into prostitution. Upon review, this question was determined to be invalid due to the wording of the question. Question



**Figure 2.** Work location. Participants were asked to indicate the location in which they worked. As they were to check all that applied the frequency total is >100%. This graph illustrates that phase 2 participants closely reflected those in phase 1.



**Figure 3.** Disciplines. Participants were asked to indicate their discipline. This graph illustrates that the disciplines reported by participants in phase 2 closely reflects the discipline frequency of phase 1 participants.

29 was answered using a 5-point Likert Scale with 1 = strongly disagree and 5 = strongly agree. The mean scores were 1.97 before education, 1.78 immediately after education, and 1.81 several months post-education, indicating that participants already understood that friends and family should not act as an interpreter.

After a one-way ANOVA was conducted, Tukey’s HSD was used to determine the nature of differences between the participants’ knowledge and confidence levels immediately post-education

and several months post-education in those questions with significant findings. When analyzing all the participants, five questions were noted to be significant when only considering the immediate post-education and several months post-education answers.

## Discussion

The primary objectives of this study were to 1) develop and implement a system-wide policy and procedure to guide appropriate response to potential TPs, 2) to provide education on HT in the healthcare setting and how to respond with a trauma-informed approach, and 3) to examine any longitudinal changes in hospital staff's confidence level after intervention. The results of the study indicate that while the participants had a significant increase in knowledge and confidence post-education, there was no significant change in confidence level post-education and three months after the implementation of the policy and procedure. However, knowledge questions related to what could be asked to help identify potential cases of HT, common health problems, local and/or national support services, and when police should be called were significantly different between the immediate post-education survey and the post policy and procedure survey, indicating a decrease in knowledge over time. While participants' perceived confidence did not significantly change over time, important knowledge areas related to effective response did have a significantly negative change.

Of the 106 participants in the phase two data collection, five reported caring for a TP in the time period between the education and three months after implementation of the policy and procedure. Only one stated the policy and procedure was used to guide the response. Further research is needed to determine the reasons the policy and procedure was not used in the other four cases.

One possible explanation that should be explored is the need for additional time and education to elicit change. Current state legislation requires all health professionals to obtain a one-time education unit on HT for license renewal. No further education is required. In this study, even with a policy and procedure in place, knowledge levels in key areas decreased over a short period of time. The implication being that without repeated education, health professionals' knowledge will fall away, and their behavior will not change. However, addition longitudinal research is needed.

Another area to explore is the emotional response to the education and maintaining the sense of urgency for behavior change. The participants attended the education and then expressed a significant change in knowledge and confidence. Also, when asked to reflect on the previous three months, their awareness of the red flags of HT elicited a strong response and possible overestimation as evidenced by a large number indicating they had possibly cared for a TP. However, once the education was complete, they returned to the status quo. The need for ongoing education and the frequency of the education should be researched further. Continuing to share the vision through education creates a sense of urgency within each department and broadens the power base that will drive engagement and the process of change (Marshall, 2011).

In addition to evaluating the project objectives, the accompanying research provided an abundance of additional data that will inform future evidence-based practice. First, as this study was multi-disciplined, the data related to question 7 which asked if the participant had cared for a TP, indicates other disciplines such as medical assistants, radiology technicians, registration personnel, and chaplains are also likely to encounter a TP. Review of current literature indicates that most healthcare organizations focus on providers and nurses when providing education. Workers occupying various roles in the healthcare setting indicated they may have interacted with a TP. Thus, all who work in the healthcare setting should be educated on human trafficking and educated about how to respond appropriately.

This study also examined the components of HT education with the intent to provide evidence toward standardization of education. The 57 (24.1%) phase one participants who had prior education reported the top three topics explored were general information and definitions, red flag indicators of HT, and types of trafficking. The least explored topics in prior education were trauma-informed approach, local resources or referral sources, national resources, and health problems associated with

HT. This indicates current available education on HT focuses on how to identify a potential TP but not how to respond appropriately. It is also concerning that 64% reported information specific to sex trafficking was covered but only 48% reported the inclusion of labor trafficking information.

For this project and study, the education modules were created using the recommendations from the *Introductory Training on Human Trafficking for U.S. Health Care Professionals: Essential Content* by HEAL Trafficking Education and Training Committee (2018). The post-education survey showed the education had a significant impact on the participants. When broken down, the survey revealed the education also significantly impacted all locations and disciplines except for those with limited response numbers. The phase two data revealed a decrease in knowledge related to five questions which were noted to be significant when considering the immediate post-education and several months post-education answers. Further research is needed to determine if this decrease is related to education content or a need for ongoing education to keep the information at the forefront.

### **Limitations**

The primary limitation of this study was that all education was provided in person by the principal investigator. While every attempt was made to offer education sessions for all departments and shifts, one person cannot meet the needs of several thousand employees. Most educational sessions needed to be completed within an hour, so time constraints were also a factor. Additionally, while the information collected included a breadth of perspectives, a convenience sampling from one Midwestern health system was used and cannot be generalized.

While previous studies have indicated that ED and OB are the primary sites for interacting with TPs, this study had limited participation from these areas. The two hospital campuses were in the process of merging onto one campus, with the ED being the first department to move into the new building space. The pressures related to this move may have inhibited the desire for or prevented a sense of urgency to obtain education on how to respond to TPs.

### **Recommendations**

The phase two study results show that knowledge decreased over time and staff did not utilize the human trafficking response policy and procedure as intended. Therefore, the primary recommendation is to provide annual education on how to respond to human trafficking with a trauma-informed approach and then incentivize attendance. These education sessions should be made available to all health professionals and ancillary staff for both the inpatient and outpatient settings, not just acute care providers and nurses. Ongoing education utilizing more interactive and innovative strategies for content delivery would also be beneficial in maintaining knowledge and confidence levels while encouraging behavior change. The content provided during these sessions should be standardized to ensure key information points are consistently included. The short-term learning outcomes should include knowledge acquisition, including cognizance of the policy and procedure, as well as improved confidence in ability to respond to TPs effectively.

The long-term goal should be to move beyond knowledge and attitude change toward behavior change that positively impacts patient-centered outcomes of TPs. Achieving this goal will require health system employees to not only attend continual education sessions on how to respond to human trafficking, but to also embrace the urgency of actively utilizing a HT response protocol or policy and procedure. According to Ekroos (2019), “Creating silos of education, rather than an overarching trauma-informed culture, for sexual assault, intimate partner violence, human trafficking, and the other forms of abuse and exploitation may contribute to a fragmented response to the unique needs of each patient population” (p. 274). To avoid this fragmented response currently being experienced, a system-wide cultural change must take place through both a top-down and a bottom-up approach where all employees receive training within a supportive infrastructure that also expects action (Ekroos, 2019).

Further research and advocacy are also needed. Longitudinal research related to education and policy is severely lacking. HCPs need to conduct and publish research that will provide evidence toward standardization of education and response protocols. Research should also identify how to best incentivize HCPs to obtain education on HT and how to appropriately respond.

## Conclusions

While education of HCPs has been occurring for over 10 years, most report they are unfamiliar with how to identify or respond to TPs effectively (Stoklosa et al., 2019). The participants of this study reflect this national trend, indicating that change occurs slowly. The objective of education is to produce awareness of the problem of HT and the needed change in how patients are approached and cared for when they seek healthcare. The purpose of the policy and procedure was to provide a system wide framework to educate and guide health professionals in confidently and effectively recognizing and responding to TPs with victim-centered and trauma-informed services.

Education based on HEAL Trafficking's recommendations had a significant impact on participants knowledge and confidence levels based on immediate post-education data. However, the follow-up survey shows that without ongoing education or awareness activity, key knowledge areas decline. This QI project and study speaks to the fact that while education and policy are important, HCPs and ancillary staff need ongoing education as well as incentive to utilize response policies and procedures.

## Disclosure Statement

No potential conflict of interest was reported by the author.

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