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Child Sex Trafficking-Recognition, Intervention, and Referral: an Educational Framework to Guide Health Care Provider Practice

Cathy L. Miller

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CHILD SEX TRAFFICKING-RECOGNITION, INTERVENTION, AND REFERRAL:
AN EDUCATIONAL FRAMEWORK TO GUIDE HEALTH CARE PROVIDER
PRACTICE

by

CATHY L. MILLER

A dissertation submitted in partial fulfillment
Of the requirements for the degree of
Doctor of Philosophy
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This is to certify that the Doctoral Dissertation of

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Abstract

Awareness of the plight of children and adolescents who are sexually exploited and trafficked for financial gain has gradually garnered the attention of the public, law enforcement, and health care providers. The discussion is slowly changing to recognize these exploited children and adolescents as victims and not criminals. Marginalization of this population is slowly changing to advocacy. However, with awareness comes responsibility for the health care system to provide improved recognition, intervention, and referral of this population. Increased health care provider responsibility demands a scientifically based framework to guide the development of health care provider education programs. To date, there are no such frameworks and no best practices to guide health care providers in the care of these children and adolescents. This Delphi study established the framework for a comprehensive, evidence-based HCP education program that focuses on the recognition, intervention, and referral of this population. Findings utilizing an international, multidisciplinary panel of subject matter experts and survivors provide the content and sub-content areas for health care provider education programs on the recognition, intervention, and referral of this population. Two manuscripts were published in the Journal of Emergency Nursing (Impact factor 1.131) first addressing the foundation of the trafficking experience of complex trauma (CT) and seeking to educate nurses on the recognition of CT in the health care setting. The second manuscript was written to educate nurses on CST in the health care setting and provide the second foundation for this study.
Chapter One

Overview of the Research

In the not so distant past, to speak of child sex trafficking (CST) would have been shocking and disbelieved. Public awareness of CST has steadily risen over the past decade, prompting calls for action against perpetrators who sexually victimize and exploit children and adolescents for financial gain. Legislative bodies struggle with terminology, scope, and the complexities involved in the human trafficking and CST experience, and this has hindered funding to advance science in this area (Shalit & Heynen, 2014). Further complicating legislative efforts is the international versus domestic aspect of CST. Although these efforts are invaluable in raising public awareness and advocacy, the recognition, intervention, referral, healthcare, and health outcomes of these survivors are in the infancy of being scientifically examined.

CST victims are subjected to unmitigated human rights violations including but not limited to sexual abuse, physical abuse, torture, and psychological abuse, the denial of basic needs such as food and shelter, and the denial of contact with support networks such as family, friends, and spiritual services. The combination of these repetitive traumas results in cumulative adverse physical health outcomes such as neurological, cardiovascular, respiratory, gastrointestinal, dental, reproductive complaints and traumatic injuries such as bone fractures, strangulation, lacerations, and contusions (Lederer & Wetzel, 2014). Adverse mental health outcomes can include but are not limited to depression flashbacks, shame, post-traumatic stress disorder (PTSD), drug abuse, and suicidal ideation (Lederer & Wetzel).
A systematic review of literature that evaluated the mental and physical health outcomes of human trafficking resulted in only 19 studies that mainly focused on sexually transmitted infections (STIs) and reproductive health (Oram, Stockl, Busza, Howard, & Zimmerman, 2012). The lack of scholarly evidence is commonly attributed in part to a lack of identification and reporting by health care providers and law enforcement. Ahn et. al. (2013) reviewed 27 items including original research and grey literature that provided a basic overview for health care professionals on human trafficking, and noted that none of the reviewed resources were available prior to 2003. This finding further highlights the infancy of scholarly inquiry into development of health care provider education programs to meet the complex health care needs of CST victims and survivors.

**Overall Purpose of Study**

Interaction between medical care providers and victims is an extraordinarily delicate situation in which the best of intentions may result in adverse outcomes for victims and survivors without appropriate training (Lederer & Wetzel, 2014). The need for a scientifically based, comprehensive education program to educate health care providers on the recognition, intervention, and referral of CST victims and survivors is clear (Ahn, et. al., 2013) and reflects the overall purpose of the main study.

**Introduction of the Articles**

Manuscript one, “Child and Adolescent Complex Trauma-ED Nurses Positioned as Advocates in Practice and Policy,” was published in the Journal of Emergency Nursing in 2013. The CST experience is one of complex trauma. The literature supports the need for trauma informed care when caring for CST survivors and victims (Chisolm-Straker &
Richardson, 2012). The purpose of this manuscript was to educate nurses on the complexities of recognition and care of patients suffering complex trauma (CT). Nurses were encouraged to become involved in interdisciplinary efforts and policy efforts to increase funding for trauma informed education programs.

Manuscript two, “Child Sex Trafficking in the Emergency Department: Opportunities and Challenges,” provided a foundation for front-line ED nurses on the scope of CST to increase awareness of CST and provide basic tools to aid recognition, intervention, and referral. The article included recommendations and resources for nurses wanting to learn more on the care of CST victims and survivors. An overview of recent legislation was provided with resources to locate state legislation.

The third manuscript, “Child Sex Trafficking-Recognition, Intervention, and Referral: An Educational Framework to Guide Health Care Provider Practice,” summarized a Delphi study involving an international panel of CST experts in nursing, academics, medicine, law enforcement, social services, international advocacy organizations, international immigration organizations and CST survivors. The study concluded that content areas of health care provider education programs should include CST introduction, barriers, recognition, rapport building and rapport building pitfalls, intervention, referral, and documentation. The findings further revealed sub-content areas: eight in the introduction, 11 in the barriers, eight in the recognition, six in rapport building, eight in rapport building pitfalls, eight in intervention, seven in referral, and seven in documentation. The findings from CST survivors highlighted three essential HCP education content areas: survivor recommendations, what worked for survivors when seeking healthcare, and what did not work. Findings further revealed sub-content
areas: nine in survivor recommendations, five in what worked for survivors, and five for what did not work. Overall, a total of 56 sub-content areas achieved expert and survivor consensus with an I-CVI of 0.80 or greater. The consensus obtained among experts and survivors provides the first scientifically developed framework for organizations seeking to develop health care provider education programs on the recognition, intervention, and referral of CST victims and survivors in the health care setting.
Chapter Two
Child and Adolescent Complex Trauma-ED Nurses Poised as Advocates in Practice and Policy

Abstract

Child and adolescent complex trauma (CT) has been reported to be on the increase with studies reporting victimization rates as high as 80% in child and adolescent populations. The preponderance of literature examines various health outcomes from exposure to CT. The literature located did not examine the relationship between CT and nursing recognition, intervention, and referral of this population. However, most notably, nor were any nursing frameworks located to direct nursing care. This finding supports the need for nurse researchers to devise assessment tools, practice frameworks, and best practice guidelines for the recognition, intervention, and referral of CT patients. Emergency nurses are uniquely positioned to be pioneers in the recognition, intervention, and referral of this vulnerable population as well as advocates for increasing funding for trauma informed services.

Keywords: Emergency Nurse, complex trauma, child maltreatment, social deviance, assessment tools, trauma
Manuscript 1

Child and Adolescent Complex Trauma: Emergency Nurses Positioned as Advocates in Practice and Policy

Introduction

The concept of Complex Trauma (CT) is a multifaceted, diffuse phenomenon that encompasses emotional abuse and neglect, sexual abuse, and physical abuse in addition to being part of, or witnessing domestic violence, ethnic cleansing, terrorism, human trafficking, prostitution, or war (Cook et al., 2005).

Literature supports the correlation between child and adolescent exposure to CT and immediate and long-term risk for development of negative sequela resulting in mental and physical illness and antisocial behaviors (Cook et al., 2005). The consequences of such exposure often manifest as cumulative impairment such as psychiatric and addictive disorders, chronic medical and mental illness, legal, vocational, and family negative outcomes in childhood, through adolescence, and into adulthood (Cook et al., 2005).

In addition to the human rights and ethical issues interwoven with CT, there are critical practical implications for society. Exposure to CT and the subsequent sequela enormously impact dollars spent on medical costs, mental health utilization, Emergency Department (ED) utilization, legal system utilization, criminality, and increasing case load for legal and protective service organizations (National Child Traumatic Stress Network Complex Trauma Task Force [NCTSN], 2003). Direct and indirect costs include hospitalization, chronic health problems, mental health, child welfare, law enforcement, judicial system costs, special education, juvenile delinquency, teenage pregnancy, and adult criminality (NCTSN, 2003).
The ED Nurse as Policy Advocate

As front-line healthcare providers, emergency nurses are uniquely positioned to be the first to recognize and intervene with patients suffering the mental and physical manifestations of CT and therefore begin the critical chain of recognition, intervention and referral. “Taking preventative measures just after the abuse is recognized is needed in order to avoid severe consequences in adulthood” (Schoedl, Costa, Mari, & Mello, 2010, p. 166).

Exact numeric data on the incidence of CT as well as the exact immediate and longitudinal costs to the individual and society have proven difficult to obtain. Lack of reporting, subsequent to lack of education in identifying victims of CT is commonly cited as the most notable obstacle to obtaining emperic evidence. Increased trauma funding for trauma informed education programs and services is key to increasing reporting. The Emergency Nurses Association (ENA) has recognized this need and has adopted a stance in support of increased funding for The Substance Abuse and Mental Health Services Administration (SAMHSA). “ENA supports increased funding for SAMHSA, which works to reduce the impact of substance abuse and mental illness by funding research and state block grants. Unmet health care jeopardizes the health and wellness of individuals while increasing unnecessary costs to society” (Emergency Nurses Association [ENA], 2011, p. 6-7).

SAMHSA has recognized that the country is operating in a time of budgetary challenges and calls for fiscal restraint. SAMHSA has responded to these challenges by adopting eight strategic initiatives in an effort to focus limited resources. Of those eight initiatives, number two seeks to reduce the pervasive, harmful, and costly health impact
of violence and trauma by integrating trauma-informed approaches across disciplines (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). Readers are encouraged to be proactive in their support of ENA and SAMHSA in efforts to advocate for increased funding for these proactive initiatives.

**Recommendations for Emergency Nursing**

The most apparent gap in nursing science is a definitive framework for nurses to recognize, intervene, and refer the high risk population of children and adolescents exposed to CT. Furthermore, there is a lack of empirical data on the health outcomes that are affected by nursing intervention. There are no evidence based nursing frameworks to guide nursing practice with this population.

1. Nurse scientists must investigate health outcomes of exposure to CT and immediate and long-term effects of nursing interventions.

2. A standardized CT screening tool for Emergency Department nurses that is commonly accepted, utilized, and stored for retrieval of data in research and policy initiatives is needed.

3. Advocate for federal and state programs to increase trauma services funding as a proactive vs. reactive measure.

4. Readers are encouraged to join ENA’s support of SAMHSA funding by becoming advocates of trauma funding within their communities and nationally.

5. Develop interdisciplinary research teams between nursing, medicine, and mental health providers would aid in the development of comprehensive recognition, referral and intervention protocols across disciplines.
Conclusion

Child and Adolescent Complex Trauma is devastating for the child and society, both immediately and long term. The consequences have dire, far-reaching, cumulative effects on the victim and society both as humanistic and financial issues. Emergency nurses are uniquely positioned to be a positive force clinically and in public policy.

Work should continue on development of nursing theory and nursing frameworks to address CT. Multiple research tools are available to assess various aspects of maltreatment and CT outcomes, but no standardized framework has yet been devised to assist and direct nursing care in recognition, intervention, and referral of this vulnerable population. Proactive clinical and policy efforts by emergency nurses now will mitigate adverse health and societal outcomes in the future.
Chapter Three

Child Sex Trafficking in the Emergency Department:

Opportunities and Challenges

Abstract

The complex trauma experienced by child sex trafficking (CST) victims poses unique and complex challenges for the emergency department (ED) nurse. Awareness of human trafficking and in particular child sex trafficking is rising, however nursing best practices have yet to be developed and research on CST is still in its infancy. This gap in the literature poses unique opportunities and challenges for the ED nurse. Opportunities to recognize and intervene in a comprehensive, holistic fashion to facilitate optimum health outcomes may be missed related to the lack of scientifically based health care provider education programs on the recognition, intervention, and referral of victims and survivors. As legislation efforts increase, it is imperative for the ED nurse to be aware of the latest legislation, clinical presentation, red flags, and resources available until research progresses and best practices for treating this population are identified.

Keywords: child sex trafficking, education program, emergency nurse, complex trauma, human trafficking
Manuscript 2

Child Sex Trafficking in the Emergency Department: Opportunities and Challenges

Shocking and torrid stories exposing the seedy world of child sex trafficking (CST) have propelled the plight of this victimized population into media headlines. The CST industry can be conceptualized as a broad phenomenon encompassing child sex trafficking, survival sex, prostitution, debt bondage, and child sex tourism among others.

De Chesnay (2013) recognizes sex trafficking as a new pandemic. Globally, the estimates for trafficking children for the purpose of sexual exploitation vary greatly from 600,000 to 2.4 million annually and are likely to be gross understatements (McClain & Garrity, 2011).

Significant adverse mental and physical health outcomes have been associated with the complex trauma experienced by the victim (Miller, 2013). “In general, health outcomes of sex trafficking result from physical violence, mental illness including psychological and substance abuse, violent and unsafe sex practices, inhumane working and living conditions and lack of access to healthcare services” (Gajic-Velijanoski & Stewart, 2007, p. 345). Physical attacks and torture result in injuries such as broken bones, cuts, mouth and teeth injuries, facial trauma, cigarette burns and other burns (Gajic-Velijanoski & Stewart, 2007). Victims may be forced to service men for 12 or more hours a day resulting in malnutrition, dehydration, and sexually transmitted diseases (STD). The forced isolation, marginalization, and abuse in all forms results in further jeopardizing the victims’ mental health (Gajic-Velijanoski & Stewart, 2007).
Making Progress-Legislation

Public awareness has steadily risen over the past decade prompting calls for action against perpetrators sexually victimizing children and adolescents for financial gain. Although these efforts are invaluable in raising public awareness and therefore advocacy; the recognition, intervention, referral, healthcare, and health outcomes for these survivors are only recently being scientifically examined. It was not until 2008 that the American Nurses Association (ANA) approved a measure to address human trafficking (McClain & Garrity, 2011). This resolution was an important step in bringing CST into nursing’s focus.

Advocacy groups such as Shared Hope International (SHI) and others have made great strides in promoting awareness and justice for these survivors as well as lobbying legislators to increase legislation for the protection of victims and the prosecution of trafficking criminals. SHI’s Protected Innocence Campaign is the result of two years of research grading each state on their legislation protecting survivors and prosecuting traffickers. Your state’s report card can be seen on SHI’s interactive map at http://sharedhope.org/what-we-do/bring-justice/reportcards/.

It is imperative that the ED nurse and other healthcare providers take a proactive legislative stance rather than reactive approach to the prevention of CST, cutting demand, prosecution of traffickers, and identification and support of victims.

Child Sex Trafficking in the Emergency Department

The groundbreaking first book of its kind, *Sex Trafficking A Clinical Guide for Nurses* provides the foundation for guiding nurses caring for CST victims. De Chesnay (2013) notes that there are no best practices for treating sex trafficking victims. An
important foundational step in the eradication of CST and appropriate intervention, recognition, and referral of this victimized population is first contingent upon healthcare providers being empowered with scientifically based education programs, practice frameworks, and best practices.

“Healthcare providers are one of the few groups of professionals likely to interact with victims of human trafficking while they are still in the control of the criminals who are manipulating and profiting from them” (Isaac et al., 2011, p. 1). Literature is replete with individual cases of CST. The majority of these cases present to the Emergency Department at some point of captivity and enslavement.

**Think Recognition, Intervention, Referral-Recommendations for the ED Nurse**

De Chesnay (2013) recommends the following as red flags:

- Patient accompanied by a person who dominates
- Patient may lie about age
- Disoriented to time or place
- Inconsistencies in accounts of injury or illness
- Branding-unusual or men’s names tattoos
- Fearful or highly anxious/submissive
- Not in control of own documents
- Sexually transmitted diseases and/or frequent bacterial/yeast infections

Safety is of paramount concern both for the patient as well as the staff. The CST patient is likely under the control of the pimp (De Chesnay, 2013). When you interfere with the pimp and their control of their commodity, the victim, you are interfering with their money and exposing them to apprehension and prosecution. If CST is suspected,
inform your security department and local law enforcement. Keep their presence very low profile. It is of paramount importance to talk with the suspected victim alone. Remember that women, “Aunts” and “Sisters” can also be traffickers. Trust your gut instincts.

Refer to your organization’s policies relating to child abuse and CST. If your organization does not have a policy on CST to guide interventions, approach your administration and advocate for the development of a CST policy addressing recognition, intervention, and referral. When in doubt, contact the national hotline at 888-3737-888 for guidance (De Chesnay, 2013).

Conclusion

ED nurses can be a survivor’s only hope of escape and help. Comprehensive scientifically based CST education programs are crucial to empower ED nurses with the tools needed in the recognition, intervention, and referral of this most victimized population. Many Non-Governmental Organizations (NGOs) such as SHI, The Polaris Project and others offer programs for those wishing to be involved in advocacy efforts. The numbers tell a tale, however each number represents a child whose flesh has been peddled for the economic gain of a trafficker. The ED nurse is positioned be the conduit to health and safety for these victimized children.
Abstract

**Purpose:** The purpose of this Delphi study was to obtain consensus among a panel of child sex trafficking experts and survivors on the most important elements needed in a comprehensive, multidisciplinary health care provider education program on the recognition, intervention, and referral of child sex trafficking survivors.

**Methods:** A two-round Delphi method was utilized to identify the most important elements of a child sex trafficking health care provider education program. A content validity index score was utilized to determine consensus and order importance of each element.

**Results:** Eight content areas including 63 sub-content areas were identified by an international panel of 21 subject matter experts representing clinical professions, law enforcement, and community support organizations. Three content areas and 19 sub-content areas were identified by survivors.

**Conclusion:** The findings of this Delphi study provide the first scientifically based framework to guide the development of comprehensive, multidisciplinary education programs for health care providers on the recognition, intervention, and referral of child sex trafficking victims and survivors.
The exploitation of a child in any fashion immediately raises calls to action. Child sex trafficking (CST) victimizes children physically and psychologically, generally for the financial gain of their captors. These grievous human rights violations call for action to prevent CST, care for survivors, and prosecute perpetrators. Despite increasing awareness of CST, scant research has been done to evaluate the mental and physical health outcomes of survivors that result from the repeated complex trauma. Available evidence indicates the physical, mental and emotional adversities involve sustained and complex trauma that can continue for decades (Lederer & Wetzel, 2014).

In the last decade, governments, researchers, and health care systems have made initial efforts to address the complexities of recognition, intervention, and referral of this marginalized, victimized population. It was not until 2008 that the American Nurses Association (ANA) adopted a position of human trafficking (HT) (McClain & Garrity, 2011), and in May 2014 that the American Medical Women’s Association adopted a position on sex trafficking (Harrison et al., 2014). Given the recent position statement adoptions within health care organizations, it is no wonder that there is little scholarly evidence to guide health care provider practice.

De Chesnay (2013) recognized sex trafficking as a new pandemic. Reid (2012) categorized sex trafficking as a global, economic and public health risk. By 2016 human trafficking will surpass drug and arms trafficking in incidence and profit (Schauer & Wheaton, 2006). The Polaris Project (2012) estimates 200,000 children are trafficked for the purpose of sexual exploitation in the United States (US) annually. Sex trafficking of children and adolescents takes many forms such as prostitution, live sex shows, stripping,
and pornography (Hepburn & Simon, 2010). The proposed global estimate of trafficking for the purposes of sexual exploitation is 4.5 million individuals annually (International Labour Organization [ILO], 2012), up from an estimated 2.4 million in 2005 (McClain & Garrity, 2011). However, it is unclear if this discrepancy is related to methodology, increasing incidence, increasing awareness and reporting, or a combination. Sex trafficking is estimated to generate $51.3 billion yearly (Kara, 2009).

CST fits under the umbrella of human trafficking (HT) which is the recruitment, transportation, transfer, harboring or receipt of persons for the purpose of exploitation (IOM, 2009). This includes, but is not limited to, the exploitation or prostitution of others, or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs. The CST industry can be conceptualized as a broad phenomenon encompassing survival sex, forced prostitution, debt bondage, and child sex tourism. Inherent to these sub-content areas are challenges that affect victims in multiple ways. For instance, in economically challenged geographic regions authorities may be complicit or simply ignore the child sex tourism industry. Trafficked children may be forced into prostitution to work off the “debt” imposed on them by traffickers by being told they will be granted freedom when the debt is paid. Survival instincts and the basic need for food and shelter result in a concept known as “survival sex” that further makes high-risk children vulnerable to traffickers. US societal norms do not allow parents to barter children to traffickers for livestock, monetary gain, and protection from warring factions, or to have “one less mouth to feed.” But in some poverty stricken colonias along the US and Mexico borders as well as economically
stricken areas globally, the practice of bartering children occurs (Ugarte, Zarate, & Farley, 2003).

The demand for children and adolescents as sex commodities has gained the attention of organized crime who exploit victims to meet growing demands (Kotrla, 2010). CST provides a lucrative income for criminals and organized crime with low start-up costs, minimal risk, high profits, and large demand (Shelley, 2010). An advantage for organized crime to engage in CST over the trafficking of drugs or arms, is that drugs and arms can be sold once, while a child can be sold indefinitely (Shelley, 2010).

In addition to sexual victimization, CST victims are subject to complex trauma (CT) with adverse mental and physical health outcomes resulting in great costs to the individual and society. Negative sequela impact communities and society as a whole, both fiscally and socially. Complex trauma is a multifaceted, diffuse phenomenon that encompasses emotional abuse and neglect, sexual abuse, and physical abuse in addition to being part of, or witnessing, domestic violence, ethnic cleansing, terrorism, human trafficking, or war (Cook et al., 2005). The consequences of such exposure often result in cumulative impairments, such as psychiatric and addictive disorders, chronic medical and mental illness, and legal, vocational, and family negative outcomes in childhood, through adolescence, and into adulthood.

These adverse outcomes have enormous impacts on individuals, families and society, including medical costs, mental health utilization, ED utilization, legal system utilization, criminality, and increased case-loads for legal and protective service organizations.
The child and adolescent sex trade is a direct result of political, economic, familial, and cultural variables woven into a fabric of coercion, abuse, and exploitation. The complexities inherent in these various situations are not easily amenable to simple and universal solutions (Long, 2004), nor are they appropriate for a cookie-cutter approach to health care for the survivors. The complex trauma experienced by survivors within a cultural, medical, socioeconomic, and safety context make delivering quality health care challenging and problematic. Diverse challenges demand a multidisciplinary, comprehensive, and holistic healthcare response. Collaborative efforts are necessary to address the diverse medical and psychological needs of this vulnerable population (De Chesnay, 2013).

An important foundational step in the eradication of CST is the facilitation of appropriate recognition, intervention, and reporting of these children and adolescents (Ahn et al., 2013). Empowered healthcare providers are uniquely positioned to begin the critical chain of survival and reintegration through improved recognition, intervention, and referral. “Healthcare providers are one of the few groups of professionals likely to interact with victims of human trafficking while they are still in the control of the criminals who are manipulating and profiting from them” (Isaac et al., 2011, p. 1). It is estimated that approximately 50% of survivors seek health care at least once during captivity (Macias et. al., 2013). A recent study reported that of a sample of 98 survivors, 87.8% had contact with a health care provider during captivity (Lederer & Wetzel). De Chesnay (2013) notes that there are no best practices for treating sex trafficking victims and that clinical research is almost nonexistent. No known statistical tools have been developed that specifically target health outcomes of this marginalized population.
Review of Literature

Data in peer reviewed journals regarding the recognition, intervention, and referral of survivors is scant. No scientific studies on the actual fiscal costs of CST to society could be located. Little research was located on health interventions and health outcomes of survivors. The literature is limited by CST-related challenges that include CST being a shadow crime, victim fears of reporting, and difficulty in identifying victims (Chisolm-Straker, Richardson, & Cossio, 2012). Inconsistent reporting by healthcare providers is a significant contributing factor to the lack of quantitative data (Peters, 2013). Other factors, such as inconsistencies in defining child sex trafficking, limited access to traffickers, limited access to victims, reluctance to share data, inability to obtain US government data, and the need for technical and financial assistance to standardize data collection have plagued scholars who have attempted to move the study of CST forward (Clawson et al., 2006).

Seven common themes in the literature were identified: 1) increasing occurrence in the US, 2) difficulty in quantifying the incidence of CST, 3) culture of tolerance, 4) re-victimization and criminalization of victims, 5) vulnerability, 6) exploitation, and 7) the need for training for healthcare providers in recognition, intervention, and reporting. The most profound findings were a lack of practice and educational frameworks and a scarcity of research evaluating the health outcomes of survivors.

Increasing Incidence Worldwide and in US

Globally, the estimates for trafficking of children for the purposes of sexual exploitation vary greatly from 600,000 to 2.5 million individuals annually and are likely to be gross under-estimates (McClain & Garrity, 2011). The prostitution of minors may
be the most ignored and undetected crime against children in the US (Reid & Jones, 2011). The exact number of victims in the US remains elusive, but estimates are in the hundreds of thousands. Toledo, Ohio and Texas have been noted as major child trafficking corridors. Contributing geographic factors include 1) geographic location, 2) major interstate highway networks, and 3) cities with numerous truck stops, conventions, tourist areas, and military bases (Kotrła, 2010; McClain & Garrity, 2011; Williamson & Prior, 2009). CST has been documented in 50 states, Washington D.C., and the US territories (Hepburn & Simon, 2010; Walters & Davis, 2011). The average age range involves children from 10 to 14, however cases of children as young as four have been documented (Rand, 2009). The US has the stigma of being one of the top 10 destination countries for human trafficking (Hepburn & Simon, 2010).

**Difficulty in Quantifying the Phenomenon**

The majority of publications examined recognized the limitations imposed by the lack of statistical data. Reasons for this lack of data can be attributed to four primary facts: 1) CST is among the most covert and hidden crimes, 2) lack of identification of victims, 3) inconsistent reporting practices among healthcare providers and law enforcement, and 4) inconsistent statistical data which are likely to be gross understatements (Clawson et al., 2006; Hepburn & Simon, 2010; Isaac et al., 2011; Kotrła, 2010; McClain & Garrity, 2011; Rand, 2009; Reid & Jones, 2011; Reid, 2012; Sager, 2012; Walters & Davis, 2011; Williamson & Prior, 2009). Rand (2009) summarized these challenges and noted that existing published literature is primarily anecdotal. Furthermore, the search for empirical data is thwarted by the scarcity of peer reviewed research on the subject of CST (Rand, 2009). Rand stated that “Few of these
articles are able to fully capture the complexity of this problem and the information they
do provide is not being widely translated into practice with this population” (Rand, 2009, p. 139).

**Culture of Tolerance**

Nelson Mandela said that there can be no keener revelation of a society’s soul than the way in which it treats its children (Lloyd, 2011). Children have historically been marginalized in societies globally (Walters & Davis, 2011). The majority of available literature recognizes that displaced and vulnerable children and adolescents, sometimes termed “throwaways”, are at the highest risk for exploitation and abuse in the child sex industry (Walters & Davis). The child sex industry is proliferating in geographical areas where local economies are heavily dependent on CST and child sex tourism (Rand, 2009). A lack of public awareness and education, economic adversity, and some cultural norms contribute to a culture of tolerance in which societies collectively “turn a blind eye” and perpetuate an environment of denial. The simple economic law of supply and demand further contributes to this culture of tolerance.

Pop culture has also created an environment that appears to glorify this criminal behavior. The term “pimp” has been used in pop and hip-hop music such as *pimping all over the world* to glorify the behaviors of pimps. Popular television has glorified the term pimp such as “Pimp My Ride” and “Pimp My Truck.” A free online game *Keep Pimpin* involves players as pimps who, “…get to ‘slap your hoes, pimp the streets, kill the competition, and ally with friends to take the pimp world by storm.” (Kotrla, 2010, p. 183). Pimps and the concept of *pimping* have become so mainstream that there is an annual Player’s Ball in which pimps are honored and awarded for generating the most
money (De Chesnay, 2013). Many famous hip-hop and rap stars have been entertainers at these events. Common pop culture has also played a significant role in the normalization of the sexual exploitation of adolescents and children (Reid & Jones, 2011). Though the Trafficking Victims Protection Act of 2000 (TPVA) has made great strides in changing the vernacular to recognize pimps as criminal traffickers, there is much more work to be done.

**Re-victimization and Criminalization of Survivors**

Ironically the TPVA does not provide the same type of comprehensive protections and assistance to domestic minor sex trafficking (DMST) or commercially sexually exploited children (CSEC) victims as it does to internationally trafficked victims (Isaac et al., 2011). Legal experts, health care and human rights advocates and scholars agree that the common practice of treating victims as criminals undermines justice for the victims. Mistrust and fear is further exacerbated when law enforcement officials treat survivors as criminals, such as when enforcement agencies use the term, child prostitution, which implies consent of the minor (Hepburn & Simon, 2010; McClain & Garrity, 2011).

Improved laws are needed to recognize survivors as victims (Walters & Davis, 2011). The TVPA of 2000 and subsequent reauthorizations defined all minors under the age of 18 involved in commercial sex acts as victims. However, state and local systems continue to classify prostituted minors who are US citizens or lawful permanent residents as offenders (Reid & Jones, 2011). Shared Hope International (SHI) suggested changing the term “child prostitution” to “domestic minor sex trafficking” (DMST) to recognize survivors as victims (Isaac et al., 2011). The SHI Protected Innocence Campaign sought to assign a score to each state on their legislative efforts to combat CST and DMST in
hopes of setting a higher bar for state legislation to protect and assist victims, and assure that survivors are not re-victimized. Anti-child sex trafficking and anti-human trafficking Non-Governmental Organizations (NGOs) such as SHI and The Polaris Group work toward ending the cycle of re-victimization experienced by CST survivors,

**Vulnerability**

The common thread in CST victimization is recognized as vulnerability. Vulnerability fosters exploitation of potential victims by perpetrators (Reid, 2012).

Common variables that predispose a child to being a CST victim include, but are not limited to: history of sexual abuse, low self-esteem, poor school performance, poor family relationships (Clawson et al., 2006), low socioeconomic status, negative or limited peer relations (Williamson & Prior, 2009), neglect, mental illness, drug abuse, isolation, history of criminal behavior, homelessness (Reid, 2012), families that collaborate with traffickers (Hodge, 2008), complex trauma experiences, being a runaway (Jordan, Patel, & Rapp, 2013), gay, or transgendered, and/or the desire for US visas (Brennan, 2002).

**Exploitation**

An existing underground network of CST with rules and roles includes, but is not limited to: connectors, recruiters, groomers, traffickers, bottoms or bottom bitches (the favorite that keeps the other victims in-line with the traffickers wishes, reports to the trafficker and has worked herself up the hierarchy), watchers, and wife-in-laws (girls under control of the same pimp) (Shared Hope International, n.d.; Williamson & Prior, 2009). Rules are determined by the trafficker; for example, who victims can talk to, the money quota for the night, and when they can eat and sleep. Traffickers use a variety of methods to lure a child or adolescent into “the life.” Kidnapping, use of rape, sodomy,
threats toward the victim's family, and force is known as gorilla pimping (Williamson & Prior, 2009). However, it is commonly recognized in anti-trafficking communities that finesse pimping is much more common (Williamson & Prior, 2009). Finesse pimping is recruitment and retention through manipulation. The promises of glamor, modeling, being in music videos, material goods, food, clothing, shelter, love and companionship, and survival sex are the tools by which the trafficker gains control of the victim and maintains control (Hepburn & Simon, 2010; Isaac et al., 2011; Kotrla, 2010; McClain & Garrity, 2011; Rand, 2009; Reid, 2012; Reid & Jones, 2011; Walters & Davis, 2011; Williamson & Prior, 2009).

The Need for a HCP Education Program

A critical, yet overlooked component of a comprehensive response to CST is the education of healthcare providers in identifying, assessing and providing care, and appropriate reporting of suspected CST cases (Ahn et al., 2013). Ahn et al. (2013) conducted a review of educational resources for health care professionals and noted that there is a clear need for the development, implementation and evaluation of high-quality healthcare provider (HCP) education programs focused on human trafficking. Training for healthcare providers is essential in the recognition of these victims to facilitate their mental and physical well-being (IOM, 2009; Isaac et al., 2011; McClain & Garrity, 2011), and to mitigate subsequent adverse societal outcomes. Quality healthcare and improved reintegration is first contingent upon healthcare providers being empowered with scientifically-based education in the application of best practices for appropriate CST assessment and management (Ahn et al., 2013). These processes will also likely contribute to current gaps in accurate statistical reporting of CST cases. De Chesnay
(2013) notes that there are no best practices for treating sex trafficking victims and that clinical research is almost nonexistent. No known statistical tools have been developed that specifically target health outcomes of this violated and marginalized population. Furthermore, no scientifically based educational or practice frameworks have been developed to guide nursing practice with this population.

Nursing has made great strides in incorporating the concept of culturally competent care into the frameworks that guide nursing practice. The culture of “the life” has its own set of values and norms. Understanding the culture of the street and of “the life” are central to developing intervention frameworks to guide nursing practice. “The language of the street provides a way for people who live ‘on the street’ to exclude members of the ‘establishment’ and to make themselves feel more powerful in relation to powerful people around them” (De Chesnay, 2013, p. 11). An important method by which to incorporate training on the culture of the life is by including survivors in research and education programs to advance the narrative beyond the theoretical and anecdotal to practical application. Development, implementation, and evaluation of evidence-based HCP education programs is critical to improving outcomes in this population (Ahn et al., 2014).

Conceptual Model

Effective healthcare delivery for CST survivors involves recognition, intervention, and referral of CST survivors to achieve improved mental and physical health outcomes. This conceptual model (Figure 1) is meant to provide a visual guide of the study concepts (educational program, recognition, intervention and referral of CST victims) that are
depicted in red, and the potential long-term outcomes (depicted in blue) that may be affected by the application of a scientifically based HCP education program.

**CST Educational Intervention Model**

![CST Educational Intervention Model Diagram](image)

**Study Conceptual Definitions**

*Human trafficking* is defined as the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat. Force, or other forms of coercion, abduction, fraud, deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments for the purpose of exploitation. Exploitation shall include, at a
minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs (United Nations, 2010).

*Child sex trafficking* is defined as a commercial sex act induced by force, fraud, or coercion, in which the person is under the age of 18 years (United States Department of State, 2010).

*Health Care Provider Education Program* is defined as a comprehensive, multidisciplinary CST education program targeting nurses, advanced practice nurses (APNs), physician assistants (PAs), physicians, social services, emergency medical technicians (EMTs), and paramedics.

*Recognition* is defined as the identification of CST victims in the health care setting via observation of actions, body language, behaviors, statements, and physical presentation by both potential victims and potential perpetrators.

*Intervention* is defined as safe, holistic medical and nursing management of immediate mental and physical health care needs.

*Reporting* is defined as contributing to numerical databases tracking occurrences of CST, thereby aiding in generation of further inquiry and statistical data. Reporting also includes law enforcement notification to support law enforcement efforts, safety of provider and victim or survivor, and data tracking.

*Referral* is defined as the provision of immediate needs of safety, healthcare, shelter, and food; facilitating the provision of referrals for long-term needs such as assistance with health care follow-up appointments, immigration issues and employment assistance and training. It is not implied that HCP will be knowledgeable about all facets of referral
for long-term needs, but HCPs should be knowledgeable about immediate resources to facilitate contact with providers of reintegration services.

*Victim* is defined as under the control of a trafficker.

*Survivor* is defined as a trafficking victim that has escaped the control of their trafficker.

Globally, governments, health care organizations, community support organizations, non-governmental organizations (NGOs), health care scholars, and advocates are expending enormous amounts of human resources, time, and funding attempting to design health care provider education programs to address the gap in HCP education programs. However, to date no scientifically based framework has been developed to guide the inclusion criteria in these programs. Science drives best practice development; HCPs must be provided the tools and education with which to contribute to science and the optimal outcomes for survivors and society at large.

This study was conducted to answer the question, “What are the crucial elements needed in a comprehensive multidisciplinary healthcare provider education program to increase reliable recognition, intervention, and referral of victims of CST?” The purpose of this Delphi study was to draw on the collective intelligence of multidisciplinary CST experts and survivors to identify crucial elements of an education program to guide provider practice. Currently, no such framework exists.
Methods

Design

This study utilized a two-round Delphi method to identify the elements that comprise a comprehensive HCP education program for the care of CST victims and survivors. The complex issue of CST necessitated the participation of multidisciplinary experts who were well versed in the societal, legal, cultural, and physical and mental health aspects of CST. Including the experiential input of CST survivors added unique perspectives for addressing the complexities of immediate and long-term care for victims and survivors. Institutional review board (IRB) approval was obtained through the University of Texas at Tyler.

The objective of the Delphi method was to obtain consensus among a panel of subject matter experts. The Delphi method has been judged to best support rigorous query of the experts and CST survivors in this study based on the following:

1. A panel study most appropriately answers the research question better than an individual expert’s response (Okoli & Pawlowski, 2004). Furthermore, the Delphi is a practical method by which to assimilate data from geographically diverse expert participants.

2. The Delphi group size does not depend on statistical power, but on group consensus (Okoli & Pawlowski, 2004).

3. The Delphi serves the dual purpose of soliciting opinions from experts and having them rank findings according to their importance (Schmidt, 1997).
4. The Delphi method enhances construct validity by asking experts to validate the researcher’s interpretation and categorization of responses (Okoli & Pawlowski, 2004).

5. Non-response and attrition is typically very low in Delphi study based on the PI having personally obtained consent to participate (Okoli & Pawlowski, 2004).

**Sample Selection for Panels**

This study utilized purposive sampling and a modified four-phase expert selection process as recommended by Okoli and Pawlowski (2004): (a) prepare a knowledge resource nomination worksheet, (b) populate the worksheet with names, (c) nominate additional experts through snowballing, and (d) invite experts. There is no consensus on the sample size of Delphi studies and a wide range of participants have been reported (Keeney et al., 2011). Although a relatively small number of experts may be available as participants, Okoli & Pawlowski (2004) note that panels of 10-18 members are appropriate. Dalkey (1969) noted a direct relationship between increasing numbers of Delphi participants and decreased average group error. Dalkey also noted that there is a clear and definite, monotonic increase in the reliability of the group responses with increasing group size. The potential participant pool was established utilizing snowball and network sampling. To support rigor, allow for attrition, and include many disciplines concerned with CST, this study sought a minimum of 18 participants including subject matter experts and survivors. The final sample was comprised of 33 participants which included 23 subject matter experts and 10 CST survivors.

The term “expert” in this study included multidisciplinary subject matter experts with a record of advocacy and work related to CST as well as CST self-reported survivors.
Survivors were identified through networking with CST survivor networks and advocacy organizations. Inclusion criteria include:

**CST Survivor.**

1. Has acknowledged he or she has been a sex trafficking victim.
2. Willingness to participate.
3. English speaking.

**Expert.**

1. Willingness to participate.
2. English speaking.
3. > 5 years of experience in their respective fields.
4. > 3 years of experience as a CST advocate.
5. Recognized as an expert on CST (either referenced as such or CST publications).
6. Computer and e-mail access.

An invitation email was sent to each selected expert (Appendix A) and survivor (Appendix B) participant that included (a) a brief purpose and outline of the study, (b) why the study is important to guide development of a framework, (c) an explanation of the Delphi process with the anticipated number of rounds, time commitment, and response format, (d) PI contact information for questions or concerns, (e) an explanation of the reason for gathering demographic information from participants, (f) a request for them to nominate additional CST experts known to them. A separate attachment containing an expert informed consent (Appendix C) and a survivor informed consent
(Appendix D) to digitally or manually sign and return to the PI was e-mailed once agreement to participate was obtained. Thirty-two content experts were approached and a final content expert sample of 23 was recruited. A total of 12 survivors were approached, a final survivor sample of nine was recruited. It is worth noting for future research four of the content experts approached were from the Federal Bureau of Investigation (FBI), Immigration Customs Enforcement (ICE), and the Department of Homeland Security (DHS). Each agent approached cited lengthy approval processes precluding the ability to participate in any research other than governmental research as the reason for not being able to participate. This policy and process is worth revisiting in the interest of future research efforts in any field when federal employee participation would be of value to advancing science. The setting was web-based utilizing Qualtrics software.

**Description of Expert Participants**

The expert panel comprised experts who represented clinical, law enforcement, and community support organizations. International clinical experts \( (n=10) \) were from the fields of academia, medicine, nursing, advanced practice nursing, paramedics, psychologists and social work. Law enforcement experts \( (n=7) \) were represented by county and state law enforcement representing all geographic regions of the US. International organizations and community support and advocacy organizations \( (n=6) \) completed the panel with a final expert sample of 23. The average number of years within their respective professions was 13.78, having cared for or encountered a total of over 3000 victims and survivors (Appendix E, Table 1). The experts reported the ages of victims and survivors encountered as 2 to 63 years old.
Description of Survivor Participants

Survivor participants (n=10) were all female and ranged in age from 16-50 with an average age of 37.5. The age of entry into being trafficked ranged from 2-21, with an average age of entry as 15. All participants had some degree of higher education: two were college students, two with some college experience, two had associate degrees, three had bachelor’s degrees, and one had a master’s degree. The average age of escape from their trafficker was 21.1. The average length in captivity was 6.8 years (Appendix E, Table 2).

Data Collection

Following attainment of signed, informed consent, a total of two survey phases were deployed. Phase 1 survey questions were based on the literature and the researcher’s professional experience with CST. The questions were approved by clinical and academic professionals. A link to the surveys was electronically mailed via Qualtrics web-based survey software (Qualtrics, 2014).

Phase one.

Phase one consisted of one survey for content experts and one survey for survivors. The content expert survey consisted of five demographic questions, seven professional and CST experience related questions, and 13 open ended exploratory questions (Appendix E, Table 3). One comment box was provided for any further information participants wanted to contribute or for any clarification. The survivor survey consisted of three demographic questions, four questions related to entry and exit from being trafficked, and 11 open-ended exploratory questions related to their experiences when they sought health care (Appendix E, Table 4).
Both expert and survivor surveys were e-mailed via Qualtrics. Participants were asked to respond within two weeks. Of the 32 surveys sent to experts, 26 responded resulting in a response rate of 81%. Of the 12 surveys sent to survivors, 10 responded resulting in a response rate of 83%.

In phase two, 26 expert surveys were sent with 23 responding. In the phase two survivor survey, 10 were sent with 10 responding resulting in a final sample of 23 experts and 10 survivors.

**Phase two.**

Once thematic analysis was applied to Phase one data, sub-content areas were identified. Both expert and survivor participants were then asked to rate identified sub-content areas on their level of importance in inclusion in a HCP education program on a 5 point Likert scale that ranged from 1 as not important to 5 as being critical. A narrative area was included to ask questions or clarify any misunderstandings. The two goals of phase two were to 1) obtain consensus on importance of inclusion of the item into the educational program, and 2) ranking of items in order of importance. The content validity index (CVI) enhances construct validity by confirming content validity (Polit, Beck, & Owen, 2007). The purpose of the individual content validity index (I-CVI) is to determine content experts’ level of consensus as to the relevance of an item to the underlying construct (Polit & Beck, 2006).

**Data Analysis**

**Phase one.**

This study followed recommendations by Braun & Clark in the following manner (a) responses were read, transcribed, re-read, coded as “raw data” and grouped by
survivor, law enforcement, clinical, and community support organizations for each phase one survey question or free-text box, (b) initial potential content areas were coded “key statements” across the entire data set, (c) “key statements” were further coded into “abstraction” with “abstraction” representing the sub-content area to be incorporated into phase two, (d) identified themes were reviewed for relevance and prevalence, and crosschecked with the initial raw data, and (e) themes were officially named for inclusion in the phase two surveys as sub-content areas, and (f) discussion of findings.

As suggested by Okoli & Pawlowski (2004) and Braun & Clarke (2006), thematic analysis was applied to participant responses to identify themes that would provide direction for establishing the sub-content areas of a comprehensive, multidisciplinary HCP educational program. The identified themes served as sub-content areas within the primary content areas (Appendix E, Tables 5-12). For instance, “introduction” is the first recommended content area of a comprehensive, multidisciplinary HCP education program. Thematic analysis revealed eight sub-content areas within the introduction section: Definitions, the HCP role, challenges, the need to humanize the material, stereotypes, risk factors for becoming a victim of sex trafficking, and myths.

**Phase two.**

The I-CVI was calculated for each sub-content area within each education program content area that were reported by experts (Appendix E, Tables 5-12) and survivors (Appendix A, Tables 13-15). The rationale for separation of expert and survivor recommendations is that survivor priorities and understanding of health care provider education differ in scope and context. However, inclusion of survivor
recommendations and experiences is essential to understanding and providing comprehensive, holistic, culturally competent (culture of the street) care.

Results

**Phase one-Experts**

The phase one survey open-ended questions targeted primary content areas needed in a multidisciplinary HCP education program. The targeted primary content areas included introduction, barriers, recognition, rapport building, rapport building pitfalls, intervention, referral, and documentation

Within an education program introduction, eight sub-content areas were identified: Definitions, the HCP role, challenges, the need to humanize the material, stereotypes, risk factors for becoming a victim of sex trafficking, and myths. (Appendix E, Table 5). The “who, what, when, where, why, and how” method was suggested by experts including, but not limited to: (a) who are the traffickers and victims; (b) what are the definitions and conceptual definitions; (c) when does CST occur including cultural, economic, familial, risk factors, vulnerability, criminal and organized crime elements; (d) where sex trafficking occurs includes local, national, and international considerations along with venues such as strip clubs, massage parlors, hotels, and major sporting events; (d) why does CST occur; and (e) how victims are recruited, retained, and controlled.

In the HCP education program barriers section, 11 sub-content areas were identified: lack of HCP education, difficult identification, lack of provider awareness, systems-issues, victim and survivor behaviors, perpetrator behaviors, provider perceptions, provider behaviors, black market health care such as illegal abortions, time, and ancillary staff behaviors. Experts reported a plethora of barriers including legal, psychosocial,
cultural, behavioral, and systematic barriers. For example; a lack of best practices, time, a victim or survivors’ hesitancy or fear in self-disclosure, trauma-bonding with trafficker, fear for friends and family safety, maladaptive coping skills, fear, and shame were some reported barriers (Appendix E, Table 6).

Within the recognition section, eight sub-content areas were identified: describing “red flags”, victim and survivor behaviors in the health care setting, clinical presentation, patient’s care need priorities, provider role priorities, pattern recognition, and challenges in recognition (Appendix E, Table 7). Rapport building included patience, empowerment, systems support, collaboration, staff behaviors, and providing comfort (Appendix E, Table 8). Eight pitfalls to building rapport included: authoritarian attitude, victim and survivor perceptions, lack of provider awareness, waiting for victim or survivor to self-identify, system issues such as the push for rapid emergency department (ED) discharge, time, lack of privacy, and dishonesty such as over-promising (Appendix E, Table 9).

Eight sub-content areas were identified in intervention content: consent, empowerment, safety, victim and survivor special considerations, the provider role, streamlined care, awareness of resource strengths and limitations, and the importance of law enforcement continued involvement with safety and reporting (Appendix E, Table 10). Appropriate referral comprised of consent, post-discharge safety, compliance issues, local, national, and international resources, continued empowerment, privacy, and the information to include in referrals (Appendix E, Table 11).

Documentation was reported as crucial to many aspects of CST, including appropriate care of the CST victim and subsequent apprehension of the traffickers. Seven
sub-content areas were identified: comprehensive, history and physical, findings, interventions, forensics, patient quoted statements and pre-hospital information such as from emergency medical services (EMS) and/or law enforcement (Appendix E, Table 12).

**Phase one-Survivors**

The open-ended questions targeted elements that survivors wanted in HCP education programs. The identified education program content areas were survivor recommendations, what worked for survivors, and what did not work. Participants were also provided a narrative section to share their experiences when seeking healthcare. It is not an objective of this study to place survivor recommendations in a specific primary content area such as introduction, barriers, or interventions, but to allow the education program developer the flexibility to utilize survivor feedback and recommendations in sections deemed individually appropriate to enrich and humanize material.

**Survivor Recommendations**

Survivors had recommendations for nine sub-content areas including knowledge of resources, the damage caused by stereotypes and labels, fear, the need for provider education, privacy, re-victimization, safety, and hope (Appendix E, Table 13). Respondents acknowledged that they felt the majority of HCPs had good intentions, but lacked resources such as time, the right people, and survivor specific referral resources to secure immediate shelter, food, clothing and safety. Many deferred health care until the problem or injury became emergent because they were made to feel like a “freak show” or be judged. Stereotypes and labels hurt. “I was labeled as ‘just another drug addict’ yet they failed to ask WHY I was on drugs. If they had, I’d have told them my trafficker fed
them to me”. Another common theme was fear on multiple levels; fear of being judged, fear of the rape kit and exam,

I was seven years old…of all the questions and meetings with the police and social workers the most invasive part was the physical examination and administration of a rape kit. My body was stretched to the point I thought I would split in two.

Additional fears included fear for their safety, fear of being ridiculed and the “crazy looks”, and surprisingly fear for the provider, “I knew my trafficker had a gun in his pocket and would hurt whoever tried to help me…NEVER ask if someone is in danger in front of a potential perpetrator.” Survivors recognized that they needed health care providers trained to care for their unique situations.

The lack of understanding and awareness by providers led to serious adverse health outcomes, “An ER doc let me go because I didn’t have ID. He didn’t treat me…I almost died”. The lack of identification and documents are well-documented “red flags”. Understandably, privacy was a large concern. The majority of respondents reported one or more privacy violations such as bringing other people in the room, their visit becoming a training event, and not having a safe, private place to talk with the provider. The concept of re-victimization was a common thread. “Seeing as I was very young, one of the nurses felt the need to make a comment about how only sluts have sex at my age” and “One nurse made it completely clear that the scars on my breasts (from being burned with a cigarette while being trafficked) were the most disgusting things she had ever seen. The same with my self-harm scars.” Despite many instances of
inappropriate or lack of intervention, the concept of hope was prevalent as well. Survivors reported returning for health care to facilities that had trained providers, they “saved my life” and reported positive experiences with trauma trained HCPs. In one instance, the physician’s concern is palpable in the survivor’s statement, “I was 10 years old with an STD. I hadn’t even had my period yet…He asked me if he needed to do something or tell someone. I told him it was over and that it wouldn’t happen again.” This statement is a concrete example that supports literature recognizing that most victims and survivors will not self-identify.

**What Worked for Survivors?**

Survivors shared what worked for them when they sought health care and identified five primary content areas: how to refer, awareness, positive provider actions and behaviors, providing privacy, and medication (Appendix E, Table 14). Appropriate referral services relate to available resources. Appropriate referral for immediate and long term needs is essential for the safety and overall well-being of the survivor.

**What Did Not Work for Survivors?**

Survivors shared instances in which they sought health care and actions that did not work, hurt, humiliated, and actually harmed them and could be categorized in the sub-content areas of: the system, provider and staff actions, privacy, re-victimization, and lack of appropriate resources (Appendix E, Table 15). The most recurrent theme in survivor responses was that health care providers did not know what to do or to whom to refer them for continuing mental and physical health care, and for the provision of immediate needs such as food, shelter, and safety.
Phase two-Experts

Polit et al. (2007) recommend utilizing a pre-set 0.80 as the lowest acceptable value to claim consensus among panelists. Based on this recommendation this study identified 39 sub-content areas as achieving expert consensus for inclusion in a multidisciplinary, comprehensive HCP education program. Perfect consensus with an I-CVI of 1.0 was achieved for sub-content areas of red flags in recognition, safety in intervention, and utilizing patient quotes in documentation. The lowest I-CVI was 0.56 for incorporating system issues in the barriers content (Appendix E, Tables 5-12).

Phase two-Survivors

Utilizing the 0.80 pre-set value for consensus, 17 sub-content areas were identified as achieving consensus for inclusion among survivor panelists. Perfect consensus among survivors was achieved for the need for victim appropriate resources, the need to educate HCPs, provision of privacy, avoiding revictimization, hope, inclusion of training on provider actions that work and those that are detrimental for survivors. The lowest I-CVI was for medications at 0.56 with some survivors responding that they felt HCPs were quick to medicate them without trying to understand the whole situation (Appendix E, Tables 13-15). Together, a total of 56 sub-content areas achieving an I-CVI greater than or equal to 0.80 were identified across 11 primary content areas for both experts and survivors.

Discussion

Ahn et al. (2013) conducted a comprehensive review of educational resources for HCPs with findings supporting the need for evidence-based education frameworks and guidelines for HCPs to prioritize educational content. These findings helped to validate
the research question for this study: “What are the most critical elements of a comprehensive, multidisciplinary health care provider education on the recognition, intervention, and referral of child sex trafficking victims and survivors?”

Within an education program introduction, eight sub-content areas were identified for inclusion. The two education sub-content areas rated with the highest I-CVI, both at 0.95, were definitions and the HCP role. A lack of standardized concept definitions, such as human trafficking and child sex trafficking, contribute to inconsistent data collection and the failure to identify victims (IOM, 2009; Clawson et. al., 2006; Gajic-Velijanoski & Stewart, 2007; Reid, 2010; Peters, 2013). Chisolm-Straker, et al. (2013) found that in a survey of emergency medicine residents, emergency department (ED) physicians, ED nurses, and social workers that only 4.8% felt confident in their role and ability to identify and 7.7% confident to treat a trafficked patient. The complexity of the CST experience makes navigating recognition, intervention, and referral challenging for HCPs. Furthermore, meeting all the complex immediate and long-term needs of survivors is outside the scope of the HCP’s role, underscoring the need for a multidisciplinary response (Dovydaitis, 2010). The plan of care focus should be placed on immediate needs including treatment of presenting complaint, safety, and assessing for suicidal ideation (Dovydaitis).

In the HCP education program barriers section, 11 sub-content areas were identified. Lack of provider awareness and recognition of victim and survivor behaviors in the health care setting ranked highest, both with an I-CVI of 0.89. Reid (2010) recognized a lack of training in awareness and recognition of victims as a significant barrier to the provision of health care. Experts related instances of victims and survivors leaving
against medical advice, hostile behaviors, and demonstrations of anger and distrust, and fear of disclosure; all of which are significant barriers to providing care. Survivors related instances of being assessed for sexually transmitted infections (STIs) and having “hundreds” of partners as an adolescent, yet the causes of high number of sexual encounters were not assessed. Instances of providers unwittingly placing themselves and the victims in harm’s way by questioning the patient in the presence of the trafficker were reported. Lack of awareness and training have been recognized as variables contributing to missed opportunities in recognition of victims and survivor as most do not self-identify (Baldwin, S., Eiseman, D., Sayles, J., Ryan, G., & Chuang, K., 2011).

Within the recognition section, eight items were identified: describing “red flags”, victim and survivor behaviors in the health care setting, clinical presentation, patient’s care need priorities, provider role priorities, pattern recognition, and challenges in recognition. Unanimous consensus at an I-CVI of 1.0 was inclusion of “red flags”, which is the common terminology used in the fields of human trafficking and advocacy. Experts, law enforcement, and advocacy groups describe risk factors and behaviors that are indicative of victimization, such as lack of personal identification or papers, fearful, submissive, branding or particular types of tattoos, signs of physical or sexual abuse or torture, signs of bondage, malnourished, and victims asking permission to perform activities such as eating, sleeping, and elimination (Polaris Project, n.d.; de Chesnay, 2013; Cole, 2009; Hodge, 2014).

Emphasis was placed on rapport building which was divided into two content areas: rapport building and rapport building pitfalls. These are related to the complex and delicate interaction between the victim or survivor and the HCP with the understanding
that developing a trusting rapport is essential in the care of these victims (Isaac et al., 2011; Gajic-Velijanoski & Stewart, 2007). Six sub-content areas were identified in rapport building and eight identified in rapport building pitfalls. Provision and respect for the victim’s privacy were identified as top priorities for developing rapport by both survivors and experts with I-CVIs of 0.95 and 0.90 respectively. A recurrent theme in survivor responses was that seeking health care was avoided because each visit turned into a training session or “freak show”. Survivors also felt empowered when HCP asked before touching, were gentle and kind, kept them informed, and listened to them which were rapport building techniques that worked. HCPs with authoritarian attitudes, applying labels such as “drug addict” and being in a hurry were identified as hindering rapport. Experts suggest that HCPs act willing to help and listen, ask the victim what they want and need, provide translators (avoid using family and friends), emphasize safety, have a dedicated social worker and/or case manager for the patient, sit at eye level with the victim to convey openness and availability, and utilize a victim centered approach.

Eight interventional sub-content areas were identified. Perfect agreement was obtained among experts that methods for ensuring safety for the victims, survivors, and providers were of most critical concern with an I-CVI of 1.0. Survivors also report safety as a priority with an I-CVI of 0.89 with one stating, “I knew he had a gun in his pocket and would hurt anyone that tried to help me.” Often overlooked is the fact that perpetrators accompany victims when seeking health care with one study reporting that 100% of the survivor sample reported the perpetrator filled out the paperwork and was the source of communication with HCPs (Baldwin et al., 2011; Cole, 2009; Clawson et
al., 2009; Gajic-Velijanoski & Stewart, 2007). Experts note that if a victim or survivor says they are in danger, believe them.

Seven referral sub-content areas were identified. Discharge safety with an I-CVI of 1.0 expanded on personal safety. The need for appropriate referral to decrease the chances of re-victimization is paramount as evidenced by survivor statements such as, “They sent me to a homeless shelter!! I could NOT believe it!!” Also reported were instances of being sent to shelters not specific to trafficking survivors and being re-victimized by various forms of abuse. The importance of a human rights focused, victim-centered approach to referral for this population should not be minimalized and may mitigate the chances of re-victimization (Adams, C., 2011; Gajic-Velijanoski & Stewart, 2007; Fong & Berger, 2010). Experts in this study recommend strong collaboration with law enforcement, utilizing culturally appropriate referral services if available, and that understanding compliance with follow-up care instructions may be problematic for the victim related to resources because of the trafficker’s control.

Seven documentation sub-content areas were identified: comprehensive, history and physical, findings, interventions, forensics, patient quoted statements and pre-hospital information such as from emergency medical services (EMS) and/or law enforcement. Experts were in 100% agreement that patient quoted statements were critical to include in documentation with an I-CVI of 1.0. The importance of quoted statements in HCP documentation include, but are not limited to, a trauma-informed (Clawson et al., 2009) approach to assist other providers and disciplines in the care of the victim or survivor without having to subject them to the same battery of questions. The streamlining of care contributes to a more comprehensive, coordinated health system response as advocated
by Macias et al. (2013). Quoted statements aid law enforcement in the location, apprehension, and prosecution of traffickers.

One expert participant noted the need to avoid terms like “alleges” or “claims” and suggested the use of direct quotes instead. Another recommended documenting victim quotes to remove potential bias and subjective documentation.

Survivor recommendations for health care providers focus on the concept of re-victimization and criminalization and the damage of some health care providers’ actions. Conversely, a common theme of resilience emerged when survivors cited positive, negative, and effective HCP actions. Furthermore, 100% of the survivor sample have gone on to achieve various levels of higher education. Sari and Khairunnisa (2014) reported that higher levels of resiliency in this population are associated with environmental support, internal motivation, such as self-confidence, and interpersonal and social skills.

A few interesting intersections and divergences emerged between expert priorities and survivor priorities. For instance, references to staff behaviors were limited in the expert comments with the focus being on staff being rushed and having personal biases. However, every survivor respondent reported at least one case of staff behaviors that hurt or humiliated in graphic detail such as a nurse commenting on the “most disgusting thing she had ever seen” when referring to the victim’s cigarette burned breasts.

Available literature reports 28% to 89% of CST survivors and victims’ seeking health care services during captivity (Dovydaitis, 2010; Macias et al., 2013; Lederer & Wetzel, 2014), with 90% of this study’s participants having sought health care during enslavement. These numbers are staggering considering the estimated 200,000 victims
trafficked annually in the US (Polaris, 2012) and 4.5 million trafficked for sexual exploitation globally (ILO, 2012), 89% of survivor participants in this study reported a misdiagnosis, missed opportunity, and one survivor reported, “I almost died”. The need for an evidence-based education framework is clear.

Limitations

Limitations of this study are related to methodological challenges with the expert and survivor samples. Local and state law enforcement were represented within the expert sample, however federal agent participation was absent. The four federal agents approached, each from different federal agencies, reported an inability to participate because of required approval to be study participants in non-federal research. In efforts to obtain the most comprehensive information and insights into the legal aspects related to care of victims and survivors, expertise from these agents would have potentially provided another dimension to legal content inclusion analysis.

Data saturation was achieved with the expert sample, however data saturation was not achieved with the survivor sample. The individual complex nature of each victim and survivor experience requires a larger sample to obtain saturation. A more robust survivor sample may have provided further insight into survivor experiences within the health care system and with HCPs as data saturation was not reached, though a moderate degree of data redundancy was noted, especially related to safety, HCP actions that worked and did not work, and the need for appropriate referral resources. This was the first study evaluating essential elements of a comprehensive, multidisciplinary HCP education program so replication studies are needed. It is beyond the scope of this study to provide all of the information to saturate the sub-content areas for each topic and the reader is
directed to this study’s references and other literature in peer-reviewed journals based on
the developer’s specific focus.

Implications for Practice, Research, and Education

This framework is of use to physicians, nurses, emergency medical services,
governments, and organizations seeking to develop comprehensive, multidisciplinary
health care provider education programs for the recognition, intervention, and referral of
CST victims and survivors. The suggested primary content areas are an introduction,
barriers, recognition, building rapport and rapport building pitfalls, intervention, referral,
and documentation. Within each primary content area sub-content areas are provided
(Appendix E, Tables 5-15). Program developers could use the I-CVI to determine
information to include based upon the time allotted for the program. It is important to
note that lower I-CVIs do not mean that the information is unimportant. For instance, in
rapport building, the content area experts rated time below the established I-CVI of 0.76.
at 0.65. However, the survivors included patience and time as one of the most important
provider actions that worked for them with an I-CVI of 1.0.

The differing opinions between survivors and providers on some topics such as time
highlight that what providers believe to be true, may not be the victims’ and survivors’
care need priorities. Other instances of conflict in priorities were noted in the prescribing
of medication for anxiety when the survivor wanted a referral for therapy.

The ultimate goal of this study was that the quantity and quality of HCP CST
education programs contribute to increased victim, survivor, and provider safety; improve
mental and physical health outcomes; improve recognition of barriers to care; improve
reporting and data generation; improved reintegration of survivors; and decrease demand
for children and adolescents as sexual commodities. Major avenues to achieve these outcomes are through increased documentation support for prosecution efforts and improved identification, intervention and referral to ultimately decrease adverse public health, societal, and economic risks.

Conclusion

Advances in legislation, provision of care, and advocacy efforts dedicated to survivors and victims of CST are occurring. The science of caring for CST victims’ mental and physical health needs to improve their outcomes is in its infancy. The literature recognizes a lack of health care provider awareness, recognition, and consistent reporting as contributing factors to the lack of empiric data (Clawson et. al., 2006). Additionally, there is a lack of scientifically based health care provider education programs (Ahn et. al., 2013).

The problem addressed by this study is the lack of evidence-based frameworks to guide the development of critically needed, quality health care provider programs on the recognition, intervention, and referral of CST victims and survivors. The purpose of this study was to advance science in the area of HCP education and assist organizations’ attempts at program development by identifying the most important elements of a comprehensive, multidisciplinary health care provider education program on the recognition, intervention, and referral of CST victims and survivors. Complicating the development of needed education programs is the reality that educational program resources vary. The range of resources and time allotments for education pose challenges in planning content.
This study provides the first evidence-based framework for the development of comprehensive, multidisciplinary HCP education programs on the recognition, intervention, and referral of CST victims and survivors. The I-CVIs for each sub-content area guide program developers on what experts and survivors deemed most important. The framework’s flexibility and multidisciplinary components make application of this framework applicable across disciplines including, but not limited to nursing, medicine, social work, emergency medical services, and law enforcement. This framework is of value to health care organizations, academics, and community support organizations.
References


Human trafficking generates an estimated 31.6 billion dollars a year worldwide and is expected to become the largest black market within the next decade, surpassing the drug trade (International Organization for Migration [IOM], 2009). The US spent 80 million in 2009 in anti-trafficking efforts (Dunn, 2012). Globally, CST is recognized as an economic and public health risk, creating overwhelming economic and societal costs to communities (Reid, 2012). However, to date there is little qualitative or quantitative data that evaluates the mental and physical health outcomes of this population. No studies could be located regarding actual fiscal costs to society secondary to CST related to medical, mental health, law enforcement, and reintegration costs such as entitlement programs for this population. Thus the area is ripe for research that could have substantial positive impacts for survivors and society at large.

Replication and expansion of this study is recommended. Further research identifying the most important information to include in each sub-content area is further recommended. Anecdotal advice and information are insufficient to adequately and holistically develop the needed HCP education programs. Furthermore, it is imperative that collaborative multidisciplinary studies are conducted to adequately capture the complexities of caring for victims and survivors of CST. A critical and often over-looked component of CST education programs are the voices and experiences of the survivors. Inclusion of survivors is critical to understanding the culture of the life and what works for them and what does not work when health care is needed, usually at a very vulnerable time during their captivity. The framework developed by this study will help to support
and streamline the development of comprehensive healthcare provider education programs. One goal was to reduce the amount of human and financial resources needed by organizations seeking to develop and to provide this education while increasing the quality of such programs. One challenge developers face is deciding what content to include based on the time allotted. For instance, education efforts may span in allotted time from an hour presentation to a semester long course. Deciding what content to include, and to what extent can be challenging and problematic. Additionally, it is imperative that any subsequently developed education program is evaluated for outcomes and validity.

With awareness comes responsibility, therefore it is incumbent on the health care profession and academia to take an increasingly pro-active approach to development, implementation, and evaluation of scientifically based, multidisciplinary, comprehensive health care provider education programs for the recognition, intervention, and referral of this population.


Appendix A: Recruitment Script-Expert

Dear Potential Expert Panel Member (will use actual name and title),

I would like to invite you to participate as an expert panel member in a research study to identify the most critical elements of a multidisciplinary, comprehensive education program for health care providers on the recognition, intervention, and referral of child sex trafficking survivors. Should you agree to participate, your participation is strictly voluntary, confidential, and you have the right to withdraw from the study at any time.

Attached you will find an informed consent document with more details and expectations to assist with your decision. Should you decide to participate, please digitally sign and return or print, sign and e-mail your informed consent to the principal investigator, Cathy Miller RN, PhDc at Cathy_Miller@Baylor.edu. If none of these consent signature methods work for you, please contact Cathy Miller at Cathy_Miller@Baylor.edu to discuss alternatives.

This study consists of 3 survey phases that require approximately 10-15 minutes of your time for each survey. The surveys will be spaced over nine weeks.

- Phase one will ask you to identify which elements you believe are the most crucial to a comprehensive, multidisciplinary health care provider education program on the recognition, intervention, and referral of child sex trafficking survivors.

- Phase two will provide you with themes identified in phase one and will ask you to confirm their necessity for inclusion in such an education program.

- The final and third round will be a description and discussion of the findings of the first two rounds with the opportunity for you to clarify any misconceptions.

I am very hopeful you will agree to participate. The depth and breadth of your experience and expertise is critical to the success of this study and the formulation of a scientifically based health care provider education program. I recognize your time is very valuable; therefore I would like to thank you in advance for considering participating on this expert panel. Please do not hesitate to let me know of any questions you have!

Kindest Regards,
Cathy L. Miller RN, PhDc
Doctoral Candidate-The University of Texas-Tyler
Cathy_Miller@baylor.edu
Appendix B: Recruitment Script-Survivor

Dear Potential Survivor Panel Member (will use actual name),

I would like to invite you to participate in an important research study to help train doctors and nurses to care for survivors of sex trafficking. Your experiences as a victim and survivor are the most crucial part of teaching doctors and nurses how to provide the best medical and nursing care possible. If you agree to participate, your participation is strictly voluntary, confidential, and you have the right to withdraw from the study at any time.

Attached you will find an informed consent document with more details and expectations to assist with your decision. If you decide to participate, please digitally sign and return or print, sign and e-mail your informed consent to the principal investigator, Cathy Miller RN, PhDc at Cathy_Miller@Baylor.edu. If you would like to talk about other options for your signature, please let me (Cathy Miller) know.

This study consists of 3 survey phases in which each which should require approximately 10-15 minutes of your time for each survey. The surveys will be spaced over nine weeks.

- Phase one will ask you to identify which elements you believe are the most crucial to a comprehensive, multidisciplinary health care provider education program on the recognizing, providing health care, and referring child sex trafficking survivors.

- Phase two will provide you with themes identified in phase one and will ask you to confirm their necessity for inclusion in such an education program.

- The final and third round will be a description and discussion of the findings of the first two rounds with the opportunity for you to clarify any misconceptions.

I am very hopeful you will agree to participate. Your real world experiences are critical to the success of this study and the formulation of a scientifically based health care provider education program. I recognize your time is very valuable, therefore I would like to thank you in advance for considering participating on this survivor panel. If you have any questions please do not hesitate to let me know!

Kindest Regards,
Cathy L. Miller RN, PhDc
Doctoral Candidate-The University of Texas-Tyler
Cathy_Miller@Baylor.edu
1. **Project Title:** Child Sex Trafficking—Recognition, Intervention, and Referral: Development of an Educational Framework to Guide Health Care Provider Practice

2. **Principal Investigator Contact:** Cathy L. Miller, RN, PhD(C)
   Cathy_Miller@Baylor.edu
   361-318-4988

You are being asked to take part in this study at The University of Texas at Tyler (UT Tyler). This permission form explains:

- Why this research study is being done.
- What you will be doing if you take part in the study.
- Any risks and benefits you can expect if you take part in this study.

After reading this consent, you should be able to:

- Understand what the study is about.
- Choose to take part in this study because you understand what will happen

3. **Description of Project**

This study’s objective is to understand what elements constitute a comprehensive, multidisciplinary child sex trafficking healthcare provider education program for the recognition, intervention, and referral of child sex trafficking survivors.

As an expert in your discipline and with a proven expertise and advocacy with child sex trafficking survivors, you are being asked to participate on this panel because it is crucial for healthcare providers to understand, recognize, and provide care and referrals understanding the complexities of such from diverse disciplines.

4. **Research Procedures**

If you agree to be in this study, we will ask you to do the following things:
Appendix C: (Continued)

a) As a person identified to qualify to serve on an expert panel, participate in three brief rounds of surveys: Round 1, Round 2, and Round 3.

b) Round 1: Complete a survey that takes about 20-30 minutes asking you to identify factors you feel are crucial for the healthcare provider to understand from the perspective of your discipline. The researcher will take all of these factors and group them according to similarity. You will also be asked questions about your age, gender, education, and other demographic information.

c) Round 2: This survey will be the factors that have been grouped into similarly, and you will be asked to agree or disagree on the importance of teaching these findings to health care providers.

d) Round 3: The researcher will provide you with preliminary findings and you will be asked to clarify any misunderstandings if any are noted.

5. Side Effects/Risks

There are no foreseeable risks for completing the questionnaires for the study. The survey will be completed on-line and should take about 20-30 minutes to complete. You may refuse to answer any question that makes you feel uncomfortable. You are free to not participate in this study or to stop participating in this study at any time without any undue consequences. If you have concerns before or after completing the questionnaires, you are encouraged to contact the principal investigator, her contact information is provided at the end of this form.

6. Potential Benefits

Your participation in this study will contribute to efforts to develop a healthcare provider education program to train doctors, nurses, and first responders how to appropriately recognize and care for survivors. Your input will be invaluable in teaching health care providers how to care for survivors in a holistic manner. You will receive no direct benefits from participation.

Understanding of Participants

7. I have been given a chance to ask any questions about this research study. The researcher has answered my questions.

8. If I sign this consent form I know it means that:

   • I am taking part in this study because I want to. I chose to take part in this study after having been told about the study and how it will affect me.
Appendix C: (Continued)

- I know that I am free to not be in this study. If I choose to not take part in the study, then nothing will happen to me as a result of my choice.

- I know that I have been told that if I choose to be in the study, then I can stop at any time. I know that if I do stop being a part of the study, then nothing will happen to me.

- I will be told about any new information that may affect my wanting to continue to be part of this study.

- The study may be changed or stopped at any time by the researcher or by The University of Texas at Tyler.

- The researcher will get my written permission for any changes that may affect me.

9. I have been promised that that my name will not be in any reports about this study unless I give my permission.

10. I also understand that any information collected during this study may be shared as long as no identifying information such as my name, address, or other contact information is provided. This information can include health information. Information may be shared with:

- Organization giving money to be able to conduct this study
- Other researchers interested in putting together your information with information from other studies
- Information shared through presentations or publications

11. I understand The UT Tyler Institutional Review Board (the group that makes sure that research is done correctly and that procedures are in place to protect the safety of research participants) may look at the research documents. These documents may have information that identifies me on them. This is a part of their monitoring procedure. I also understand that my personal information will not be shared with anyone.

12. I have been told about any possible risks that can happen with my taking part in this research project.

13. I also understand that I will not be given money for any patents or discoveries that may result from my taking part in this research.
Appendix C: (Continued)

14. If I have any questions concerning my participation in this project, I will contact the principal researcher: Cathy Miller at Cathy_Miller@Baylor.edu or at 361-318-4988.

15. If I have any questions concerning my rights as a research subject, I will contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttyler.edu, or the University’s Office of Sponsored Research:

Participant Signature__________________________________
Appendix D: Informed Consent for Survivors

THE UNIVERSITY OF TEXAS AT TYLER

Informed Consent to Participate in Research-Survivors

1. **Project Title:** Child Sex Trafficking—Recognition, Intervention, and Referral: Development of an Educational Framework to Guide Health Care Provider Practice

   a. **Principal Investigator:** Cathy L. Miller, RN, PhD(C)
      Cathy_Miller@Baylor.edu
      361-318-4988

You are being asked to take part in this research at The University of Texas at Tyler (UT Tyler). This permission form explains:

- Why this research study is being done.
- What you will be doing if you take part in the study.
- Any risks and benefits you can expect if you take part in this study.

After reading this consent, you should be able to:

- Understand what the study is about.
- Choose to take part in this study because you understand what will happen.

3. Description of Project

This study is to gather information that will help make an education program to teach nurses and doctors how to take care of trafficking survivors. Nurses and doctors can take better care of survivors if they understand more about recognizing, treating, and referring survivors.

As a survivor, you are being asked to be in this study because no one can understand your experiences when you went to the hospital or clinic better than you. Only survivors can tell nurses and doctors what worked for them and what did not work for them.
Appendix D: (Continued)

4. Research Procedures

If you agree to be in this study, we will ask you to do the following things:

   e) Verify that you are 18 years old or older at the bottom of this consent
   f) Participate in three short online surveys: Round 1, Round 2, and Round 3.

   g) Round 1: The online survey takes about 20-30 minutes and is about how health care providers you saw during captivity could have recognized, treated, and/or referred you for more resources when you sought healthcare. The researcher will take all of the information you give her and put the information into groups. You will also be asked questions about your age, if you are male or female, did you graduate high school and if you went to college.
   h) Round 2: This online survey will ask you if you agree on the groups of important information the researcher made.
   i) Round 3: The researcher will send you the findings of the research and you will be asked to let her know if she did not understand any of the information you gave.

5. Side Effects/Risks

   Even though you may agree to be part of the study, memories from the past may make you feel bad or become upset. You might also feel like you are not ready to be a part of the study or share your experiences. If you feel bad, or become upset, or don’t feel like you are ready, you are free to drop out of the study at any time. If you want to stop at any time, it is no problem. Also, while you are in the study, and you at any time feel like you need counseling or help coping, please let the researcher (Cathy Miller) know. Her contact information is at the top of the form and at the bottom in number 14.

6. Potential Benefits

   No one knows what survivors experienced when they went to the hospital or clinic better than survivors! Your help in this study will help the researcher make an education program for doctors and nurses that teaches them how to recognize, treat, and refer survivors for more help. Only survivors know what works and what does not work when they go to the hospital or clinic. You will be given a $20 Amazon.com gift card for your time and participation at the end of the study.
Appendix D. (Continued)

Understanding of Participants

7. I have been given a chance to ask any questions about this research study. The researcher has answered my questions.

8. If I sign this consent form I know it means that:

   - I am taking part in this study because I want to. I chose to take part in this study after having been told about the study and how it will affect me.

   - I know that I am free to not be in this study. If I choose to not take part in the study, then nothing will happen to me as a result of my choice.

   - I know that I have been told that if I choose to be in the study, then I can stop at any time. I know that if I do stop being a part of the study, then nothing will happen to me.

   - I will be told about any new information that may affect my wanting to continue to be part of this study.

   - The study may be changed or stopped at any time by the researcher or by The University of Texas at Tyler.

   - The researcher will get my written permission for any changes that may affect me.

9. I have been promised that that my name will not be in any reports about this study unless I give my permission.

10. I also understand that any information collected during this study may be shared as long as no identifying information such as my name, address, or other contact information is provided. This information can include health information. Information may be shared with:

   - Organization giving money to be able to conduct this study
   - Other researchers interested in putting together your information with information from other studies
   - Information shared through presentations or publications
Appendix D: (Continued)

11. I understand The UT Tyler Institutional Review Board (the group that makes sure that research is done correctly and that procedures are in place to protect the safety of research participants) may look at the research documents. These documents may have information that identifies me on them. This is a part of their monitoring procedure. I also understand that my personal information will not be shared with anyone.

12. I have been told about any possible risks that can happen with my taking part in this research project.

13. I also understand that I will not be given money for any patents or discoveries that may result from my taking part in this research.

14. If I have any questions concerning my participation in this project, I will contact the principal researcher: Cathy Miller at cathy_miller@baylor.edu or at 361-318-4988.

15. If I have any questions concerning my rights as a research subject, I will contact Dr. Gloria Duke, Chair of the IRB, at (903) 566-7023, gduke@uttyler.edu, or the University’s Office of Sponsored Research:

I have no questions about my participation in this study, and agree to be a participant. I am 18 years old or older.

Participant Signature____________________________
## Appendix E. Tables

### Table 1. Expert Demographics and Experience

[Law Enforcement (LE), Clinical (C), Community Support Organizations (CS)]

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<th>Highest level of Education</th>
<th>Profession</th>
<th>Years in Profession</th>
<th># Survivors Encountered</th>
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<tr>
<td>O</td>
<td>F</td>
<td>33</td>
<td>Doctorate</td>
<td>C</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>P</td>
<td>F</td>
<td>33</td>
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<td>C</td>
<td>4</td>
<td>3</td>
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<tr>
<td>Q</td>
<td>M</td>
<td>55</td>
<td>Some College</td>
<td>LE</td>
<td>25</td>
<td>2000</td>
</tr>
<tr>
<td>R</td>
<td>F</td>
<td>38</td>
<td>MS</td>
<td>C</td>
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<tr>
<td>S</td>
<td>F</td>
<td>55</td>
<td>Doctorate</td>
<td>C</td>
<td>15</td>
<td>160</td>
</tr>
<tr>
<td>T</td>
<td>F</td>
<td>43</td>
<td>MS</td>
<td>LE</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>U</td>
<td>F</td>
<td>54</td>
<td>MS</td>
<td>CS</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td>V</td>
<td>F</td>
<td>47</td>
<td>Doctorate</td>
<td>C</td>
<td>18</td>
<td>150</td>
</tr>
<tr>
<td>W</td>
<td>F</td>
<td>68</td>
<td>BS</td>
<td>CS</td>
<td>14</td>
<td>200</td>
</tr>
</tbody>
</table>
Table 2. Survivor Demographics and Experience

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Gender</th>
<th>Age</th>
<th>Highest Level of Education</th>
<th>Age Entry into Trafficking</th>
<th>Age When Escaped Trafficking</th>
<th># Years in Captivity</th>
<th># Times Health Care Sought During Captivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>F</td>
<td>34</td>
<td>SC</td>
<td>14</td>
<td>15</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>F</td>
<td>29</td>
<td>MS</td>
<td>19</td>
<td>19</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>F</td>
<td>49</td>
<td>BS</td>
<td>18</td>
<td>32</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>D</td>
<td>F</td>
<td>29</td>
<td>SC</td>
<td>14</td>
<td>15</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>F</td>
<td>50</td>
<td>BS</td>
<td>16</td>
<td>22</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>F</td>
<td>F</td>
<td>48</td>
<td>SC</td>
<td>16</td>
<td>18</td>
<td>2</td>
<td>“2-3 times”</td>
</tr>
<tr>
<td>G</td>
<td>F</td>
<td>49</td>
<td>BS</td>
<td>18</td>
<td>31</td>
<td>13</td>
<td>“100s”</td>
</tr>
<tr>
<td>H</td>
<td>F</td>
<td>16</td>
<td>SC</td>
<td>2</td>
<td>9</td>
<td>7</td>
<td>“8-12”</td>
</tr>
<tr>
<td>I</td>
<td>F</td>
<td>30</td>
<td>AS</td>
<td>21</td>
<td>23</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>J</td>
<td>F</td>
<td>41</td>
<td>BS</td>
<td>8</td>
<td>10</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

- Some College (SC), Associate’s Degree (AS), Bachelor’s Degree (BS), Master’s Degree (MS)
<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your highest level of education?</td>
</tr>
<tr>
<td>What is your professional designation (MD, DO, RN, LCSW…)?</td>
</tr>
<tr>
<td>What is your primary employment (Clinical, academic, law enforcement)</td>
</tr>
<tr>
<td>Are you female or male?</td>
</tr>
<tr>
<td>What is your age?</td>
</tr>
<tr>
<td>How many years have you been working in your discipline?</td>
</tr>
<tr>
<td>Please estimate the total number of victims and survivors you have encountered in your line of work.</td>
</tr>
<tr>
<td>What was the age of your youngest victim/survivor?</td>
</tr>
<tr>
<td>What was the age of your oldest victim/survivor?</td>
</tr>
<tr>
<td>What are the most important elements to include in the introduction of the problem?</td>
</tr>
<tr>
<td>What are the most important elements to include in the recognition of the victims and survivors?</td>
</tr>
<tr>
<td>What are the most important elements to include in intervention with victims and survivors?</td>
</tr>
<tr>
<td>What are the most important elements to include in the referral of victims and survivors?</td>
</tr>
<tr>
<td>What are the most important elements to include in the provider’s documentations?</td>
</tr>
<tr>
<td>What are barriers to recognition in the health care setting?</td>
</tr>
<tr>
<td>What are the barriers to intervention in the health care setting?</td>
</tr>
<tr>
<td>What are the barriers to referral in the health care setting?</td>
</tr>
<tr>
<td>What perceptions are barriers to recognition?</td>
</tr>
<tr>
<td>What perceptions are barriers to referral?</td>
</tr>
<tr>
<td>What Perceptions are barriers to intervention?</td>
</tr>
<tr>
<td>In your practice what techniques were most valuable in establishing rapport with the victim/survivor?</td>
</tr>
<tr>
<td>In your practice, what techniques were least valuable and/or counter-productive in establishing rapport with the victim/survivor?</td>
</tr>
<tr>
<td>Have you ever felt in danger when treating a victim/survivor?</td>
</tr>
<tr>
<td>Have you ever felt the victim/survivor you were interacting with was still in danger?</td>
</tr>
</tbody>
</table>
Appendix E. (Continued)

Table 4. Survivor Round #1 Survey Questions

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your age?</td>
</tr>
<tr>
<td>How old were you when you were first trafficked?</td>
</tr>
<tr>
<td>How old were you when you escaped your trafficker?</td>
</tr>
<tr>
<td>What is your highest level of education?</td>
</tr>
<tr>
<td>Are you female or male?</td>
</tr>
<tr>
<td>Please estimate the number of times you sought health care during your captivity.</td>
</tr>
<tr>
<td>After escaping your trafficker, how many times have you sought mental or physical health care for injuries you got during captivity?</td>
</tr>
<tr>
<td>Please describe your experiences with health care providers and/or the health care system. Be as detailed as you feel comfortable.</td>
</tr>
<tr>
<td>What actions by your health care provider worked best for you?</td>
</tr>
<tr>
<td>What actions by your health care provider did not work, made you angry, made you feel bad, or made you leave the health care facility without treatment?</td>
</tr>
<tr>
<td>What is the most important information for a health care provider to know when they suspect that one of their patients might be the victim or survivor of child sex trafficking?</td>
</tr>
<tr>
<td>Please describe your experience during and after you were trafficked as much as you feel comfortable. If you do not want to share your experience, you do not have to and can leave this section blank.</td>
</tr>
<tr>
<td>From your experience, is there anything else you think health care providers should know about caring for trafficking victims and survivors?</td>
</tr>
<tr>
<td>What tips can you give health care providers to help them recognize victims and survivors?</td>
</tr>
<tr>
<td>What tips can you give health care providers to help keep victims and survivors safe while they are at the health care facility and after they leave?</td>
</tr>
<tr>
<td>Did you feel safe when you were with the health care provider? Why or why not?</td>
</tr>
</tbody>
</table>
## Appendix E. (Continued)

### Table 5. Introduction Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Content</th>
<th>Sample Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Definitions</td>
<td>International vs. National</td>
<td>0.95</td>
</tr>
<tr>
<td>HCP Role</td>
<td>Role in suspected and confirmed; national and international</td>
<td></td>
<td>0.95</td>
</tr>
<tr>
<td>Challenges</td>
<td>Difficult identification, misconceptions about who and what trafficking is</td>
<td></td>
<td>0.80</td>
</tr>
<tr>
<td>Humanize</td>
<td>Include case studies and victim/survivor testimony to humanize the material, not just statistics</td>
<td></td>
<td>0.75</td>
</tr>
<tr>
<td>Stereotypes</td>
<td>Drug seeker, frequent flyer, child prostitute</td>
<td></td>
<td>0.70</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Runaway, history of abuse and neglect, poverty, homeless, history of previous prostitution charges, victimology</td>
<td></td>
<td>0.70</td>
</tr>
<tr>
<td>Scope</td>
<td>Prevalence locally, nationally, and internationally</td>
<td></td>
<td>0.65</td>
</tr>
<tr>
<td>Myths</td>
<td>Can leave if they want, does not happen here, not in my ER</td>
<td></td>
<td>0.65</td>
</tr>
</tbody>
</table>
Table 6. Barriers Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Sample Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers</td>
<td>Lack of Awareness</td>
<td>Hidden problem, lack of education, difficult identification and ineffective screening, not knowing what to ask</td>
<td>0.89</td>
</tr>
<tr>
<td></td>
<td>Victim and Survivor</td>
<td>“Dishonesty; the fall was not a fall it was a push and the brother is not the brother.” Especially in children, they may not be aware that something is wrong, patient trust issues, fear they will get in “trouble”, harm may come to family and friends. Love and acceptance-trauma bonding. Frequent leaving against medical advice (AMA). Victims will lie. Complaints linked to life-style choices.</td>
<td>0.89</td>
</tr>
<tr>
<td></td>
<td>Provider Behaviors</td>
<td>“We want to trust our patients-it feels better and is faster,” superficial history taking, rushed, ineffective rapport building techniques and ineffective interview techniques. Not knowing what to do. Not wanting to have to report to authorities (time). Authoritarian.</td>
<td>0.84</td>
</tr>
<tr>
<td></td>
<td>Difficult Identification</td>
<td>Victims do not usually self-report. Parent or guardian denial.</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Staff Behaviors</td>
<td>Judgmental, bias, rushed</td>
<td>0.84</td>
</tr>
<tr>
<td></td>
<td>Perpetrator Behaviors</td>
<td>Fills out paperwork, is the one to communicate with staff</td>
<td>0.84</td>
</tr>
</tbody>
</table>
## Appendix E. (Continued)

### Table 6. Barriers Content with I-CVI (Continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Sample Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Perceptions</td>
<td></td>
<td>Personal bias, believes child is the offender and a bad kid</td>
<td>0.74</td>
</tr>
<tr>
<td>Lack of HCP Education</td>
<td></td>
<td>On how to engage law enforcement, not knowing what to do, unaware of resources for referral, no best practices, no formal training</td>
<td>0.56</td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td>Length of time it takes to build rapport</td>
<td>0.47</td>
</tr>
<tr>
<td>Black Market Health</td>
<td></td>
<td>A bigger barrier is probably the silent denominator, the people who get black market health care</td>
<td>0.39</td>
</tr>
<tr>
<td>Systems Issues</td>
<td></td>
<td>This is exactly nobody’s problem, lack of resources, lack of policy and procedures, access to translators, victim or survivor gets lost in the system.</td>
<td>0.37</td>
</tr>
</tbody>
</table>
## Appendix E. (Continued)

### Table 7. Recognition Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Sample Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition</td>
<td>Describe “Red Flags”</td>
<td>Inconsistency of injuries and statements, fear, shame, late presentation of illness or injury, presence of controlling figure in room, mental health issues, drug substance abuse, genitourinary complaints, retained foreign bodies vaginally or anally, illegal, runaway, homeless. Recognize you are looking for patterns.</td>
<td>1.00</td>
</tr>
<tr>
<td>Victim and Survivor Behaviors</td>
<td></td>
<td>Don’t expect gratitude for being “saved”, may not want intervention, high rate of leaving AMA, may not see themselves as a victim</td>
<td>0.95</td>
</tr>
<tr>
<td>Patient’s Care Need Priorities</td>
<td></td>
<td>Recognize that a patient’s care needs may be at odds with the provider’s care priorities. Allow choices and include them in plan of care.</td>
<td>0.95</td>
</tr>
<tr>
<td>Challenges</td>
<td></td>
<td>Trafficker may be with patient, victims don’t typically self-identify, provision of provider and survivor safety</td>
<td>0.85</td>
</tr>
<tr>
<td>Clinical Presentation</td>
<td></td>
<td>Late/acute, mental health issues, substance abuse, psychological trauma, genitourinary complaint, retained foreign bodies vaginally or anally.</td>
<td>0.80</td>
</tr>
<tr>
<td>Provider Role Priorities</td>
<td></td>
<td>Safety, acute then chronic issues. Elevated triage level.</td>
<td>0.80</td>
</tr>
<tr>
<td>Perpetrator Behaviors</td>
<td></td>
<td>Controlling, speaks for patient, someone somewhere is controlling the victim.</td>
<td>0.75</td>
</tr>
<tr>
<td>Pattern Recognition</td>
<td></td>
<td>Recognize as the clinician you are looking for patterns such as injuries inconsistent with story</td>
<td>0.75</td>
</tr>
</tbody>
</table>
Appendix E (Continued)

Table 8. Rapport Building Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapport Building</td>
<td>Patience</td>
<td>Sit, take time to develop rapport, empathy, understanding, calm, do not show shock or disgust, don’t judge, victim-centered, trauma-informed approach. Stop multi-tasking.</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>Empowerment</td>
<td>Let patient take the lead. Assure the patient they are in control of the exam and interview, explain exactly what you are doing, ask permission to touch them, ask what they want and need. Be honest and earnest, translator when necessary.</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>System Support</td>
<td>Have a dedicated social worker/case manager for the patient, multidisciplinary victim-centered response.</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>Collaboration</td>
<td>Assure patient that law enforcement is an ally. Be aware of patient origins and their experiences/perceptions of law enforcement.</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>Staff Behaviors</td>
<td>Need to know basis, provide the staff with the most time, and provide same-sex staff if possible.</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>Comfort</td>
<td>Provide a quiet, warm, comfortable place, emphasize safety, and ask what makes them comfortable. Provide food and drinks when not contraindicated.</td>
<td>0.80</td>
</tr>
</tbody>
</table>
### Table 9. Rapport Building Pitfalls Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapport</td>
<td>Lack of privacy</td>
<td>Open exam bays, need to know basis</td>
<td>0.95</td>
</tr>
<tr>
<td>Pitfalls</td>
<td>Victim and Survivors Perceptions</td>
<td>That you are judging them, being dishonest, not listening, that you are lecturing them</td>
<td>0.90</td>
</tr>
<tr>
<td></td>
<td>Awareness</td>
<td>Cry for help, not “attention seeking”, lack of awareness of this population’s culture such as the language used (Daddy is not Daddy). Word choices can be offensive. Get on their level.</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>Dishonesty</td>
<td>By the provider and/or victim or survivor. Accepting their story without evaluation, overpromising.</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>Authoritarian</td>
<td>Don’t be judgmental, overly soft or overly stern. Avoid life lessons, lecturing, and threatening. “Even though I tell myself I would never do that, I have.”</td>
<td>0.68</td>
</tr>
<tr>
<td></td>
<td>Waiting for Victim/Survivor to Self-Identify</td>
<td>“Waiting for them to voluntarily come to a clinic, even if the clinic is advertised as being ‘friendly’ or ‘welcoming’, and especially without any invitation.”</td>
<td>0.68</td>
</tr>
<tr>
<td></td>
<td>System issues</td>
<td>Lack of translator, door to discharge culture, need for support of a MDRT, staff judgmental and negative.</td>
<td>0.65</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>Rush to treatment, rush to discharge, heavy volume. “Going against the agency’s pressure and moving at the victim’s pace can be very conflicting among hospital employees.”</td>
<td>0.65</td>
</tr>
</tbody>
</table>
Appendix E (Continued)

Table 10. Intervention Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Safety</td>
<td>Ensure provider and victim/survivor safety. Consider everyone with the victim as a potential trafficker. Recognize the role of organized crime and gangs as potential threats.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Awareness</td>
<td>Be aware of pre-hospital contact with law enforcement and EMS. Be aware of needs and care wishes, may be in counseling associated with abuse, understand trauma informed, victim-centered care. Be aware of resources such as victim advocates and resource centers.</td>
<td>0.95</td>
</tr>
<tr>
<td></td>
<td>Provider Role</td>
<td>Respect scope of practice, know what to do and what NOT to do. Recognize intervention may not work the first time, victim-centered approach and know resources.</td>
<td>0.95</td>
</tr>
<tr>
<td></td>
<td>Empowerment</td>
<td>Allow choices, encourage participation in care, build rapport, do not over promise and under deliver.</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Victim/Survivor Considerations-Other</td>
<td>Do not retraumatize, criminalize, ensure language and cultural translation, maintain confidentiality, recognize spiritual needs, use holistic approach, remind them they have done nothing wrong, and understand the underlying thread of vulnerability.</td>
<td>0.85</td>
</tr>
<tr>
<td></td>
<td>Consent</td>
<td>Obtain consent when appropriate. Ask permission with each step of exam.</td>
<td>0.80</td>
</tr>
</tbody>
</table>
Appendix E. (Continued)

Table 10. Intervention Content with I-CVI (Continued)

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Sample Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of Continued Law Enforcement Inclusion</td>
<td></td>
<td>Critical member of the multidisciplinary response team, knowledgeable about community resources, provides safety support, provides pre-hospital information, “The most important elements are effective victim services that are delivered collaboratively between law enforcement and service providers.”</td>
<td>0.80</td>
</tr>
<tr>
<td>Streamlined Care</td>
<td></td>
<td>Critical to develop and establish policies and procedures for both US citizens and foreign national; who to notify, how to separate the victim from the potential trafficker, how to engage health care organization security, and how to protect medical and nursing staff</td>
<td>0.70</td>
</tr>
</tbody>
</table>
## Table 11. Referral Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>Safety post-discharge</td>
<td>Assess risk from trafficker, if victim says they are in danger, believe them. Know community resources in advance. “It is not the expectation of the HCP to be responsible for post-discharge safety, however awareness of community resources, systems processes, and potential danger can increase the victim or survivor’s safety.”</td>
<td>0.95</td>
</tr>
<tr>
<td>Privacy</td>
<td></td>
<td>Only trusted partners on a need to know basis.</td>
<td>0.85</td>
</tr>
<tr>
<td>Information to include in referral</td>
<td></td>
<td>Social history, safety planning, mental health issues, age, gender, nationality, how and when they want to be notified of potential admission, any specific information they require prior to consideration for admission, needs.</td>
<td>0.85</td>
</tr>
<tr>
<td>Local, national, and international resources</td>
<td></td>
<td>Know resources in advance, have an awareness of the Trafficking Victims Protection Act (TVPA), assess needs for best fit. Know who to call and who NOT to call. Have a back-up plan.</td>
<td>0.80</td>
</tr>
<tr>
<td>Consent</td>
<td></td>
<td>Obtain consent to refer.</td>
<td>0.75</td>
</tr>
<tr>
<td>Empower</td>
<td></td>
<td>Allow choices. Inform victim or survivor of the resources available at each potential referral resource, if services refused, at minimum provide them with the national hotline number and local resource numbers</td>
<td>0.75</td>
</tr>
<tr>
<td>Compliance issues</td>
<td></td>
<td>Assess ability to be compliant with discharge instruction such as their resources, freedom from trafficker, willingness.</td>
<td>0.55</td>
</tr>
</tbody>
</table>
### Table 12. Documentation Content with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Expert Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>Patient quotes</td>
<td>Verbatim statements</td>
<td>1.00</td>
</tr>
<tr>
<td>History and physical</td>
<td>Routine History and Physical. Include patient affect, attitude, and non-verbal behaviors. Include substance abuse history, trauma assessment, and history of infectious diseases, medications, sexual abuse history, and appearance.</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td>What was done and NOT done. Including interventions to provide for referral, and immediate needs provision.</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Forensics</td>
<td>Forensic photography, MDRT</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Findings</td>
<td>Routine findings documentation</td>
<td>0.85</td>
<td></td>
</tr>
<tr>
<td>Prehospital</td>
<td>Information provided by law enforcement and EMS. Obtain a reliable 24 hour contact.</td>
<td>0.85</td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Objective, only what you are willing to testify to in court. Take notes or you will forget.</td>
<td>0.85</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix E (Continued)

**Table 13. Survivor-Driven Content with I-CVI**

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Survivor Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivor</td>
<td>Resources</td>
<td>Good intentions, but lacked resources.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Provider education</td>
<td>The worst thing was that they did not know what to do with me. They would ask the right questions, but I would not tell them.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Privacy</td>
<td>Turned into a training event for practitioners. Freak show aspect.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Re-victimization</td>
<td>Realized the necessity of the exam but, “My body was stretched to the point I thought I would split in two. Graphic photography was taken for evidence.” Dropped as a patient. Clear discrimination. Labeled.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Hope</td>
<td>Health care providers are getting better. I returned to clinics that knew how to handle the situation and it saved my life. Reported positive experience with mental health services and trauma trained therapists.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Labels and stereotypes</td>
<td>Just another drug addict. Only sluts have sex with that many people.</td>
<td>0.88</td>
</tr>
<tr>
<td></td>
<td>Fears</td>
<td>Fear of judgment, fear of the rape kit and exam, fear of the photography.</td>
<td>0.67</td>
</tr>
<tr>
<td></td>
<td>Missed opportunities</td>
<td>Never asked why I was on drugs. Never asked why I had so many sexual partners. Would not see me because I did not have ID. I almost died. “The staff asked me how many sexual partners I had in the last month, I responded with hundreds and no one asked why.”</td>
<td>0.63</td>
</tr>
</tbody>
</table>
### Table 14. What Worked for Survivors with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Survivor Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Worked</td>
<td>Awareness</td>
<td>Knew I don’t like to feel trapped. Don’t want to have to feel like I have to worry about the provider’s feelings.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Provider Actions that worked</td>
<td>Remembering what I told her. Knowing that I don’t like to be touched. It helped to feel like someone cared. Treating me like a human. Offering me options. Gentle and kind. Asked permission before touching me. Kept me informed.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Privacy</td>
<td>Don’t discuss me like I am not there or stupid. Safe place to talk. Interview without others in the room.</td>
<td>0.89</td>
</tr>
<tr>
<td></td>
<td>How to appropriately refer</td>
<td>Offer resources and referrals that can really be used-now. Refer to appropriate places. “They sent me to a homeless shelter!! I couldn’t believe it!!”</td>
<td>0.78</td>
</tr>
<tr>
<td></td>
<td>Medications</td>
<td>Too quick to medicate. Gave me anti-anxiety medications. Antibiotics for infection</td>
<td>0.56</td>
</tr>
</tbody>
</table>
Table 15. What Did Not Work for Survivors with I-CVI

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Example Survivor Statements</th>
<th>I-CVI</th>
</tr>
</thead>
<tbody>
<tr>
<td>What Did Not Work</td>
<td>Provider Actions</td>
<td>Don’t assume I need drug therapy. Too quick to medicate without getting to the heart of the problem. Assuming or stating that it “happen a long time ago” so it doesn’t matter, judging, lack of caring, wait time, lectures, putting me down. Don’t place me with drug addicts. Made promises that could not be kept.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Lack of Privacy</td>
<td>Spectacle aspect. The crazy looks. Bringing others into the room.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Re-victimization</td>
<td>Hurtful words. Withholding treatment until I answered certain questions. Blaming. Nurse stated my cigarette burned breasts were the most disgusting things she had ever seen. By others in inappropriate placement. Left feeling like it was ok to be victimized. Nurse stated that only sluts have sex at my age.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Lack of resources</td>
<td>Lack of financial resources for the prescribed therapy.</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>The system</td>
<td>Important to have survivor specific services, other survivor/patient advocated. Don’t put survivors with drug addicts.</td>
<td>0.89</td>
</tr>
</tbody>
</table>