Medical Treatment of Victims of Sexual Assault and Domestic Violence and Its Applicability to Victims of Human Trafficking

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I. INTRODUCTION

In 2008, the Office of the Assistant Secretary for Planning and Evaluation within the U. S. Department of Health and Human Services sponsored the National Symposium on the Health Needs of Human Trafficking Victims. This symposium was designed to bring healthcare workers and members of the anti-human trafficking community together to discuss identification of and service provision to victims of human trafficking in medical settings. One of the major issue areas identified during the symposium was the importance of learning from and building on best practices used by medical providers working with similar, marginalized populations. Particular attention was paid to the efforts and ways that protocols and procedures have been established for victims of domestic violence, and whether they can be applied to or modified for victims of human trafficking.

CONTENTS

This issue brief examines the procedures and protocols that currently exist for assessing and treating victims of domestic violence and sexual assault in healthcare settings in an effort to evaluate their applicability to victims of human trafficking. Given the similar trauma experienced by victims of domestic violence, sexual assault, and human trafficking, the procedures and protocols for domestic violence and sexual assault offer the best foundation on which to learn from and build proper response systems for victims of human trafficking. Since the procedures and protocols related to domestic violence and sexual assault typically focus on the sexual nature of the offense, this issue brief will primarily focus on victims of sex trafficking as well as victims of labor trafficking who are sexually assaulted.

II. THE MEDICAL AND MENTAL HEALTH CONSEQUENCES FOR VICTIMS OF HUMAN TRAFFICKING

Research indicates that victims of human trafficking often have a wide variety of physical and mental health needs (Clawson, Dutch, &Williamson, 2008). The physical health issues experienced by this population can include headaches, memory loss, gastrointestinal problems, chronic pain, broken bones, head and neck trauma, infectious diseases, sexually transmitted infections, dental or oral problems, respiratory illness, unhealthy weight loss due to food deprivation and poor nutrition, pregnancy, pelvic inflammatory disease, and other gynecological problems (Alexander, Kellogg, & Thompson, 2005; Family Violence Prevention Fund, 2005;

International Organization for Migration, 2006; Raymond et al., 2002; Zimmerman, 2003; Zimmerman et al., 2006).

Studies have found that 76–100 percent of female survivors of sex trafficking report being physically assaulted and 67–100 percent report being sexually assaulted while they were trafficked (Clawson, Dutch, &Williamson, 2008; Raymond et al., 2002; Zimmerman, 2003; Zimmerman et al., 2006). In addition to physical consequences, victims of human trafficking often experience severe and complex mental health consequences as a result of the trauma they have endured. Similar to victims of domestic violence and other traumatic experiences, many victims of human trafficking suffer from posttraumatic stress disorder (PTSD) (International Organization for Migration, 2006; Pico-Alfonso, 2005; Zimmerman et al., 2006). Studies have also shown that victims of trafficking often suffer from mood disorders, anxiety disorders, dissociative disorders, and substance related disorders (Family Violence Prevention Fund, 2005; International Organization for Migration, 2006; Zimmerman, 2003).[1]

III. DOMESTIC VIOLENCE AND SEXUAL ASSAULT AS THEY RELATE TO HUMAN TRAFFICKING

Similar to human trafficking, the existence of domestic violence far preceded its recognition by healthcare professionals as a phenomenon that resulted in adverse health consequences that therefore needed to be addressed by them. Despite the noteworthy differences between domestic violence and human trafficking, the victims of these crimes often suffer similar physical and mental health consequences, requiring heightened sensitivity by service providers. Additionally, many adolescents and women are trafficked by individuals who they consider to be their boyfriends, fiancés, or lovers. Adolescents and women may continue to have an intimate relationship with their trafficker as they are trafficked. These relationships often mirror those in which there is intimate partner violence (Sheridan & VanPelt, 2005).

While the issues of domestic violence and human trafficking have received national focus relatively recently, attention to domestic violence precedes that given to human trafficking. This longer period of attention has resulted in significant integration of protocols and procedures related to domestic violence into various healthcare settings. In 1985, the American College of Obstetricians and Gynecologists became the first national medical organization to recognize and address the issue of domestic violence (Jones & Horan, 1997), and in 1991, the American Medical Association launched a campaign against family violence (Office for Victims of Crime, 1998). Although current practices and procedures for identifying, evaluating, and treating victims of domestic violence are not flawless, they provide an important foundation for the human trafficking field to learn from and build upon.

IV. PRACTICES AND PROCEDURES FOR MEDICAL PROFESSIONALS SERVING VICTIMS OF DOMESTIC VIOLENCE AND SEXUAL ASSAULT AND THEIR APPLICABILITY TO HUMAN TRAFFICKING

[1] A more complete discussion of the physical and mental health consequences of human trafficking can be found in Clawson, H. J., Dutch, N. M., & Williamson, E. (2008). *National symposium on the health needs of human trafficking: Background document.* Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Screenings

Domestic violence, like human trafficking, is considerably under reported in healthcare settings (Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999). One important tool for proper identification is comprehensive screening practices. Healthcare and social service providers working in the area of domestic violence generally agree that healthcare providers should employ universal screening for domestic violence. They note that while universal screening is recommended for all healthcare providers, it is particularly important for those working in primary care, urgent care, ob/gyn and family planning, mental health, and inpatient settings. (Family Violence Prevention Fund, 1999; Institute for Clinical Systems Improvement, 2006). Unlike many survivors of sexual assault, victims of human trafficking may not initially enter medical facilities as a direct result of their sexual assault due to their inability to access medical care during their captivity (Zimmerman et al., 2006); therefore, screening by medical providers in all healthcare settings is important to ensure proper identification and service provision.

A number of tools and guidelines currently are available to assist providers in identifying and interviewing both adult and juvenile victims of domestic violence and sexual assault. Some of these tools, such as the Family Violence Prevention Fund's suggested screening questions[2] and the American College of Emergency Physicians' guidelines for interviewing children[3] provide a good foundation from which to screen for domestic violence in general and could be modified to incorporate screening questions for human trafficking.

Guidelines for identifying victims of domestic violence note that, similar to human trafficking, victims can be men, women, transgender, or come from a variety of backgrounds and experiences (Institute for Clinical Systems Improvement, 2006). While some guidelines for domestic violence put the minimum age for screening at 14 (Family Violence Prevention Fund, 1999), healthcare providers should be aware that victims of human trafficking can be much younger; according to Estes and Weiner (2001) the average age of entry into prostitution in the United States is 12-14.

Guidelines for domestic violence screening suggest posting signs and literature to supplement routine screening and reinforce the healthcare setting as a safe place to seek assistance. They also recommend conducting all screenings in private settings away from perpetrators who may accompany victims to healthcare settings (Institute for Clinical Systems Improvement, 2006). These guidelines can be adopted for victims of human trafficking who may be accompanied by either male or female traffickers.

Examinations

A limited number of evidence-based clinical practices exist for the examination and treatment of victims of sexual assault. This is due, in large part, to the limited number of experimental or quasi-experimental studies evaluating current examination and treatment practices (Agency for Healthcare Research and Quality [AHRQ], 2003).

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[2] A complete list of screening questions can be found in Appendix B of Family Violence Prevention Fund. (1999, October). *Preventing domestic violence: Clinical guidelines on routine screening.* San Francisco, CA: Author.

[3] A complete list of screening questions can be found in American College of Emergency Physicians. (1999, June). *Evaluation and management of the sexually assaulted or sexually abused patient.* Dallas, TX: Author.

Despite significant efforts to standardize care for victims of domestic violence, protocols and standards for proper examination vary greatly across facilities and States, particularly in the following areas: comprehensiveness of standardized protocols, procedures, and rape testing kits; use of trained providers and expert consultants; quality of examination facilities and technology; and capacity for DNA and drug testing (AHRQ, 2003). One example of disparity in standards is the fact that some hospitals have special areas and/or separate facilities to examine victims of sexual assault and abuse. Some of these hospitals even have age-appropriate facilities for children, as well as clothing for victims whose clothing is removed for evidentiary processing (AHRQ, 2003). However, other hospitals lack a sufficient number of private examination rooms to ensure the privacy of all victims. Since a number of these protocols and standards affect all victims of sexual assault, they likely will affect victims of human trafficking.

While universal screening for domestic violence is recommended across the healthcare field, the majority of guidelines for examination of victims of domestic violence, family violence, and sexual assault focus on the importance of evidentiary examinations. During evidentiary examinations, healthcare providers assess the medical needs of victims while collecting evidence for law enforcement purposes (AHRQ, 2003; American College of Emergency Physicians, 1999). Evidentiary exams typically involve: attainment of a patient's medical history and description of the crime; assessment of psychological functioning; performance of a physical examination; collection, documentation, and preservation of evidence; collection of lab samples; treatment for medical needs; and referral for medical and psychological services (Littel, 2001). Further research is needed to determine the effectiveness of evidentiary examinations on victims of human trafficking, especially since it can often take significant time for victims of human trafficking to perceive that they are victims of a crime and trust someone enough to disclose their victimization.

Some protocols for evidentiary examinations, however, appear appropriate for victims of human trafficking. For example, it is recommended that victims of sexual assault be examined in a private room and by trained medical providers. Protocols also stress the importance of having a rape crisis advocate, medical health professional, social worker, or pastoral caregiver trained in crisis intervention present (American College of Emergency Physicians, 1999).

As with screening, a number of tools have been developed to assist with the evaluation of domestic violence and sexual assault. The Domestic Violence Survivor Assessment (DVSA) tool assists healthcare practitioners and patients in identifying psychological processing of the abuse as well as movement toward a violence-free life (Dienemann, Glass, Hanson, & Lunsford, 2007). This tool can be used for victims of sex trafficking whose relationship with their trafficker emulates that of intimate partner violence.

THE DVSA TOOL ASSESSES 12 PERSONAL AND RELATIONSHIP ISSUES COMMONLY FACED BY VICTIMS OF INTIMATE PARTNER VIOLENCE

1. Accessing help from friends, family, and organizations
2. Self-identity
3. Self-efficacy to be on one's own
4. Feelings and emotional response to abuse
5. Mental health, stress, depression, and PTSD
6. Seeking medical care for stress and injuries
7. Triggers of abusive incidents
8. Actions to manage partner abuse
9. Actions to seek legal sanctions
10. Attachment to the relationship
11. Views of the relationship and options
12. Managing loyalty to norms and own beliefs

Additionally, this and other tools can be modified for successful use with all victims who experienced sexual assault while they were trafficked.

Evidentiary exams should only take place after all emergency needs have been met, including appropriate protective action for victims who are actively homicidal or suicidal (American College of Emergency Physicians, 1999; Institute for Clinical Systems Improvement, 2006; Littel, 2001). The decision regarding whether to conduct an evidentiary exam is often based on State laws and whether law enforcement and prosecutors feel it will be useful in court; however, evidentiary exams are never to be conducted without the written consent of the patient. As with other medical procedures, evidentiary exams should never be done against a patient's will (Littel, 2001). Additionally, evidentiary examinations, as well as all medical and mental health examinations, should be based in culturally competent practices that respond to the cultural needs of the victim. Particular care should also be taken when conducting examinations on children (AHRQ, 2003). As previously mentioned, little is known regarding the effectiveness of evidentiary exams on victims of human trafficking; therefore, while guidelines for sexual assault and domestic violence can inform healthcare efforts related to human trafficking, further research is needed to assess their effectiveness with the trafficking victim population.

Sexual Assault Nurse Examiners

When not done by specialized trained professionals, evidentiary examinations can retraumatize victims (Littel, 2001). Recognizing this, the first Sexual Assault Nurse Examiner (SANE) program was established in 1977 to train registered nurses to specialize in forensic examination of sexual assault victims. By March 2001, SANE had grown to more than 400 programs (Ledray, 2001). This growth can be attributed, in part, to the fact that many physicians do not wish to examine victims of sexual assault because they feel they lack the specialized training required for evidentiary examinations (AHRQ, 2003; Littel, 2001).

The SANE program can be adapted for various regions and medical settings, including hospital-based and community-based settings (Littel, 2001). SANEs receive classroom and clinical training as well as certification on sexual assault (AHRQ, 2003; Littel, 2001). As part of their training, SANEs are taught the skills to provide assistance to patients from the initial evidence collection through prosecution (Littel, 2001). They are also trained to present forensic evidence at trial (Office for Victims of Crime, 1998). SANEs are not victim advocates; their training is in forensic examination of sexual assault. However, SANEs often collaborate with advocates to ensure that necessary crisis intervention, safety planning, and referrals are provided (Littel, 2001).

SANE and Human Trafficking

Most SANEs operate as members of a Sexual Assault Response Team (SART). SARTs utilize a multi-disciplinary approach, bringing together healthcare providers, law enforcement, prosecution, victim advocates, and public health organizations (AHRQ, 2003). SARTs oversee coordination of and collaboration among service providers as they relate to the initial response after a sexual assault. The goal is to ensure victim-centered service delivery and prevent revictimization (American College of Emergency Physicians, 1999; Littel, 2001). This model may be similarly beneficial for victims of human trafficking who also tend to be connected to multiple service providers, requiring a victim-centered service delivery approach. For example, members of SARTs could respond to cases of human trafficking through the same basic

guidelines that they use to respond to cases of other forms of sexual assault. Case managers on SARTs could familiarize themselves with the local community-based agencies serving this population and act as a liaison between these service providers and the SARTs, similarly to their coordination of service delivery for victims of domestic violence. Additionally, in communities that have specific law enforcement units focused on the crime of human trafficking, SARTs could invite representatives from these units to become members of the SARTs. While all SARTs follow basic unifying guidelines and principles, each is unique in its structure and composition; therefore, communities will need to asses the best way to integrate human trafficking into their current response system on an individual basis. Future research, however, can help to identify best practices for how SARTs can effectively integrate human trafficking into their service delivery models.

SANE programs and SART models have dramatically enhanced the services provided to victims of sexual assault in communities throughout the United States (AHRQ, 2003; Littel, 2001). SANE programs have proven to be so successful that the Office for Victims of Crime has facilitated replication of SANE programs by funding the creation of the *SANE Development and Operation Guide.* Additionally, a Web site has been developed where SANE/SART programs can register and receive assistance with analyzing their program data (Littel, 2001).

Documentation

A crucial component of evidentiary examinations is documentation. Written records are not only used to describe physical injuries but also to address the emotional impact of the abuse. Evidentiary examinations must document injuries in an accurate, comprehensive, and objective manner that can be submitted to a court of law. Written records should document the time between the abuse and the time the exam is conducted as well as describe the patient's demeanor. It is suggested that when working with victims of sexual assault patient's words should be set off in quotation marks; should not use phrases implying doubt, such as "patient alleges"; should only use medical terms rather than legal jargon; should not summarize the patient's report; and should not refer to the perpetrator of the abuse with terms that might be used by the patient, such as "my boyfriend." (American College of Emergency Physicians, 1999; Isaac & Enos, 2001). Written reports should always be supplemented by photographs documenting physical injuries and body maps identifying the extent and location of the injuries. When observations conflict with a patient's statement, healthcare providers should record reasons for the differences (Isaac & Enos, 2001). For example, if a patient's injuries are consistent with being struck by an object but the patient reports falling down stairs this should be recorded and medical providers should document the specific elements of the injury that are consistent with the impact of an object and inconsistent with a fall. The impact of such documentation techniques on legal cases involving human trafficking is still unknown; therefore, until this issue has been further explored, medical professionals are encouraged to consult local district attorney offices to determine the form of documentation that best protects the victims they work with.

In the case of children, it is valuable to document their chronological age as well as the developmental changes related to sexual maturing (American College of Emergency Physicians, 1999). [4] Since it may take years for a case of human trafficking to be heard in court, this

[4] According to the American College of Emergency Physicians (1999), this information should be recorded in the form of Tanner so that it is consistent and reproducible from one profession to another.

documentation will accurately inform the court of the child's age and development at the time of the violence or exploitation.

Protocols and procedures for evidentiary examinations tend to focus on sexual assault in which there is one perpetrator and/or one incidence of sexual assault. Victims of human trafficking, especially sex trafficking, have often been sexually assaulted multiple times by various perpetrators during their captivity. Additionally, one study conducted in the United States found that 28 percent of Russian women who were trafficked into the United States and 46 percent of U.S. citizens trafficked internally reported childhood incestuous sexual abuse (Raymond et al., 2002). Significant time may have elapsed between the time of childhood incest as well as the time of the assaults and the evidentiary examination, resulting in reduced physical ramifications of the assaults. Therefore, particular attention should be paid to documenting the statements of these patients and their accounts of the assaults.

Proper training is essential since documentation often plays such an important role in ensuring that patients receive appropriate and effective medical services. Factual information obtained in evidentiary exams may qualify victims for special status or exemptions in obtaining public housing, welfare, health and life insurance, victim compensation, and/or immigration relief. Additionally, documentation also plays a critical role in criminal proceedings. Medical providers who are not trained in proper documentation may actually hinder victims' cases by trying to remain neutral and unintentionally using language that subverts the case (Isaac & Enos, 2001).

Informed Consent

Informed consent is imperative for treating sexual assault victims. Allowing victims to make informed decisions regarding their care can be an empowering first step toward recovery. Informed consent should be obtained prior to each component of an evidentiary examination: physical examination, medical treatment, evidence collection, and photodocumentation. Additionally, informed consent should be obtained before reporting the crime to law enforcement and transfer of evidence. In cases regarding children, local and State law should be consulted to assess the need for parental consent (American College of Emergency Physicians, 1999). With youth and children, attaining patient consent can give the same important sense of empowerment that consent can provide for adults.

Medical records for evidentiary examinations should be kept separate from patients' other medical records to ensure limited access by authorized personnel (American College of Emergency Physicians, 1999). Findings from evidentiary examinations are only released to law enforcement when victims provide consent or when it is mandated by law (AHRQ, 2003; American College of Emergency Physicians, 1999). While all States have laws regarding mandatory reporting of child abuse, States vary with regard to reporting sexual assault (American College of Emergency Physicians, 1999). Healthcare providers should be well versed regarding laws related to mandatory reporting of sexual assault in their jurisdiction. In cases where victims are uncertain whether they want to file a police report, evidence can be collected and maintained per State statutes without being shared with law enforcement (Littel, 2001).

Coverage

While all 50 States and the District of Columbia have victim compensation programs to cover the cost of emergency medical assistance not covered by private insurers or other medical benefits (Office for Victims of Crime, 1998), many States have also passed specific laws protecting victims from having to pay for medical evidentiary examinations (AHRQ, 2003). Some of these State laws limit coverage to victims who are willing to file a police report and/or cooperate in prosecution, while other States provide coverage to all victims regardless of any decision pertaining to prosecution (AHRQ, 2003; Office for Victims of Crime, 1998). Despite laws protecting victims' anonymity and mandating that victims not be charged for the cost of evidentiary exams, cases have been reported where claims have been submitted to third-party insurance companies, breaching victims' rights to privacy. In some of these cases, victims who were not the primary insurance holders have been forced to disclose the assault to the primary persons covered. Additionally, numerous studies have found reports of victims being directly billed for evidentiary exams despite laws explicitly prohibiting this practice (AHRQ, 2003). Healthcare workers and facilities serving victims of human trafficking should familiarize themselves with local and State laws pertaining to coverage for victims of sexual assault to ensure compliance and assess applicability to victims of human trafficking.

V. THE IMPORTANCE OF TRAINING

All healthcare providers and non-healthcare providers working in healthcare settings should be trained in proper screening techniques for victims of human trafficking as well as domestic violence. Despite the need for training, a dearth of knowledge exists regarding how many healthcare practitioners have been trained to accurately identify, examine, and treat victims of domestic violence and sexual assault (AHRQ, 2003). For example, one study found that while 88 percent of physicians acknowledged having female patients who were victims of abuse, only 6 percent routinely asked their patients about possible domestic violence (Elliott, Nerney, Jones, & Friedmann, 2002).

Healthcare providers report not screening for domestic violence because they feel that they do not possess the necessary training, time, skills, and resources to care for victims (Elliott et al., 2002). In another study, more than 25 percent of physicians and almost 50 percent of nurses and medical assistants reported not having any confidence in their ability to screen for physical abuse. This same study found that only 23.9 percent of physicians, nurses, and medical assistants felt that they possessed strategies to assist victims of domestic violence (Sugg et al., 1999). Lack of training results in misconceptions among healthcare providers, hindering identification of and service provision to victims (Institute for Clinical Systems Improvement, 2006). Without proper training on human trafficking and other forms of violence, abuse and exploitation, erroneous beliefs regarding this population of victims are likely to be perpetuated as well.

Training Content

The goals of training on domestic violence, sexual assault, and human trafficking should center on increasing awareness about the problems and the internal and external resources available to support comprehensive service delivery. While, most training programs offer a broad overview of sexual assault and/or domestic violence focused on identification, management, and referral of victims (AHRQ, 2003), training should also teach skills and identify barriers to identification and

treatment (Institute for Clinical Systems Improvement, 2006). Skill development is especially important in terms of interview techniques, safety assessment, and documentation. Similarly, training on human trafficking must offer healthcare providers and others in the healthcare field information and practical skills that can be used to identify, assess, and treat victims of human trafficking.

Training for healthcare providers on evidentiary examinations is required to ensure exams are conducted correctly and with rigor that will stand up in a court of law. The growing number of programs and training in forensic science can be credited to expanded State reporting requirements. A few States, such as Alaska, California, Florida, Iowa, Kentucky, and New York, have established mandatory education requirements for healthcare professionals on intimate partner violence, child abuse, and/or sexual assault. But most of these requirements focus on reporting incidents as opposed to enhancing clinical skills (AHRQ, 2003). Current training programs on related issues can be evaluated to assess the potential of incorporating the issue of human trafficking into training programs already focused on domestic violence, intimate partner violence, and child abuse. Such evaluation can provide a platform to compare and contrast different forms of sexual and physical violence while reducing redundancy in training.

There has been little examination of current trainings on domestic violence and sexual assault to assess their content, duration, and scientific basis (AHRQ, 2003). However, one study found that training physicians in identification and treatment of domestic violence increased their screening from 3.5 percent to 20.5 percent. (Thompson et al., 2000). Further assessment of domestic violence and sexual assault trainings is imperative to understand their impact on identifying and treating victims of domestic violence as well as the expected success of incorporating human trafficking.

The Role of Academic Programs, Hospitals, and Medical Associations

One way to ensure successful training of healthcare professionals is to integrate sexual assault, domestic violence, and human trafficking curricula into university and other educational programs. While some programs currently provide a broad overview on the issues of sexual assault and domestic violence, only a few university-based healthcare training programs integrate content on performing medical evidentiary examinations. Additionally, the International Organization on Migration concluded that the programs that do exist are often inadequate (IOM, 2006). To improve university-based training, the Health Resources and Services Administration and other agencies within the U.S. Department of Health and Human Services have begun collaborating with nursing schools to develop and implement improved curricula on issues related to violence against women (AHRQ, 2003).

In 1982, the President's Task Force on Victims of Crime recommended that all hospitals implement the following: provide training to all hospital personnel sensitizing them to the needs of victims of violent crimes, especially victims who have been sexually assaulted; offer emergency medical assistance to victims of violent crime regardless of their ability to pay; provide emergency room crisis counseling; develop relationships with all victim assistance and social service agencies in their communities; and work with prosecutors to develop a standardized rape kit (Office for Victims of Crime, 1998).

The Joint Commission on Accreditation of Healthcare Organizations, a nonprofit organization that evaluates and accredits more than 17,000 hospitals, healthcare networks, and other healthcare organizations in the United States, has adopted guidelines requiring that member hospitals and organizations have objective criteria for identifying victims of physical assault, sexual assault, domestic violence, and abuse of elders and children. Members must train staff on identification and maintain a list of referral organizations that provide assessments and care for victims (AHRQ, 2003). In an attempt to standardize care, the Delphi Instrument for Hospital-based Domestic Violence Programs features 37 performance measures in nine categories and assesses the program's physical structure as well as the provider's process of care (Kass-Bartelmes & Rutherford, 2004). This tool provides a solid foundation for development of a similar tool for human trafficking.

Several professional organizations and accreditation bodies have developed clinical protocols, policies, professional standards, training materials, and courses related to domestic violence and/or sexual assault. These professional organizations include the American College of Obstetricians and Gynecologists, American Medical Association, American College of Emergency Physicians, American Professional Society on the Abuse of Children, and the Centers for Disease Control and Prevention. The National Health Initiative on Domestic Violence, through the Family Violence Prevention Fund, developed a training program that has been used in more than 100 hospitals (Office for Victims of Crime, 1998). In 2003, AHRQ identified 72 unique sexual assault training programs, policy statements, and protocols related to healthcare providers and practices. By incorporating human trafficking into these training programs, healthcare providers can learn about the similarities and differences in identifying, examining, and treating victims of human trafficking when compared to victims of other forms of sexual assault. Additionally, the healthcare providers who attend these trainings are the same healthcare providers who would benefit from training on human trafficking. Providers who see victims of domestic violence and sexual assault are often also serving victims of human trafficking regardless of whether or not they are aware of this; training them to recognize and treat the specific needs of human trafficking victims is a critical step to effective care for this population.

Current Training on Human Trafficking Aimed at Healthcare Professionals

The majority of trainings designed to educate medical professionals on human trafficking provide a broad overview of the issue and its proper identification. The Rescue and Restore Campaign in conjunction with the National Human Trafficking Resource Center offers toolkits, phone consultations, and in-person trainings for healthcare practitioners to improve their understanding and identification of human trafficking. The Christian Medical & Dental Association also offers an online introduction to human trafficking course for which medical professionals can receive continuing education credits. In addition to these nationally recognized training programs, other anti-trafficking organizations provide trainings to healthcare professionals.

As with sexual assault and domestic violence, more targeted training is needed to enhance skills and recognize barriers to identification and treatment. According to service providers working with victims of human trafficking, the shortage of this targeted training may be due, in part, to the limited number of qualified medical professional trainers available (Williamson, Dutch, & Clawson, 2008).

VI. CONCLUSION

While further research and evaluation is needed to specifically identify how healthcare procedures and protocols that currently exist for assessing and treating victims of domestic violence and sexual assault can be used to support victims of human trafficking, given the similar trauma experienced by these populations, these procedures and protocols currently serve as the best foundation on which to begin to identify successful ways of working with victims of human trafficking within healthcare settings. Given the serious and often co-morbid medical and mental health consequences of human trafficking, it is imperative that the healthcare industry begin to establish comprehensive protocols and procedures to adequately care for this population. By building on the accomplishments of and lessons learned from the domestic violence field, important advances can be made to improve proper identification and provide appropriate services for victims of human trafficking.

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