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Ceasar, Danial. 2019. Intersections of Human Trafficking and the Opioid Epidemic, and Barriers to Data Collection in Human Trafficking. Doctoral dissertation, Harvard Medical School.

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Scholarly Report submitted in partial fulfillment of the MD Degree at Harvard Medical School

Date: 27 January 2019

Student Name: Danial Ceasar

Scholarly Report Title: Intersections of Human Trafficking and the Opioid Epidemic, and Barriers to Human Trafficking Data Collection

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Abstract for Appendix I

TITLE: Human Trafficking and the Opioid Epidemic: Quelling a Growing Problem
Hanni Stoklosa, MD, Danial Ceasar
Purpose: To further elucidate the contributors to the intersection between human trafficking and the opioid epidemic, discuss the barriers to providing aid to this specific population, and create recommendations for best steps forward in both coming to full understanding of the scope as well as enabling practitioners to address the needs of these patients effectively.
Methods: A literature search was conducted by standard means to understand the current state of the field. Phone interviewers were then conducted with current experts in the field and the interviews were analyzed via thematic content analysis. Conclusions were drawn based on broad themes identified across interviews.
Results: Broad themes in this intersection fit into 3 main categories- Intentional Perpetrator Patterns of Behavior (IPPB), Systemic Societal & Medical Barriers (SSMB), and Long-Term Barriers to Treatment (LTBT). Intentional Perpetrator Patterns of Behavior included targeting vulnerable peoples, promising drugs to addicted peoples, threatening victims with withdrawal, exploiting chronic pain disorders, and sabotaging recovery efforts among others. Systemic Barriers included possible entrapment by legal policies regarding immigration and child services, difficulty rapport building, and lack of ubiquitous trauma-informed approaches to care. Long-Term Barriers include ineffective identification of coping mechanisms and inability to permanently extricate victims from high-risk, familiar environments.
Conclusions: In order to properly treat this patient population in an effective and durable manner, identifying and traversing each barrier is necessary. Solutions to this problem must be comprehensive in approach both in any given clinic and from a clinic to governmental standpoint. Effective treatment mechanisms and plans have been identified in small clinics, but must be better funded, popularized, and adopted widely. This should occur in conjunction with pushes for research on the interventions of these clinics and strong policy reform to minimalize the penalties that have historically been given to these victims.

Abstract for Appendix II

TITLE: The Role of U.S. State and Territorial Health Organizations in Human Trafficking Data Collection and Other Activities (Working Title)
Susie Baldwin, MD, MPH; Brian Willis, JD, MPH, Maggie Carlin (ASTHO), Danial Ceasar
Purpose: To better elucidate the role of public health entities and the barriers faced in data collection on Human Trafficking
Methods: A survey was sent to all 59 members of the Association of State and Territorial Health Organizations (ASTHO). The survey was created by the primary authors of the paper through a collaborative process and both quantitative and qualitative questions. The data was then collected and analyzed.
Results: Almost half (48%) of the organizations that participated in the study reported that they had no plans of doing data collection in HT at the time of the survey. Many reported that it was the responsibility of other agencies. Other barriers implicated in the results were funding and lack of personnel to carry out the task of data collection.
Conclusion: The baseline data collection of many public health institutions in the country does not begin to address the need of human trafficking. Because of this, there is a lack of data on the scope of the problem and this creates a barrier within itself to good, evidence-based treatment strategies and action plans. In order to create more robust responses nationwide, both the medical and public health sectors must push for better data collection rather than deferring responsibility to other agencies.

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Glossary of Abbreviations

Human Trafficking: HT

Intentional Perpetrator Patterns of Behavior: IPPB

Systemic Societal & Medical Barriers: SSMB

Long-Term Barriers to Treatment: LTBT

U.S. Trafficking Victims Protection Act: TVPA

Labor Trafficking: LT

Sex Trafficking: ST

Association of State and Territorial Health Organizations: ASTHO

Faith-Based Organizations: FBO

Non-Governmental Organizations: NGO

Commercial Sexual Exploitation: CSE

International Classification of Disease: ICD

Office of Crime Victims Advocacy: OCVA

Statement of Questions and Description of Work:

For my scholarly project, I have addressed questions related to Human Trafficking. My goal was to gather data related to a significant public health epidemic while also learning about a phenomenon that disproportionately affects women. In pursuing this work, I came across two important questions that I set out to answer over the course of my project. The first question is, "How does the Opioid Epidemic- a growing concern in the northeastern states- impact human trafficking and what could/should be done to address the specific population of people affects by both human trafficking and opioids?" In the pursuit of answering the first question, a second poignant question presented itself organically. There is a current dearth of data surrounding Human Trafficking although the problem is recognized as both a national and international crisis. The second question was simply, "Why?...What are the major barriers to gathering data in Human Trafficking? How can we identify and breakdown these barriers to better create paths forward to addressing the issue broadly?" Given this, for my scholarly work I am putting forth two papers and their associated abstracts.

Manuscript #1

The first paper, entitled "Human Trafficking and the Opioid Epidemic: Quelling a Growing Problem," is meant to provide one step forward in creating consensus in how we best affect change in the arena of human trafficking. Although the overarching goal is ending human suffering through the creation of effective treatment methods, as the field currently is, there is a lack of robust collaboration across facilities, counties, states, and certainly countries. Moreover, there is no evidence-based approach to the care of victims in this particular intersection. Much of this is based in the historic handling of human trafficking as well as current public policy differences between states and between countries. In order to create momentum, all invested parties must have one unifying plan to push the agenda forward. This work contributes to that push forward.

This work is meant to be used as a stepping stone to research in the interventions that currently have only anecdotal evidence of working. My hope is that I will be able to continue to work on this in residency and/or pass along what I've done and various ideas for future projects to a more junior medical student so that they can seek out further collaboration with clinics who can easily create interventions and study them. Works such as those can then contribute to a body of literature that pushes toward better funding and policy change to further affect the state of the field.

Description of Work

Under the mentorship of Dr. Hanni Stoklosa, I aided in bringing the current version of the manuscript for this paper to fruition. Upon initiation of the project, Dr. Stoklosa tasked me with thinking

of this intersection. From there, I added to the concept by planning to gather expert consensus. I then set up phone calls with various experts, analyze the content of the interviews, and incorporated that content into the current product. My role was to flesh out some of the ideas and methods of how to best create recommendations solidly based in consensus of the current field. The work was written according to publication guidelines, as a perspective piece. I, then, with the guidance of Dr. Stoklosa, revised the section on "Intersections of the Opioid Epidemic and Human Trafficking", and added the sections "Complications in Treatment of Intersecting Conditions", "Combatting the Complexities", and "Next Steps Forward" using the data I'd collected.

Brief Overview of Research Area

Human Trafficking is defined by The US Trafficking Victims Protection Act (TVPA) of 2000 as, "(A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or (B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. A 2017 estimate from the ILO states that 40 million people are victims of human trafficking- with 25 million of those being victims of forced labor and the other 15 million being victims of forced sex trafficking and marriage but these estimates of prevalence are hampered by limited ability to detect victims and differences in public policy in various arenas.

The opioid epidemic is a large problem that the medical profession has had to contend with in recent decades. The source is multifactorial with contributions from over-prescribing of medications and influxes in street drug sales across the nation. This problem is well recognized and under much scrutiny, but there is a blind spot in how the opioid epidemic impacts victims of human trafficking in the policy arena and in the practices of various medical agencies across the country and world.

<u>Manuscript #2</u>

The second paper, "The Role of U.S. State and Territorial Health Organizations in Human Trafficking Data Collection and Other Activities," began as an adjunct to my first project because of the dearth of data I'd noticed through my work. In this work, which was focused on highlighting the barriers to data collection in Human Trafficking from a public health perspective, I served as a secondary data analyzer/editor. Though this was not the focus of my primary scholarly project, it was significantly related to the work that I was doing, and I devoted a substantial amount of time to this work as well.

Description of Work

For this project, I was called in to assist with the data analysis and summarization of the data in the manuscript. I assisted with presentation of the figures to best represent the data in an understandable fashion. Also, with the direction of Dr. Baldwin, I significantly aided with the synthesis of the discussion and conclusion sections of this manuscript. Succinctly, my contributions to the work can be found in the Results, Discussion, and Conclusions of this paper because the original data gathering had concluded before I became involved with the project.

Short Overview of Research Area

For the majority of time since it's recognition as an issue, Human Trafficking has been conceived as a criminal justice problem. From this framework, victims of human trafficking have been punished for their "crimes" of "prostitution" rather than recognized as victims of abuse and trauma. This has created large issues in the overall treatment of victims, the stigma associated with their particular predicament, and has stopped many victims from seeking help when needed.

Modernly, the criminal justice framework has shifted its purview toward the traffickers, but this still has not led to proper response for the victims of trafficking. Because of this, specific efforts have been made to shift human trafficking from a criminal justice issue to a public health concern. This will allow for the proper creation of policies meant to dismantle human trafficking. But although this shift has been happening for almost two decades, little has been done to create specific top-down interventions and policies at a state level. This lack of progress is explained by a lack of data on the scope of the issue and proper description of who is most affected. Understanding the barriers to data collection at the state must first be done to further break down those barriers and create gather robust data in the field.

Appendix I:

Manuscript 1-
Human Trafficking and the Opioid Epidemic: Quelling a Growing Problem

Scope and Definition of the Opioid Crisis

Opioid substance use disorder has reached epidemic proportions in the United States.[1] An estimated eleven-million people in the U.S. have a substance use disorder involving prescription or illicit opioids.[2] Woman have higher rates of non-medical use of prescription opioids than men, specifically woman between the ages of 12 – 17 years of age.[3] Sexual identity can also play a role in substance use disorder as those who identify as gay, lesbian, bisexual or transgender are more likely to suffer from substance use disorder.[4] The importance of this is that these groups tend to be the most vulnerable as targets for sex trafficking. [5,6] The underlying reasons for this are multifactorial and includes the mechanisms by which traffickers recruit victims as well as some of the vulnerabilities of victims including not just substance use disorder but also poverty, homelessness, and isolation. There is an intersection between the opioid epidemic and human trafficking and understanding this issue will serve to improve recognition, recovery and treatment.

The Intersection of the Opioid Epidemic and Human Trafficking

Federal law defines sex trafficking as the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age (*22 USC § 7102*). Approximately 18,000 people are trafficked in the United States annually, and this is likely a conservative estimate.[7] Eighty-percent of trafficked individuals are engaged in sex trafficking although labor trafficking remains an important issue as well. Females account for almost 80% of individuals involved in sex-trafficking, with half of these cases involving minor children.[8] The average age for females at entry into sex-trafficking is 12-14 years old. These victims are often recruited through on-line dating sites or other on-line sites. Homeless persons, marginalized individuals, single parents and those with substance abuse are also potential targets of sex-traffickers. Sex trafficking occurs primarily through on-line adds but also includes illicit massage parlors, strip clubs, bars and in brothels.

Traffickers target vulnerable people to exploit. People with substance use disorder are the ideal victims because traffickers can easily use drugs as a way to lure them into the trade and leverage their addiction to keep them controlled. Traffickers use the desperation that accompanies addiction to their advantage by promising a steady stream of drugs or threatening victims with the possibility of withdrawal. Some common mechanisms employed by traffickers include recruiting victims from substance use treatment centers, exploiting physical injuries and pain management needs, sabotaging efforts towards recovery, or using drugs and trafficking history against a victim to discourage seeking help. As a result, opioid use disorder and sex trafficking have become intertwined. Although actual figures are difficult to assess, one report by Polaris identified that there had been over 2,000 calls from woman who were both engaged in

sex-trafficking and had an opioid substance use disorder, and this is likely to be a very conservative figure.[9]

Complications in Treatment of Intersecting Conditions

This intersection is not only caused by perpetrators of trafficking, but also perpetuated by systems on a societal level. Many victims of trafficking who also have substance use disorder fear entrapment by the legal system, immigration policy, child welfare services, or other agencies that seek the best interest of children or the state.[10] This fear in concert with the stigma associated with both of these conditions creates strong disincentive to seeking help.

Even after initiating contact with the healthcare system, there still exists many barriers to optimal long-lasting care. In clinic, traversing cultural differences and the stigma associated with trafficking hampers opportunities for building rapport and disclosing trafficking. Overcoming mistrust in the medical system is a problem faced by survivors of trafficking and those with substance use disorder separately. Those two issues in concert could heighten the possibility for mistrust.[11] Moreover, examinations, tone, and word-choice during intake visits can also be a barrier to care in the clinic as they can both re-traumatize survivors or de-incentivize them from coming back to other providers in the future. Minimizing these barriers requires healthcare providers to be well-versed with the recognition and treatment of patients who suffer from trafficking and substance use disorder.

Long-term care for these patients faces a different set of complications- many of which stem from the fact that there are many reasons why patients use. One example of why some survivors use is because substances offer them connection to someone they use with. For some, this connection may be one of few relationships they have and giving that up could be incredibly difficult. Others use for pain management or to cope with past trauma.[12] Therefore, other coping mechanisms must be found in order to get successful treatment. Others are constantly in the environments where people use and face constant implicit and explicit pressure to use. The same vulnerabilities that pulled some survivors into substance use are the same that keep them from recovery.

Combatting the Complexities

Creating solutions for victims at this intersection requires comprehensive and collaborative approaches both inside the hospital and at all adjunct facilities. In addressing the barriers to identification of victims, all healthcare providers trained to work in acute/urgent evaluation centers need to be well-versed in trauma-informed practices to properly build rapport, address the problem sought by the patient, and attain disclosure. Moreover, these same providers need to be well-versed in the services that can be called upon to help each victim in their unique circumstance.

Victims at this intersection also require wrap-around services and frequent follow-up to combat the possibility of retaliation or coercion from their traffickers. Wrap-around services can most frequently be achieved through strong partnership between hospitals and community facilities dedicated to the care of survivors of sexual assault and trafficking. While these partnerships are most often championed by social

workers at hospitals, there is room for more frequent and robust relationships to be made in order to facilitate better patient care.

Proper treatment of patients at this intersection also requires complex understanding of the myriad of social, mental, and physical conditions that interplay. Proper communication between community agencies and health systems can work to combat the physical and mental components, but broader funding for community agencies also must be pushed for in order to facilitate change for the social component of patients. Housing services, access to public benefits, job trainings, and support groups lie at the core of services that would maximize benefit to patients.

Next Steps Forward

Although there are a myriad of challenges, some organizations have found ways to operationalize solutions. Centers in Maine collaborate with hospitals and offer intensive case management to care for the many needs of trafficking survivors. Others employ survivor-led support groups to build good relationships and coping strategies for the future. Next steps in combatting this intersection include expanding successful and impactful work done at these local agencies by increasing funding to these organizations and conducting research on their interventions so that other agencies can implement these strategies. Furthermore, creating robust partnerships with hospitals in high-impact areas while also increasing education on identification of victims can increase the pipeline from identification to successful treatment.

All of this should also come in parallel to continued pushes for stronger policy reform on the issue of human trafficking and substance use disorder. Policies in immigration, child welfare, and criminal justice must continue to be re-evaluated to ensure justice for survivors of human trafficking. Similarly, housing policy and policy on public resources can continue to be improved to further ensure that patients who exist at this intersection recover to lead better lives.

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Appendix II

Manuscript #2:
The Role of U.S. State and Territorial Health Organizations in Human Trafficking Data Collection and Other Activities

Susie Baldwin, MD, MPH; Brian Willis, JD, MPH, Maggie Carlin (ASTHO), Danial Ceasar

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LAC/HEAL Trafficking
Global Health Promise
Association of State and Territorial Health Organizations

Acknowledgements
Katie Sellers DrPH
Allison Mendoza Waters

Introduction

Since the passage of the United Nations Palermo Protocol and the U.S. Trafficking Victims Protection Act (TVPA) in 2000,[1] which codified the crime of human trafficking (HT) into international and U.S. law, respectively, approaches to HT largely have been rooted in a criminal justice framework. The criminal justice system focuses on the identification, capture, and successful prosecution of traffickers, relying primarily on the threat of criminal sanctions as a deterrent.[2]

A public health paradigm for HT, on the other hand, recognizes that HT results from modifiable policies and often-preventable human behaviors. HT negatively impacts individuals, families, and communities, requiring prevention and intervention strategies for each of these levels of society, as well as through laws and policies.[3] Given that available metrics suggest that the criminal justice approach to HT has yielded limited success, a public health approach to mitigating and eliminating HT through multi-disciplinary, collaborative, evidence-based approaches is warranted. [2,4,5,6]

In the public health approach, the first step toward development and implementation of effective policies and programs involves assessment of a problem, including identifying its scope, where it is occurring, and which populations are affected. [7,8] While such data on HT are notoriously difficult to collect, given the diversity of trafficking operations, the inherently hidden nature of the crime, and the reluctance of victims to come forward,[9] it is well established that victims of human trafficking commonly interact with health care providers. Victims of HT may also interface with other public health specialists including disease investigation specialists, environmental health investigators, health education and outreach workers, and needle exchange program staff. However, eighteen years since HT was recognized as a federal crime, little is known about the extent of HT data collection by public health entities, or how public health programs address the issue. Indeed, more has been done regarding sex trafficking (ST) rather than labor trafficking (LT)- two specific entities under the human trafficking umbrella, but much work is still left to do for both.

Currently, most data collection around HT reflects priorities of law enforcement and the criminal justice system. Data on victims and perpetrators are inherently limited to cases identified through arrest and advanced to prosecution, with limited data sharing to other agencies and the public. Public health data collection, on the other hand, encompasses myriad social, economic, and health-related factors, which

can illuminate foundational information about HT, and provide multidisciplinary stakeholders understanding essential to improving response and expand prevention efforts. In addition, public health data are increasingly transparent for stakeholders and the public through websites, query systems, and reports.

To establish a baseline snapshot of the role of public health entities in HT data collection, the barriers they face in obtaining such data, and their work in other HT-related other activities, this study employed a cross-sectional survey of select public health leadership in the U.S. and closely aligned jurisdictions.

Methods

Three organizations, the Association of State and Territorial Health Organizations (ASTHO), Global Health Promise, and HEAL Trafficking partnered to plan and execute the survey, analyze the data, and disseminate results. ASTHO membership includes the top-level health official in the 50 states, Washington DC, 5 territories (US Virgin Islands, Puerto Rico, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands), and 3 freely-associated states (the Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands). ASTHO tracks, evaluates, and advises members on the impact and formation of public or private health policies and provides guidance and technical assistance to improve the nation's health. Global Health Promise is dedicated to assisting mothers and their children worldwide who are trafficked or in sex work, through research, service, and advocacy. HEAL Trafficking (HEAL) represents multidisciplinary professionals, most working in the health sector, who aim to shift the anti-trafficking paradigm toward trauma-informed, survivor-centered approaches rooted in public health. HEAL works through advocacy, direct services, education and training, protocol development, and research.

The authors developed the survey through a collaborative process. The instrument incorporated both quantitative metrics and open-ended, qualitative questions. ASTHO electronically mailed an invitation to participate in the survey, along with a link to a Qualtrics ™ (Provo, UT) questionnaire to each of its 59 members, initially on July 24, 2015. Reminder emails were sent twice during the month of August 2015. Study enrollment and data collection both ended on August 28, 2015.

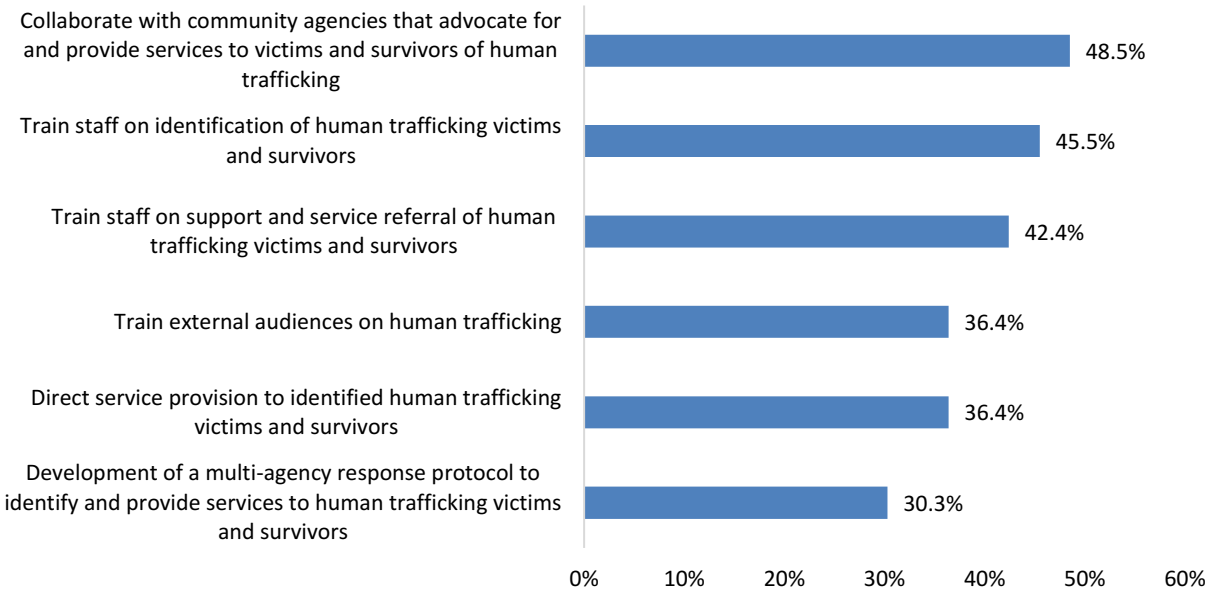
In total, thirty-three health officials in thirty-two U.S. states and one U.S. territory responded, representing a response rate of 55.9%. These agencies provided their name and jurisdiction and completed at least 50% of the survey items.

Results

Activities Related to Human Trafficking:

Health officials reported that their agencies were currently engaged in several types of activities related to HT (Figure 1).

Figure 1. State/Territorial Health Agency Activities Related to Human Trafficking (n=33)*



Note: Respondents were able to provide multiple responses.

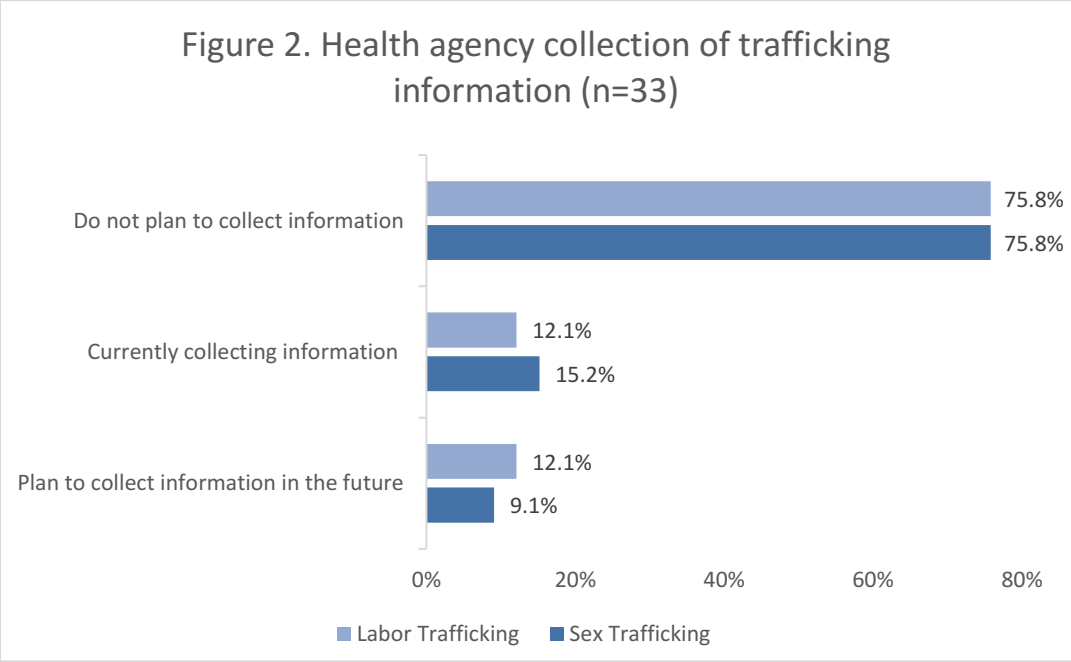
Reflecting the multi-sectorial nature of public health work, almost half of responding health officials reported that their department engaged in collaboration with community agencies that advocate for and provide services to victims/survivors of HT (48.5%, n=16). They described partnerships with a variety of public and community agencies including children's services (for home-based services), faith based organizations (FBOs) for education and post-intervention support, HIV prevention and services providers, juvenile justice system for screening, non-governmental organizations (NGOs), reproductive health providers, school nurses, shelters, sexually transmitted infection testing programs, and tribal organizations for health care access. One state/territory stated that they work with funded agencies to ensure that relevant staff receive training and that community agencies are collaborating.

Nearly 46% (n=15) of agencies trained staff on identification of victims/ survivors, while 36% trained external audiences (n=12). Thirty seven percent (n=12) of agencies described the direct services they provide to HT victims/survivors. These included testing for sexually transmitted infections (mentioned by 5 agencies); refugee health assessment (mentioned by 5); immunizations (mentioned by 4); family planning services (mentioned by 3); health screenings/assessment (mentioned by 2); primary care (mentioned by 1); interpretation services (mentioned by 1); "other social services" (mentioned by 1). One jurisdiction described a wide range of services provided by grantees in certain parts of the state to commercially sexually exploited minors, including advocacy, mental health screening and treatment, legal services, case management, aftercare, and "some culturally specific services."

Thirty percent of responding health officials (n=10) stated that their agency was engaged in developing a multi-sector response protocol to identify and provide services to victims/survivors. Multiple health agencies described membership in a human trafficking task force made up of various government agencies including law, public safety, education, juvenile justice, and child and family services agencies.

Primarily, the role of these task forces was to disseminate information to aid in the identification of trafficking victims and to make recommendations to lawmakers on effective strategies to curb the rate of human trafficking. Additionally, health officials described protocols requiring collaboration between law enforcement agencies and social service agencies such that as soon as law enforcement identified a human trafficking event, social services agencies were notified to offer victim assistance.

Data Collection on Human Trafficking



Health officials noted that Information was collected to inform service impact, to improve access and quality of medical and mental health services, and to identify criminal trends and inform law and policymakers.

Data Collection on Human Trafficking: Sex Trafficking

Over three quarters of responding health officials (75.8%; n=25) reported that their health agency did not collect information on sex trafficking and did not have plans to start collecting such data; 15.2% (n= 5) reported that their health agency currently collected information on sex trafficking (Figure 2). Those who collected information on sex trafficking (n=5) reported that this information started to be collected as early as 2013.

Sex trafficking-related data collected included information on the individuals for which their programs provided care, including the number of victims, demographics, and the type of sexual exploitation experienced. Additionally, health agencies described the collection of data on mental and medical health services available in their jurisdiction, the type of services requested, and the type of services provided to victims of sex trafficking. Some health officials described only data collection related to the trafficking of minors. One described their clinic intake form as collecting data on whether patient has been physically hurt, insulted, or threatened; been touched sexually against their will or consent; or been forced to do work they do not want to do. That state noted that to date these data were used only for individual patient assessment, not in aggregate.

One health official reported comprehensive data collection around the issue of sex trafficking. Such data were collected through the state's Safe Harbor programs, which serve minors experiencing commercial sexual exploitation (CSE), and through the state's Department of Health. Individual, non-identifying data collected from minor CSE include demographics (age, gender, race/ethnicity), what type of CSE they experienced (engaging in survival sex or trafficked by third party), involvement in child protection services, social supports or lack thereof, frequency of medical visits, mental health issues, enrollment in school, employment, and whether the minors have children. The state also collects data on services requested, services provided, and referrals made by service providers, and tracks ineligible referrals and reason for ineligibility (referrals for labor trafficking or adult victims of sex trafficking).

Most health officials, however, indicated that data collection on sex trafficking was the responsibility of other agencies, including the Department of Human Services, the Department of Child and Families, the Office of the Attorney General, the Department of Labor, the Cabinet for Health and Family Services within the Department of Community Based Services, human trafficking health advisory boards, and clinicians.

Data Collection on Human Trafficking: Labor Trafficking

Over three quarters of responding health officials (75.8%; n=25) reported that their health agency did not collect information on labor trafficking (LT) and did not have plans to start collecting such data; 12.1% (n=4) reported that their health agency currently collected information on labor trafficking (Figure 2). Three additional jurisdictions reported that they plan to start collecting information about LT within 12 months. One state/territory plans to collect data in 12 months or further into the future.

State officials provided minimal information about the mechanism for gathering LT data but included collecting data via certain programs, such as Refugee Health Assessment Program, and clinic intake/assessment forms.

One agency reported that it collects information on the total number of human trafficking (HT) victims seen in the Refugee Health Program, while another collects information on "total number of child human trafficking victims." A third, through its Human Trafficking Health Advisory Board, collects information concerning medical and mental health services available to survivors of HT in the state in order to improve access to and quality of care, and improve the public's, providers', and victims' awareness of available medical and mental health services.

Two states noted that their LT data collection is performed by agencies other than health/public health, in one case by the child and family services division, and in another by the state Department of Labor. Almost half of the health organizations (48%) that responded noted that they were not interested in HT data collection at this time. Among those who were interested, 38% noted that personnel and funding were barriers, while 24% replied that they were unsure where to collect data. Thirty one percent of health jurisdictions cited an "other" reason for not collecting HT data. The most commonly cited "other" reason described (33%) was that another state agency has jurisdiction.

"Other" barriers to data collection on HT
as described by agencies who are interested in collecting data

- Law Enforcement collects data on human trafficking offenses. We would not want to duplicate efforts, but collaborate.
- Lack of awareness or denial of the problem
- Need to learn more about labor trafficking
- Timing issues in getting questions added to reports
- Hard to collect data on this population
- Have discussed collecting data however we do not have funding and even if we did we are not sure what we would do with the data beyond training our agencies which we are already doing.
- The Department of Health Services wants to be aligned with initiatives as defined by the Human Trafficking Council. Current collection practices do not align well with being able to use existing data sources to separate out data pertinent to human trafficking. The development of data collection would require a strategy that aligns with the Council's work, systems to collect the data, requirements to compel the reporting, personnel to support data collection and reporting, and the funding necessary to do all of these activities.

Discussion

Overview

State and territorial health agencies have engaged in varying levels of human trafficking data collection- highlighting the role that these agencies have in documenting human trafficking from a public health perspective. To date, various agencies have used community partnerships as one method of attaining the scope of human trafficking in their regions.

Multiple agencies have also turned attention towards the training of lay people and health care professionals in hopes of empowering vulnerable populations and decreasing human trafficking through prevention as well as increasing identification and care of trafficking victims. The American Public Health Association released a policy statement in 2015 calling for increased training of health professionals incorporated in curricula that currently exists on domestic violence, intimate partner violence, and abuse of elders and children. Medical societies similarly have called for increased education and training for their practitioners regarding human trafficking. The American College of Obstetricians and Gynecologists released a statement highlighting the need for increased identification of victims of human trafficking. This statement was echoed by both the National Association of Nurse Practitioners in Women's Health and the American Medical Women's Association. Both of these organizations called specifically for more training on the identification of victims as well as a validated screening tool.

The education of healthcare providers is currently hampered by the dearth of data in this area. In order to properly build education tools, the scope of the problem needs to be more clearly elucidated. Therefore more efforts must first be placed on generating health-related data in the field of human trafficking.

In addition to community partnerships and training for healthcare professionals, one avenue that has been employed successfully in discrete locations across the country are multisector response protocols. These protocols aim to respond comprehensively to human trafficking and its victims utilizing the legal sector, health care education, victim support services, and the commercial sector. Multisector protocols take into account the complexity of human trafficking and recognize that one agency alone cannot

adequately grapple with the issues victims face. Though there are recognized benefits to a multisector approach, these protocols remain enacted primarily to aid minors who are victims of trafficking, with prime examples being in Washington State, Multnomah County, Oregon, Alameda County, California, and Suffolk County, Massachusetts.

Data collection

Evidence-based public health approaches to human trafficking first requires basic data on the prevalence, demographics, risk and protective factors, health of survivors and a myriad of other healthcare information. This data would provide a good foundation on which to build effective systems for caring for this patient population. Although, data is necessary, the results above show that few US state or territorial agencies currently collect data on human trafficking.

One long-cited barrier to data collection is the underground nature of the crime. Certainly, trafficked people seek health and public services, but there have not been standardized data measures or collection mechanisms to assess service utilization and health needs. Similarly, estimates of the prevalence of trafficking in the U.S. remain elusive, despite federal recognition of the need for new data collection mechanisms and improved sharing of data and reports. Local agencies have attempted to create estimates of prevalence of survivors, but they lack the data to create truly comprehensive estimates and the information they do generate is often inadequately disseminated. The advent of ICD codes relevant to human trafficking may push data collection forward in a significant way.

Besides, the nature of the crime, there are other factors that continue to hamper data collection. Luckily, many of these factors are modifiable: lack of awareness, lack of focus on prevention of HT, disproportionate attention and resources allocated towards criminal justice, and lack of investment in evidence-based assessment. The recent lack of investment and resources can be traced back to public health budget cuts during the 2008 recession. Ten years later, the public health sector continues to face significant budget cuts even in the face of strategic action plans set up to respond to human trafficking. Although these strategies are in place, the financial investment to execute these plans is currently lacking.

For some health agencies, human trafficking data collection falls outside of their purview. Others conduct work to address the health needs of trafficking victims but rely on shared data from organizations and agencies who have been working in the area for a longer period, have stronger relationships with victims, and have access to more reliable data collection methods.

However, the majority of health officials expressed interest in collecting human trafficking data. Barriers cited by those interested collecting data included personnel and funding as well as not knowing where to collect data. To improve our understanding of trafficked people's needs, the federal agencies involved in implementation of the federal strategic plan have engaged with states around this issue and shared best practices.

Another issue with HT data is the fact that it is not a reportable condition in most states. Though child trafficking is a form of child abuse and is therefore reportable, much like domestic violence, adult trafficking continues to fly under the radar. Though this mandatory reporting would be useful in data collection, the question remains of whether it would be ultimately helpful for victims. Mandatory reporting would aid in the acquisition of various services for victims, but may also disincentivize trafficking victims from presenting to health care at all. Other fields such as addiction and firearm injuries face similar problems in data collection given the non-reportable nature of the conditions. Non-reportable conditions face issues of under-reporting and underestimates of prevalence and scope.

Data collection for sex trafficking may also depend largely on the legal implications of engaging in the sex trade in a given state. The state with the most thorough data collection on human trafficking focused only on sex trafficking of minors. This state has a safe harbor law that decriminalizes prostitution among minors, allowing youth who are identified as selling sex to avoid detention. Instead, minors involved in prostitution and related crimes, or those who are identified as engaging in survival sex- which is defined as "sex acts (including prostitution, stripping, pornography, etc.) done to meet the basic needs of survival (i.e., food, shelter, etc.) without the overt force, fraud or coercion of a trafficker, but who felt that their circumstances left little or no other option," become eligible for supportive and rehabilitative services. Twenty-five states, plus the District of Columbia, have similar safe harbor laws for minors.

Only minors who have been trafficked for sex are eligible for this program and its referrals to housing, case management, educational and vocational assistance, etc. Adult sex trafficking survivors and all labor trafficking survivors, including children, are excluded from these benefits. By specifically tracking the survivors who are denied benefits, however, this state is assessing the unmet need for services among trafficked people.

Strategies for data collection on human trafficking by health care professionals have been proposed and implemented by various public and private entities. One significant proposal involves the creation of human trafficking, sexual exploitation, and labor exploitation codes for the eleventh version International Classification of Diseases (ICD 11).[10] ICD is the World Health Organizations' standard diagnostic tool for epidemiology, health management and clinical purposes. The codes are used to monitor the incidence and prevalence of diseases and other health problems, providing a picture of the general health situation of countries and populations.[11]

Because ICD codes are used by physicians, nurses, other providers, researchers, health information managers and coders, health information technology workers, policy-makers, insurers and patient organizations,[12] inclusion of "suspected, stated, or confirmed human trafficking" codes could provide invaluable data not only in the U.S. but globally. The creation of such codes, which would also distinguish between trafficking of adults versus minors and trafficking for commercial sex work versus other types of labor, would enable documentation of human trafficking among the formal ICD listing of other health problems and diseases that are routinely collected for medical and vital records, including death certificates.[12] ICD codes for human trafficking would therefore provide data that will drastically improve our epidemiologic and clinical understanding of human trafficking and its associated health effects. Because ICD is also used for reimbursement and resource allocation, analysis of trafficking codes will provide a population-based needs assessment of this population, illuminating the level of investment needed to enable trafficking survivors to achieve mental and physical health following their experience.

A major limitation of the use of ICD codes to estimate the prevalence of human trafficking is that many trafficked people will never encounter a health care professional and that most of those who do visit a doctor, nurse, dentist, pharmacist, or public health practitioner do not realize that they are victims of a crime or are too afraid to admit that they are. Even those who understand that they are being exploited generally do not disclose their situation to health care providers or other service providers due to fear for themselves or their loved ones, feelings of shame and guilt, trauma bonding with their trafficker, or other mental and emotional incapacities resulting from trauma. Furthermore, many health care providers are not aware of human trafficking and most have not been trained to identify or respond to victims.

Limitations

Given the nature of human trafficking and the lack of mainstream information on the topic, one limitation of this study is a response bias. Agencies who respond are likely those who have some baseline knowledge of human trafficking. Conversely, those with little to no knowledge on the topic likely did not respond. Similarly, it is hard to pinpoint who in each agency actually completed the survey and whether the person practically tasked with filling out the survey knew the organizations involvement in programmatic or data collection activities. Although the survey was often addressed to people with high levels of experience, they may have been completed by high level administrators who may or may not have been well-versed in human trafficking data collection and how their institution conducts research on the subject.

Moreover, agencies that reported having collected data were not required to describe the type of data they'd collected, which means there is further data needed to truly understand what these agencies are gathering. In the instance of five states, it was reported that labor trafficking data had been collected, but explanations of the types of LT data only mentioned human trafficking in general or sex trafficking-related information. This suggests a lack of knowledge on the specific differences between the three terms, which may be exacerbated by the focus of mainstream media on sex trafficking or the large proportion of education and training modules specifically for sex-trafficking rather than labor trafficking. The lack of specificity regarding these terms may also have been caused by the survey tool itself and some of the language used in the questions.

In addition to the language of the survey tool, demographic information on the people answering the survey was not collected until all other responses had been entered. This makes it impossible to know who opened the survey and did not start or complete it.

This survey also excludes local health jurisdictions that may be taking novel approaches to data collection and services offerings in HT. Further surveying local health jurisdictions that are currently offering multisector response protocols, such as Suffolk County, Alameda County, Washington State, and New York City would for more robust data collection.

One large limitation of this study is that the original survey was sent out in 2015. At this point, much has changed and expanded in data collection on human trafficking. In addition to the multisector response protocol developed in different counties across the nation, specific legislation and action plans have been laid out to better respond to human trafficking in a systematic fashion. One such example is PHL § 2805-y, set in place by the New York State Department of Health, which is legislation mandating the establishment of written procedures and policies for responding to identified victims of HT as well as better training for hospital staff around the identification and care of this patient population. Data sharing has also become a higher priority in the time since this survey was sent out. Washington State and the Office of Crime Victims Advocacy (OCVA) have taken steps to share data and practices online. Strides have also been made in the way of increasing awareness of human trafficking as shown by the Florida Department of Health who, in early 2018, increased awareness among healthcare providers as a part of HT month.

Conclusion

The problem of human trafficking is complex and requires a systematic approach to solving. This systematic approach must start with data collection as the first step while concurrently creating systems and cultures of data sharing. Data collection, however, is still a large barrier for many states and jurisdictions. Data collected by law enforcement, social service providers, advocates, and the justice system each provide a piece of the picture of human trafficking. The trafficked persons seen by health

care professionals are not necessarily the same trafficked persons engaged with other agencies. For this reason, true understanding of the scope of the problem and the best ways to serve these victims will come through the creation of structures for collaboration between different sectors in a large-scale, sustainable fashion.

Data collection and sharing should then be met with high quality, unbiased analyses grounded in science. This would provide the field with robust information on which solutions can be built. The ultimate goal would be to inform policy and programs aimed at reducing and abolishing trafficking. Goals of prevention must be coupled with public health solutions to support survivors of trafficking along with providing them with free and low cost supports and tools such as education, sexual health and STI clinics.

Creating frameworks for addressing victims of human trafficking in a victim-centered manner and comprehensive manner would ultimately include universal access to health care, behavioral and mental health care, housing, social services. Caring for these patients requires using intersectional approaches that take into account the unique identity and experiences of each individual. To make these aspirations a reality, we must push to invest in clinics, providers, and teaching centers dedicated to supporting this population and truly listening to the voice of survivors.

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