

Chapter 2

Sex Trafficked and Missed

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2.1 Introduction

Health care professionals are among the few frontline professionals who come into contact with persons who have experienced human trafficking; however, vulnerable patients are often missed in health care settings. In one study, nearly 88 % of sex trafficking survivors reported having contact with a health care system while being exploited. This study underscores that medical professionals are often “woefully unprepared” to identify and respond to trafficked persons [1].

Would you be able to identify a trafficked person? Of the following three case scenarios, which patient might you suspect to be at risk of human trafficking?

- Scenario 1: A 33-year-old female presents to the emergency department. The patient is bleeding and covered in bruises. She has a broken finger so swollen that she cannot remove her ring. She states that she got drunk and had a fistfight with her roommate, a 27-year-old female, who has accompanied her to the emergency department.
- Scenario 2: A 19-year-old female presents to the hospital, going into labor with her first child. She is accompanied by two young adults: a female, who is also pregnant, and a male, who identifies himself as the patient’s boyfriend and the baby’s father. The female companion remains in the patient’s room and is supportive. The boyfriend frequently steps out of the room to speak on the phone or to meet privately with other female visitors.
- Scenario 3: A 25-year-old female accompanied by law enforcement presents to a mental health facility. The officers explain that the patient originally presented to an emergency department with claims of “going crazy.” Under direction from the emergency department, law enforcement then transported the patient to the

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mental health facility. The patient admits to suicidal thoughts and hearing voices but cannot remember what the voices say. Additionally, she has two children; she says that the father visits but is not in the picture consistently.

If you guessed the patient in the second scenario, you would be right. However, if you guessed the patient in the first or third scenario, you would also be right. All three are based on actual interactions between a health care system and a survivor of sex trafficking: Coauthor Wendy Barnes was trafficked for more than 10 years, beginning at age 17. These scenarios describe actual clinical presentations based on her experiences in which she was the patient or companion.

Trafficked persons can present in a number of ways. In order to be better prepared to screen for red flags, health care professionals must first be educated on what human trafficking really means and which patient populations might be at greater risk of exploitation. Key health care professionals like clinicians and social workers should also be educated on trauma-informed care. The authors propose this foundation of education as the first step in preparing professionals on how to identify and effectively respond to trafficked persons.

2.2 Discussion

2.2.1 *Essential Knowledge*

2.2.1.1 Overcome Misconceptions

For many people in the USA, the term “human trafficking” is associated strictly with images of exploitation overseas. However, every country is affected by human trafficking, including the USA [2]. Even among those who do recognize that trafficking occurs in the USA, the term often conjures an image of people being smuggled into the country or small children being chained to beds. If this is a health care professional’s understanding of what human trafficking looks like in the USA, then that professional has likely missed, and will continue to miss, opportunities to intervene in human trafficking cases.

In 2000, the USA passed the Trafficking Victims Protection Act (TVPA), which outlaws two common forms of human trafficking: sex trafficking and labor trafficking [3]. Based on the TVPA’s definition of human trafficking, the National Human Trafficking Resource Center (NHTRC) [4] identifies three “victim” populations associated with these federal crimes:

- Anyone *under age 18* who is induced *under any circumstance* to perform a commercial sex act¹

¹TVPA defines a commercial sex act as “any sex act on account of which something of value is given to or received by any person.” This can include money, drugs, or survival needs like food and shelter.

- Anyone *over age 17* who is induced *through the use of force, fraud, or coercion* to perform a commercial sex act
- Anyone, *of any age*, who is induced to perform labor or services through the use of force, fraud, or coercion. Labor trafficking includes situations of *debt bondage, forced labor, and involuntary child labor*

It is critical that health care systems educate all of their staff—from security officers and registration staff to physicians, physician assistants, nurses, and social workers—on the realities of human trafficking. In order to ensure that all staff members have basic knowledge on the topic, the authors recommend several educational options, including in-person classes and self-study modules. For example, Dignity Health, the largest hospital provider in California, created a self-study basic education module and offered it as a resource to staff: *Human Trafficking 101: Dispelling the Myths* addresses ten untruths associated with sex and labor trafficking as well as a description of red flags in the health care setting with instructions for frontline staff to follow in the event red flags are recognized.

There are many misconceptions about human trafficking, many of which are perpetuated by the media. For example, one falsehood covered in Dignity Health's *Human Trafficking 101* module is that human trafficking and human smuggling are the same crime. The US Department of Homeland Security Office of Immigration and Customs Enforcement (ICE) defines human smuggling as "the importation of people into the United States involving deliberate evasion of immigration laws." [5] Human smuggling is a violation of these laws, whereas human trafficking is a violation of a person's basic human right to life, liberty, and the pursuit of happiness. It is also untrue that persons trafficked in the USA are always foreign nationals. In 2015, the NHTRC hotline received 5500 cases of reported human trafficking in USA, and at least 1660 cases involved US citizens or lawful permanent residents [6].

Another misconception covered in *Human Trafficking 101* is that trafficked persons will always reach out for help. The media often portray the most sensationalized scenarios of this crime. The public sees images or movies portraying children being abducted or people held against their will. The viewer consequently assumes that the "typical" trafficked person is not only waiting to be rescued but also that they will reach out for help at the first opportunity. However, more often than not, trafficked persons do not seek help for many reasons, including the following, highlighted in *Human Trafficking 101*:

- They may not self-identify as a victim, and may blame themselves for their situation.
- They may have trauma-bonded with the trafficker. As defined by Austin and Boyd [7], traumatic bonding is "a strong emotional attachment between an abused person and his or her abuser, formed as a result of the cycle of violence."
- They may not know their rights or options.
- They may fear retaliation against them or their families.
- They may fear authorities and the possibility of being charged with a crime and going to prison or being deported.

2.2.1.2 Recognize High-Risk Patient Populations

Clinicians must not rely on trafficked persons to self-identify. Basic education should include a description of vulnerable patient populations. Human trafficking is a crime based on exploitation. As such, traffickers often prey on those who are most vulnerable, like people with substance use disorders, young people struggling with homelessness or mental health issues, immigrant workers lacking adequate resources, and so on. Practitioners should screen all vulnerable patients for human trafficking victimization, especially if there are signs of abuse or assault.

2.2.1.3 Incorporate and Appreciate Survivor Perspectives

Dignity Health's education modules also include the voices of survivors. Without hearing from survivors, health care professionals are missing the most important perspective in a trafficked person's health care experience. Moreover, survivor stories help health care professionals see the humanity in patients often stigmatized by society. Survivors come in all ages, classes, races, genders, ethnicities, and sexualities; and their stories of labor and/or sex trafficking are all different. Some survivors are trafficked by pimps, gang members, or companies, while others are trafficked by family members, friends, and/or neighbors.

In this chapter, we share Wendy's story as one example of human trafficking in the USA. Wendy was trafficked by a violent man. He lured young women and girls into abusive "romantic" relationships—in fact, he is the father of Wendy's three children—and then he forced the women and girls into street prostitution and escort services. He was ultimately sentenced to life in prison.

In the first two scenarios outlined in the Introduction, Wendy was the companion; in the third, she was the patient. In the first scenario, Wendy did not assault the patient; rather, the patient's wounds were inflicted by the trafficker and the women were forced to fabricate a story to explain the injuries. In the second scenario, Wendy and the female companion were both pregnant by the same man. There have been many cases in which male traffickers have fathered children with women under their control. Oftentimes, the result is that the bond between the trafficker and the trafficked person is strengthened [8]. In the third scenario, Wendy was seeking refuge in a psychiatric ward to escape the cycle of violence and forced prostitution. She was discharged by the mental health professionals who did not identify the underlying cause for her presentation. Wendy's perspective can help medical professionals understand why a trafficked person might not explicitly reach out for help.

As a child, Wendy felt unloved and bullied, and she also experienced sexual abuse at the hands of her stepfather. Child protective services removed Wendy from the home, but Wendy's mother later moved Wendy back in with her stepfather because it was the only way her mother could provide a warm home for her two children. In her memoir, *And Life Continues: Sex Trafficking and My Journey to Freedom*, Wendy describes how she perceived the consequences of disclosing the abuse [9]:

I had destroyed my mother's life. Everything she had ever wanted was ruined because I had told the counselor what [my stepfather] had done...I was relieved and grateful when she moved out of [his] house so I could live with her again. When ... [we] moved back into [our] cold house without any food or cable...[my mother] once again had to work a second job. I watched her grow more tired and angry with each passing day—and it was all because of me.

So, when Wendy's mother asked Wendy if she would be willing to move back into the stepfather's house, Wendy agreed. Acceptance of abuse became part of Wendy's understanding of love, family, and home. Abuse was so normalized in her life that Wendy had become the perfect target for a sex trafficker. And the lesson she had learned was that reaching out for help either created more harm or accomplished nothing.

Today, Wendy has rebuilt her life, published her memoir, and is a national speaker and advocate for current and formerly trafficked persons. Below, Wendy describes her initiation into sex trafficking and some of her interactions with health care:

I met my first boyfriend when I was 15. At 16, I was pregnant with his child. When I was 17, he convinced me to distance myself from my mother and move into a homeless shelter. I was naïve, shy, and desperate to be unconditionally loved. I wanted to believe his promise that our life would be "happily ever after," but he had other plans for me.

Neither of us had a job or a way to support our daughter. He was suave and convincing, excellent at calming my nerves and giving me hope for a bright future in what I believed would be "the perfect family." He didn't stay at the shelter with me and our daughter, and chose instead to stay with his grandmother a few miles away. At least that is what he told me, and what I believed.

It wasn't long before the diapers and formula ran out. What I didn't see then was that this was all part of his plan. By isolating me in the shelter, he knew I would be vulnerable and scared. He needed for me to be desperate. My daughter not having diapers and formula did, indeed, make me desperate. Then Greg revealed his plan for how "we" could make money to take care of our daughter. He had only one question for me: "How much do you love your daughter?" If I loved my daughter, he said, then I would do anything for her, including trade sex for money.

Two months after I entered the shelter, I received my first welfare check and was able to get my own apartment. A rundown, roach-infested studio room and a shared bathroom, the apartment had a pullout bed, couch, and kitchenette. It was "perfect" to me because it was where our family was going to start our journey to becoming a "happily ever after" family. The apartment was a few blocks from a medical center, which in turn was only two blocks from the track² where I worked. Our only income was my welfare check and food stamps, which were meant for one adult and one child, not the two adults and one child that made up my "family."

Greg again put the responsibility on me to provide for our daughter, insisting that if I didn't, I was a bad mother. I didn't turn tricks every day. It was usually a Friday night that Greg would talk me into going out, reminding me that I could "easily" make a hundred dollars doing a few tricks. I would bring home the money and hope I wouldn't have to go out again until the following Friday—but Greg always had other plans for the money. By Saturday night, we still had no food, no diapers, no formula.

Looking back, I realize Greg knew how to manipulate me. I yearned to be a good mother and wife, and that is how Greg presented the "work opportunity" to me. If I were a good mother, I would do anything for our child. If I loved them, I would make this sacrifice. I

²In the subculture of prostitution, a "track" is an area known for street prostitution.

didn't see myself as someone who had sex with men for money. I saw myself as a mother making sacrifices for her child. For this reason, I didn't identify with the idea of being a "prostitute." To me, a "prostitute" chose to do this work. Of course that begs the question: How many others involved in prostitution are like I was? How many others are performing commercial sex work due to coercion or a lack of options as opposed to an actual choice?

One day my bare foot caught the metal strip holding the carpet under the doorway. Blood spewed everywhere. Greg grabbed our daughter and we made our way to the medical center, where Greg bounced the baby on his knee as they sewed up and bandaged my foot. As I recovered at home over the next couple of days, Greg cared for our daughter and me, cooking the last bit of food and changing our baby with the last of the diapers.

I woke up the third morning with a throbbing foot. It was still bandaged; I was too scared to unwrap it. Greg took me back to the emergency department; when nurses removed the bandage, my foot was severely swollen and so black and blue I couldn't bear to look at it. The doctor came in, checked my foot, and admitted me to the hospital.

Greg assured me that he would take care of our daughter. I worried about them, but also was looking forward to not having to go out on the street Friday night. All day Thursday and Friday I had an IV drip. I was scared and worried because Greg did not visit. Just after the nurse removed the IV on Saturday afternoon, Greg walked in with our daughter. I was so happy to see them both! I hugged our daughter and held her close while I asked Greg why he had not visited me, but he turned the conversation to our daughter. What kind of mother was I that she was out of formula and diapers? Breaking me down with his "bad mother" manipulation, he told me his plan: We would wait until the nurse checked on me, and then I would go outside, hobble the two blocks to the track, and make some money for diapers and formula. I complied, then returned to the hospital and continued treatment.

I was treated at the emergency department when I cut my foot, but for several years I mostly saw doctors at the public health clinic to be treated for venereal diseases. Although Greg instructed me to refuse a trick unless a condom was used, he also told me to forego the condom if the trick paid extra money. When I did contract a venereal disease, I could always tell whether I got it from a trick or from Greg. Usually, it was Greg who gave me the diseases. He was constantly having sex with other girls³ as he groomed them to be under his control.

Over the years, I never perceived the doctors to be people who care. In the typical visit, the nurses ask only the questions that complete blocks on the chart: weight, age, height. Then the doctor walks in, looking down at the chart, and asks, "What seems to be the problem?" I respond with the exact issue at hand, and no more. I was a naturally shy and quiet person; I didn't talk to people I did not know well, and Greg had taught me never to volunteer information. The doctor looks at the health issue, fixes it, prescribes medications, and leaves the room. I have always thought of doctors as "fixers." They fix the problem. They may care about the problem, but I have never had any reason to believe that they cared about me. That may not be true; that may be what Greg put into my head so that is what I saw. Or, maybe, it's a little bit of both.

In my late teens, I had two abortions at a private clinic. Nobody—neither the nurses nor the doctors—ever asked me if I really wanted the abortion. Nobody asked me if it was a trick baby.⁴ I had three or four more abortions at nonprofit community clinics. All of them were the same as any other doctor visit. The nurse prepared me, and the doctor came in, "fixed" the problem, and left.

³Wendy refers to the other victims under Greg's control as "girls" without regard to age. In Wendy's case, Greg trafficked both underage girls and adult women. Note that trafficked persons can be of any age or gender.

⁴A "trick baby" is a term often used in the subculture of prostitution to describe a baby fathered by a sex buyer, otherwise known as a "john" or "trick."

A year later, Greg and I moved to another state to make a new start. We moved in with his parents and, pressured by his father, Greg got a real job. I didn't have to turn tricks—mostly because he didn't want his mom to be suspicious and because, being new to the area, he didn't know where the track was.

I got pregnant again with Greg's baby and visited a gynecologist twice. The only thing I remember about that doctor is how uncomfortable he made me feel. I remember he performed a breast exam and seemed to linger over my breasts for an unusual amount of time. He also attempted to make small talk and made an inappropriate comment about the size of my breasts. He felt like a trick to me.

During my pregnancy, Greg lost his job, his parents lost their home, and again we were homeless. With Greg's blessing, I called my mom; she sent me a plane ticket and offered me a place to live until Greg and I could get on our feet. At that time, my mom lived in an upscale suburb, and I was able to go to a major medical center for my care. That was in 1989. "Human trafficking" wasn't yet a well-known term.

When I went into labor, I called Greg and asked him to drive me to the hospital. He arrived at my mom's with a new girl, who was 16 years old. He said he was only using her so he could get an apartment for us and our children. He blamed me, telling me he needed her since I wasn't able to make money. If I were a good mother, he said, I would already have a place for us to live. While I was in labor at the hospital, Greg dropped the new girl off on the track and went back and forth between my contractions to pick up her money.

After our son was born, Greg had all he needed to control me and other girls. He had learned from his mistakes and had honed his pimping skills. He could easily run more than one or two girls at a time. My life became a world of girls, tricks, and drugs by night; by day I tried to live a "normal" life. I took my kids to their regular appointments. Nobody asked why I moved around or changed doctors so much. I don't blame the doctors for not noticing that something was wrong. I rarely went to the same one twice. However, a patient's moving from city to city should be a red flag of potential exploitation, especially if there are indicators of vulnerability like poverty or drug use.

As Greg became even more skilled in the art of pimping, he was able to seduce more girls who would make him money. All of us believed we were there by choice. I was there because I loved him. I was there because I believed he was someday going to be my husband and a good father to our children. His verbal beatings manipulated and controlled me:

Nobody will ever love you but me.

You are pathetic.

You're a bad mother.

Your children don't love you.

Then he would embrace me and tell me how much he loved me even though I was so worthless. This tactic kept me tied to Greg—it was a cycle. I believed I was worthless. Greg confirmed I was worthless. I thought nobody could love me. Greg said he loved me despite my being worthless, which made me feel grateful.

He embedded other "truths" in us: People in the real world don't want you. You'll never make it in the real world. Encounters with "real world" people almost always reaffirmed Greg's truths. We were only allowed to have contact with tricks, and there was no empathy or caring from them. Police officers would arrest us or sweep us off their streets like garbage. In our many visits to emergency departments, it wasn't that we were treated badly; rather, we put on the act that we were "normal" and no one ever seemed to notice signs to the contrary like frequent STIs, bladder infections, repeated abortions or pregnancies, pregnancy with little to no prenatal care, pregnancy with positive drug use, medical and physical neglect, etc.

Suicide attempts should be another red flag. I cannot tell you how many times I have overdosed on pills and cut my wrists. Sometimes, I completely wanted and expected to die. Other times were cries for help. One time I took two bottles of sleeping pills over a four-

hour period. When I started hallucinating, I drove myself to the emergency department. They had me drink charcoal and then admitted me. When I woke the following day, I begged one of the hospital workers to admit me into the mental health ward. I told her that I needed a break. She thought that was ridiculous. Who needs such a drastic “break” from life? She told me that life is hard and we all need to learn how to handle it. Greg came to the hospital soon after that to tell me that he loved me. I was released from the hospital, back into the arms of my oppressor.

When our injuries were caused by Greg’s beatings, we knew better than to ask him to let us go to the emergency department or doctor—we knew he wouldn’t allow it. Beatings were common. Some of us were beaten more often and more severely than others, and the worst beatings fell to a girl I will call April. One time, he beat her beyond recognition. I had never seen a person’s entire back so battered. Her finger had swollen around her ring and she couldn’t stop crying. I begged Greg to let me take her to the hospital. Furiously, he refused. As April continued to cry and her finger got bigger, I begged again, asking him why he wouldn’t let me take her. His response was twofold: How did we know she wouldn’t tell them that he had beaten her? How would we explain her condition? I had a bright idea that addressed his concerns. April and I promised that we would not mention him at the hospital. To allay any suspicion, we could say that she and I were drunk and got into a really bad fight.

I drove her to the hospital and we told our story. The doctor came in, looking down at his chart. He saw the injuries, had the nurse cut the ring off April’s finger, gave her medication, and sent her home. No one seemed to notice that she was half a foot taller and 75 pounds heavier than me. No one noticed that neither of us would look them directly in the eye—maybe because they never tried making eye contact with us. Any signs of abuse or assault should be a red flag, as well as any signs of fearfulness or submission.

Sometimes Greg would have as many as 15 girls working for him. Other times, it was just me. There were times that we would live a “normal” life, nurturing my dream that we would live “happily ever after” as husband and wife. Our living situation went from one extreme to another. Sometimes we were homeless, sleeping in his car or moving from one sleazy hotel room to another. Other times, I would have my own apartment and Greg would keep all the girls in hotels near the track.

If you are looking for one specific situation that describes every sex trafficking case, you will miss many opportunities to see trafficking right in front of you. We were in plain sight. We were not hiding ourselves; we were hiding the pain and suffering we endured. We went to the grocery store, we went to the movies, we went to the beach and played. A person can be forced or coerced into sex work while living in an expensive home, a college dorm room, or a homeless shelter. The only thing that trafficked persons have in common is our vulnerability, but you have to get to know us to see it. Anytime you see a patient (whether it’s in the emergency department, clinic, or physician’s office), it’s an opportunity to ask questions.

2.2.2 Extended Education: Victim-Centered and Trauma-Informed Care

In addition to basic education, Dignity Health created an extended education module to be assigned to key staff like clinicians and social workers who will likely engage with trafficked persons. This module addresses a “victim-centered” approach and trauma-informed care as well as ways to engage patients and internal protocols.

As defined by the US Department of Justice Office for Victims of Crime, a victim-centered approach gives priority to a patient’s “wishes, safety, and

well-being ... in all matters and procedures” [10]. If health care professionals remain focused on “the needs and concerns” of a patient, they can ensure a “compassionate and sensitive delivery of services in a nonjudgmental manner” [10]. As described in Dignity Health’s *Human Trafficking 102* module, a victim-centered approach is important for all patients but especially for patients who have experienced a crime like human trafficking. Traffickers often make all decisions for persons under their control, including when to work, how long to work, and when and where to sleep and eat. To help a trafficked person recover, health care professionals must help to instill in the patient a sense of safety and personal agency *as soon as possible*.

Dignity Health’s extended education module also stresses the need to maximize the patient’s input in all decisions regarding care, *including if and when to contact law enforcement*. Patients who have experienced sex or labor trafficking are often fearful of law enforcement. Therefore, clinical education should emphasize that law enforcement *not* be contacted against the patient’s wishes *unless* a report is mandated by law, there is a threat of serious harm to the patient or other individuals, or there is imminent danger in the clinical setting. Clinicians should offer to contact a survivor advocate or service provider when a patient does not want law enforcement involved. Recalling her own experiences, Wendy emphasizes the importance of an approach that maximizes a patient’s decision-making abilities:

People ask me what is needed when encountering a trafficked person and I tell them, first and foremost, a genuine caring about that person. There must also be a sense of respect for his or her choices, even if those choices differ from what is considered best for them.

For those of us under Greg’s control, our minds were scrambled; our thinking was not our own. We were trained not to make eye contact. Hearing a question as simple as “Are you okay?” was and is powerful—it plants a seed of dignity. For me, it planted a counter-narrative to what Greg was saying all along—that nobody in the world cared about me. A trafficked person may not respond at that moment, but each respectful, caring encounter encourages that planted seed to grow, which in turn creates a foundation for personal strength and hope.

What you don’t do may be as important as what you do. Don’t expect to save a trafficked person, especially if they have been isolated from and stigmatized by society over time. If you “rescue” them, they may go back to the trafficker. You cannot save them—but you can offer them tools that will enable them to save themselves. Trafficked persons need to dig themselves out of the hole of trafficking; if you try to dig them out, they will never develop the muscles they need to live fully in the outside world.

At Dignity Health, one “tool” offered to suspected or known trafficked persons is the NHTRC hotline: 1-888-373-7888 or text 233733 (BeFree). The NHTRC hotline is available 24/7 to report potential cases of human trafficking and provide information on local, regional, and national resources. NHTRC hotline specialists speak both English and Spanish and can communicate with callers in over 200 additional languages using a 24-h tele-interpreting service. Dignity Health clinicians and social workers are equipped with plastic “shoe cards” with the NHTRC hotline printed on them. These cards, available in several languages, are small enough to be hidden in a patient’s pocket or shoe if the patient chooses to take one. The patient can then contact the hotline at a later time when ready to seek help.

In the extended education module, Dignity Health also emphasizes the importance of trauma-informed care. It is essential that clinical staff understand trauma and how trauma can affect a trafficked person's response "to services and the criminal justice process" [10]. Clawson et al. [11] describe varying levels of trauma:

Trauma exposure occurs along a continuum of "complexity," from the less complex single, adult-onset incident (e.g., a car accident) where all else is stable in a person's life, to the repeated and intrusive trauma "frequently of an interpersonal nature, often involving a significant amount of stigma or shame" and where an individual may be more vulnerable, due to a variety of factors, to its effects.... It is on this far end of the continuum where victims of human trafficking, especially sex trafficking, can be placed.

From a *trauma-informed care* perspective, health professionals understand that a trafficked person's response may be influenced by past trauma rather than a deliberate attempt to be difficult. For example, consider the third case scenario presented in the Introduction of this chapter. After years of victimization, Wendy turned to an emergency department for help. She claimed to be "going crazy" in order to gain a temporary escape. The health professional recognized that Wendy was lying; however, did she recognize that Wendy's lying might be a response to trauma, even a cry for help?

How would you respond? Would you and your staff see a difficult patient, a criminal, a "frequent flyer," a drug addict, a prostitute, a bad mother, an irresponsible wife? Or would you see a potential victim of abuse or exploitation, possibly human trafficking? If you did see red flags associated with human trafficking, what protocols are in place to guide staff on how to respond to a patient like Wendy? As you reflect on these questions, consider Wendy's perspective, as a trafficked patient, on her encounter with the psychiatric hospital.

Greg and I were living in the northwest and had been together for over a decade. By this time I had learned how to manage the relationship with Greg well enough that we were able to live in one place for a year or two. Greg seemed to realize that he had to have a 'normal-looking' face, and that was the face of a husband and father. I don't know what neighbors thought about all the girls who would come and go—some would stay only a short time, others for a couple of years, still others for a lifetime. I don't know what the difference was between the girls—why one had the nerve to leave and another would stay.

At one point, I lived in one apartment with our two children and all the other girls lived in another apartment. I only had to turn tricks on Friday and Saturday nights, and this occurred at one man's home. This guy would have a 'party' and invite all of his friends. Twenty to 40 men would come and go during the evening, and five to eight of us girls would be prostituted to the men. As long as Greg felt he had complete control over all of us and everything that happened, he wouldn't have a reason to beat me. I was often beaten for reasons out of my control. Sometimes, he wouldn't come over for an entire week and I could live my fairy tale that I was a mother taking care of her children while her husband was overseas working. Those weeks were really wonderful, but I also knew that at any time, Greg could blow up and invent a reason to come over and torture me.

As it always did, that evening came. I don't remember what triggered his rage; I just remember him coming over with all the girls and humiliating me in front of them. I remember the other girls making fun of me while Greg berated me and pushed me around the house, causing me to knock over lamps and break dishes. Then he yelled at me for breaking the dishes and told me what a horrible mother I was. I knew the only thing that would stop this was to go make money for him. Then I was out on the street, crying, not wearing any make-up, and realizing that it was going to take me forever to earn enough money to keep

Greg from hurting me. My children were in the house with him and all the girls. Because over the years Greg had managed to convince me that my children would be happier without me in their lives, I pictured them all playing games and laughing and eating dinner together. That, of course, was a figment of my imagination. Abuse was the “normal” reality for my children—not fun and games.

I walked to the hospital emergency department. I kept my eyes to the ground because that is what Greg had programmed us to do. I quietly told them that I needed help. I needed to be admitted into the mental health ward. To me, this was a break from the insanity. I had been to a different hospital’s mental health ward a few times over the years after suicide attempts or threats to attempt. I would stay there for three or four days and I would get rest, a break from the drugs and the violence.

Someone had me sit in a waiting room for what seemed like forever, but it was probably only a couple of hours. Someone finally called me and asked me all the typical questions: weight, age, height, address, emergency contact. My emergency contact was one of the other women under Greg’s control. Then two officers put me in a police car and drove me about two miles down the road to another building, which I assumed was their mental health ward.

It was about nine o’clock at night. The police took me to a room where I waited until a lady came in and asked why I wanted to be admitted. I told her I was going crazy. She kept asking questions that I could not answer so I started making up answers.

“Do you hear voices?”

“Yes.” I thought that would be my ticket into the hospital.

“What do the voices say?”

“I don’t know.” I hadn’t realized I should have been prepared with more details.

“Do you want to kill yourself?”

“Yes.” I didn’t really want to kill myself. I wanted life as I knew it to end. I wanted a better life, but I believed there was no hope for a better life.

The woman prodded me with questions. There was no sympathy in her voice. I stared at the wadded up, tear-drenched tissues in my hands. She asked me where I lived and about my children. I gave her my ‘look normal’ story: I have an apartment with my two children. The kids’ father visits sometimes but I don’t know where he lives or is at most of the time—quickly adding, “He’s a good father to our children.”

The lady explained to me that the mental health ward is not a place for people to take a break from life. This was a hospital for seriously ill people. I started to feel really bad—I just wanted to leave. I informed her that I was feeling much better and I wanted to go home. She asked me again if I wanted to kill myself, and I said, “No.” She asked me what my plans were; I told her I was going to go home and go to bed.

I walked out of the hospital around midnight, with no money and no transportation. I didn’t need transportation where I was headed. I knew I couldn’t continue this way, I believed I had to die. I walked a couple of miles in the dark and stood on the tallest bridge in the city. I was alone, crying. I wanted to jump, but I was too afraid—afraid that I wouldn’t die and I would be left in the weeds and bushes at the bottom of the bridge with broken bones and no one to help me.

I walked back to the track to make the money that would make Greg happy.

2.3 Conclusion

To ensure that health care professionals do not miss trafficked persons in the health care setting, the authors recommend providing education similar to what has been implemented at Dignity Health. Basic education on sex and labor trafficking should

explain what human trafficking really means, including legal definitions, descriptions of vulnerable populations, and red flags in the health care setting. Extended education should include a discussion on victim-centered, trauma-informed care as well as suggestions on how to engage patients and an in-depth review of internal protocols. Whether education is in-person or self-study, the modules should include survivor stories to help facilitate understanding of trafficked persons' perspectives and vulnerabilities. Armed with knowledge, tools, and protocols, health care professionals are in an extraordinary position to identify trafficked persons, initiate their return to safety, and instill a sense of personal agency necessary for recovery.

2.4 Recommendations

The authors encourage health care systems to implement staff education programs that provide the following:

1. Basic education on sex and labor trafficking that includes survivor stories, along with a deconstruction of misconceptions often associated with human trafficking, red flags in the health care setting, and instructions for all frontline staff in the event red flags are observed.
2. Extended education for key staff who will engage with suspected or known trafficked persons. These key staff should be clearly identified in internal protocols. Extended education should include a discussion of a victim-centered approach, trauma-informed care, and an in-depth review of internal protocols. Whenever possible, include survivor stories or perspectives.
3. Ongoing education, including case scenarios, should be part of staff training. For example, Dignity Health created a third module, *Human Trafficking 103: Case Scenarios*, which presents ten clinical scenarios based on experiences of sex and labor trafficking survivors. This module is meant to be used in a group setting for staff to discuss concepts covered in education, protocols, resources, and tools like the NHTRC shoe card.
4. An internal multidisciplinary team should meet regularly to debrief on clinical cases and discuss protocols, education needs, awareness events, and other projects.

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Human Trafficking Is a Public Health Issue
A Paradigm Expansion in the United States
Chisolm-Straker, M.; Stoklosa, H. (Eds.)
2017, XXXVII, 457 p. 15 illus., Hardcover
ISBN: 978-3-319-47823-4