Implementation and Evaluation of the "Human Trafficking 201 Workshop" Pilot conducted in partnership with Seattle Children's Center for Diversity and Health Equity

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A thesis submitted in partial fulfillment of the requirements for the degree of

Master of Public Health

University of Washington

2021

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Program Authorized to Offer Degree:

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Abstract

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Human trafficking (HT) is a public health issue. The trafficking of children and adolescents is of special concern due to their increased vulnerability. Health care professionals (HCPs) are uniquely positioned to detect, support, and aid in the care of patients suspected of or known to be involved in HT. There have been many attempts to develop HT trainings for HCPs but there is no standard, evidence-based, HT-specific training curricula and/or course. Many HCPs are unaware of the ways in which HT involvement manifests in their patients especially pediatric patients. It is important for HCPs to have a standard, evidence-based, HT-specific training curricula and course to best address unmet pediatric patient needs. This evaluation aimed to determine if the "Human Trafficking 201 Workshop" pilot increases perceived participant knowledge around supporting patients suspected of or known to be involved in HT, and if the workshop was more effective at increasing perceived participant knowledge among the Psychiatry and Behavioral Medicine Unit (PBMU) care team participants compared to the Odessa Brown Children's Clinic (OBCC) care team participants. A mixed-methods evaluation was conducted to address these aims and utilized a pre/post-workshop self-assessment survey and follow-up qualitative interviews. Although the data analysis shows that the workshop was successful at improving average workshop participant perceived knowledge regarding support patients suspected of or known to be involved in HT, it is difficult to draw any generalizable conclusions due to the limitations of the evaluation. Future steps for the "Human Trafficking 201 Workshop" pilot include testing with other care teams associated with the hospital and improving evaluation techniques.

Background and Significance:

Human trafficking is a public health issue. It is the second largest criminal industry (behind drug trafficking) and has been detected in all 50 states and Washington DC in the United States[1–3]. It involves the "the exploitation of a person for labor and/or commercial sex acts through the use of force, fraud or coercion, or in cases of sex trafficking, when the exploited person is under 18 years of age" [3] and can result in various negative health outcomes. The human trafficking industry continues to grow[4], and it is estimated that between 40.3 million people are victims of forced physical or sexual labor and of this group 25% are children[3]. Human trafficking is not only a national issue but occurs internationally, with the movement of peoples across country borders[2,3,5–7]. This covert movement of people has caught the attention of many countries and there are several national and international organizations that have been working to address this humanitarian crisis[4,5,7]. Unfortunately, these efforts remain ineffective due to lack of enforcement of policies, the hidden nature of the human trafficking industry and the lack of public knowledge about the issue.

Children and Human Trafficking

The trafficking of children and adolescents is of special concern due to their increased vulnerability[4,6,8]. Children and adolescents have not yet developed the intellectual and emotional ability to navigate the world on their own and rely heavily on adults[6]. This dependence on an adult figure puts children and adolescents at greater risk of human trafficking involvement because they are less likely to understand what constitutes a human trafficking act. This lack of knowledge can make a child and/or adolescent more easily manipulated into actions that fall under the umbrella of human trafficking.

There are additional factors that increase the likelihood of a child or adolescent to be involved in human trafficking. Societal influences such as the experience of poverty, discrimination, and gender bias all put children and adolescents at greater risk because of the potential hope of escaping these circumstances[5,6,9–14]. Many individuals who initially get involved in human trafficking due so to gain money for themselves

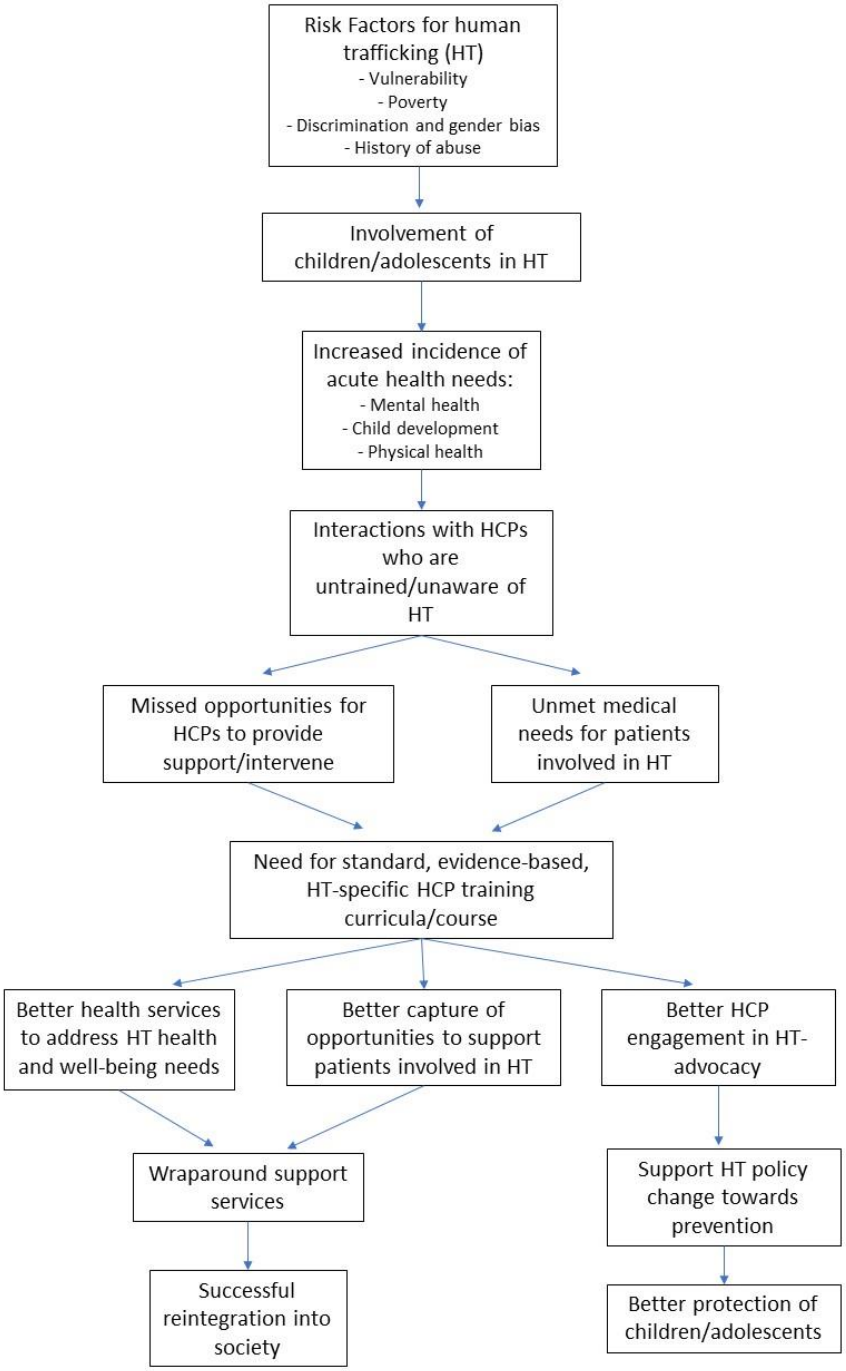
and/or their family, move to the United States for more opportunities (immigration), escape unhealthy home environments, or are expected to play a certain role in their family because of their gender association[5,10–12,14,15]. These societal factors may cause a child or adolescent to see human trafficking as a means to an end, but in reality, puts them at risk for additional health and behavioral outcomes and continued involvement.

Conceptual Model

The following model (see Figure 1) can be used to better understand the interplay between children and adolescents, human trafficking involvement, and the role health care providers (HCPs) can play to stop the cycle. Once an individual is involved in human trafficking, they become exposed to various negative health outcomes. Individuals who are victims of human trafficking are more likely to suffer from bodily injuries, develop sexually transmitted diseases (STDs), become pregnant and/or suffer health complications because of pregnancy and/or forced termination of the fetus (for individuals with a uterus), develop post-traumatic stress disorder (PTSD), depression, and/or anxiety, and many more negative health outcomes.

It is especially concerning to have children and adolescents involved in human trafficking because their development is likely to be impacted. Child and adolescent brains continue to develop until about the age of 25 years so any traumatic experience will impact the way in which their brain develops and their ability to navigate the world. Involvement in human trafficking is a particularly traumatic experience due to the lack of a trustworthy adult figure, removal from family support, the human trafficking acts they are doing, and the continuous stress they most likely experience. These negative health outcomes (mental, physical, and developmental) may end up manifesting in bodily ways and a human trafficking victim will eventually find themselves requiring medical attention, most likely in an Emergency Department setting[2,16,17].

Figure 1: Conceptual model of pediatric human trafficking involvement and health services involvement



Human Trafficking and Health Services

Health care professionals (HCPs) are uniquely positioned to detect, support, and aid in the care of patients suspected of or known to be involved in human trafficking[1,3,10,11,15]. Unfortunately, many HCPs often lack adequate training and do not feel that they have the skills to address patient needs[2,3,5,11,16]. These gaps in HCP knowledge regarding human trafficking and the ways patients present in health services settings is also influenced by the hidden nature of the human trafficking industry[4–6,10,18–20]. Human trafficking is being discussed more often in health services settings but is still not normalized as a common social determinant of health[16]. As a result, patient needs continue to go unmet, and children and adolescents continue their involvement in the industry regardless of their interactions with HCPs (see Figure 1). It is important for HCPs to develop the skills needed to notice, support, and connect patients with multidisciplinary service providers to address these health and well-being issues.

Current Human Trafficking Trainings for Health Care Providers (HCPs)

There have been many attempts to develop human trafficking trainings for HCPs but there is no standard, evidence-based, human trafficking-specific training curricula and/or course. Research has shown that education for HCPs around human trafficking makes a difference for HCPs, but no study has demonstrated prolonged behavior change among HCPs[1,3,16]. Previous research has only assessed immediate pre/post knowledge change but there is no evidence-based training that creates sustained change in the ways in which HCPs provide care and support to patients suspected of being involved in human trafficking[2,3].

Many HCPs are unaware of the ways in which human trafficking involvement manifests in their patients especially pediatric patients[1,3,6,16]. There is no standardized screening or assessment tool for HCPs to use for detecting human trafficking involvement[3,6,17]. This has been difficult to develop due to the hidden nature of the human trafficking industry; it is difficult to distinguish between the way a patient presents in general and what constitutes a symptom of human trafficking involvement [4,5]. The experience of human

trafficking can present like many other injuries and/or illnesses (i.e., bruises, abrasions, rape/assault, mental health symptoms, etc.)[5] which makes it difficult to pinpoint human trafficking specific presentation. Often this takes a more in-depth assessment of the entire patient and multiple health services visits/interactions before a HCP is able to notice signs/red flags of possible human trafficking involvement[6]. Furthermore, patients are unlikely to disclose their involvement in human trafficking due to stigma, mistrust of health services, fear (of deportation, retaliation by trafficker, and/or not ready to leave the industry), or lack of their awareness of what constitutes human trafficking[1,3,8,14,17,20,21]. All these factors are important for HCPs to know in order to build trust with patients and best support them where they are at in their experience.

Addressing Unmet Pediatric Patient Needs

It is important for HCPs to have a standard, evidence-based, HT-specific training curricula/course to best address unmet pediatric patient needs[2,3,11,16]. Having a training like this would enable HCPs to learn the necessary skills to truly support the health and well-being of their patients regardless of where they are in their human trafficking experience (see Figure 1). Moreover, a standard training would allow for a standard licensure and/or a certificate of completion which states that the HCP has completed the thorough education needed to be equipped with the skills necessary to best serve patients suspected of or known to be involved in human trafficking[14]. This sort of standardization of training would provide all those certified with a common pathway for supporting these patients from a trauma-informed, patient-centered care approach [2,3,11,16]. In this way, all participants would be learning the skills necessary to build trust with this unique patient population and allow for better service delivery and relevant support[6,12].

This training would also give HCPs the skills necessary to collaborate with other providers in a multidisciplinary way to best support patients who may be involved in human trafficking[1,6,10,14]. Often HCPs are unaware of the work being done in the community or nationally to address the needs of children and adolescents involved in human trafficking. This training should have a component that teaches HCPs about what supports are available and how to go about connecting with referral organizations depending

on patient need (see Figure 1). Participating in a standard, evidence-based, human trafficking training would allow participants to refer and connect pediatric patients to various multidisciplinary professionals who can continue working with the patient towards human trafficking prevention and reintegration into society when the child/adolescent is ready[1,5,6,10,14].

A standard evidenced-based human trafficking training for HCPs will also inform them enough about the topic so that they could be an informed advocate for human trafficking related research, funding, and policy changes towards prevention[3,5,10,11,15,19]. Learning more about the human trafficking industry and how pediatric patients become at greater risk for involvement will enable HCPs to feel equipped to make decisions and influence change around this topic (see Figure 1). Once HCPs have the knowledge to make more informed decisions when it comes to human trafficking issues, they can become advocates for their pediatric patients and be an additional support towards sustained enforcement of related laws and enforcement of protections [3,5,10,11,15,19]. A standard evidence-based human trafficking training would aid in moving us towards protecting children and adolescents through prevention and education rather than continuing the hidden nature of the human trafficking industry.

Research Question and Specific Aims

1. Does the "Human Trafficking 201" workshop increase perceived participant knowledge around supporting patients suspected of or known to be involved in human trafficking.
2. Was the workshop more effective at increasing perceived participant knowledge among the Psychiatry and Behavioral Medicine Unit (PBMU) care team participants compared to the Odessa Brown Children's Clinic (OBCC) care team participants?

Design:

This study utilized a cross-sectional prospective cohort design. Both the PBMU and OBCC care teams served as cohorts that were provided the workshop in January and February of 2021. And pre/post-workshop self-assessment surveys were conducted to get cross-sectional information about workshop

participants' knowledge at two points in time—before and after participating in the workshop. This design served the study well because it allowed for snapshots to compare participants' perceived knowledge regarding human trafficking and their behaviors supporting patients suspected of or known to be involved in human trafficking.

Setting:

The workshop was provided to two care teams affiliated with Seattle Children's Hospital. Due to the COVID-19 Pandemic, the workshop was provided virtually to both care teams. Although the workshop was virtual, the care teams reside in Seattle Children's Hospital (the PBMU care team), and the affiliated Odessa Brown Children's Clinic (OBCC) located in the Central District of Seattle, Washington.

The Psychiatry and Behavioral Medicine Unit (PBMU), located on the main hospital campus in Seattle's Sand Point neighborhood, and serves pediatric patients (ages 3-17 years of age) with "complex mental health issues"[24] in an inpatient setting. The main goal of the care provided by the PBMU team is to "give your child short-term care during a mental health crisis [by] stabiliz[ing] the behaviors that led to hospitalization and teach your child and family skills that can help after your child leaves the hospital…[and] these skills can help you and your child cope and help you prevent crises in the future" [24]. The PBMU team also works on discharge planning with the child and family and refer to additional supports in the community as appropriate.

The Odessa Brown Children's Clinic, located in Seattle's Central District (CD), has been serving this community since 1970. Over the past 50 years, the OBCC "has grown into a comprehensive facility with medical, dental, mental health and nutrition services that embrace patients and families in [their] community"[23]. The mission of the OBCC "is [to be] an enduring community partner with a dedication to promoting quality pediatric care, family advocacy, health collaboration, mentoring and education in a culturally relevant context"[23]. The clinic "has been committed to delivering equitable health and wellness care to lower-income and ethnically diverse children… regardless of their ability to pay"[25]. Additionally,

the historically black CD community has been facing the quickest gentrification compared to other Seattle neighborhoods, and many black families have been moving further into South Seattle as a result[22].

The workshop was delivered through a PowerPoint presentation and was conducted online via virtual meeting on the WebEx platform. This format was selected due to the COVID-19 Pandemic and the social distancing regulations that are currently in place. Workshop participants were asked to complete the pre/post workshop surveys online via Microsoft Forms rather than in-person.

Study participants:

Study participants included providers and staff affiliated with Seattle Children's Hospital's Odessa Brown Children's Clinic (OBCC) and the Psychiatry and Behavioral Medicine Unit (PBMU). These two care teams were selected because team leaders had a high interest in receiving continued training on human trafficking. Care team leaders noted the need for additional training among their staff because of the high-risk populations with which they work. All members of each care team were invited to participate in the workshop.

Care team members who participated from the PMBU included psychiatrists, psychologists, advanced registered nurse practitioners, dieticians, educators, nurses, occupational therapists, pediatric mental health specialists, and speech and language specialists. There was a total of 28 individuals who attended the PBMU workshop.

Care team members who participated from the OBCCC included pediatricians, nurse practitioners, nurses, social workers, nutritionists, dentists, orthodontists, psychologists, psychiatrists, and therapists. Care team members for PBMU include psychiatrists, psychologists, nurse practitioners, and social workers. A total of 16 individuals attended the OBCC workshop.

Methods:

A mixed-methods evaluation was conducted to determine if the workshop was effective at increasing perceived knowledge among workshop participants regarding human trafficking. This project involved virtually implementing workshops with both the OBCC and PBMU care teams, distributing pre/post-workshop self-assessment surveys to care team members used for quantitative data analysis, and conducting follow-up qualitative interviews. Given the small number (n=3) of participants who completed the pre/post-workshop self-assessment surveys, we were unable to do a matched-pair data analysis. The pre/post-workshop self-assessment data does include different groups of people and could potentially cause some of the changes in perceived knowledge rates.

Two separate workshops were held via the WebEx platform used by Seattle Children's Hospital for virtual meetings and webinars. The interviews were conducted a month apart with the PBMU team first (1/19/2021) and OBCC second (2/16/2021). Both workshops lasted one-hour and provided time for participants to learn the content, engage in discussions, and ask additional questions. Email invitations to join the workshop were forwarded to care team members and the workshop was advertised as optional to both care teams.

The workshop was implemented with the OBCC care team on January 19th, 2021. The PBMU care team was provided with the pre-self-assessment survey link via e-mail one week prior to the workshop and participants were asked to complete the survey before attending. Directly following the workshop, the PBMU care team was provided the post-self-assessment survey link via e-mail and asked to complete as soon as possible. The workshop was then implemented with the PBMU care team on February 16th, 2021. Workshop participants on the PBMU care team were provided with the pre-assessment link 2 weeks prior to their workshop date and were reminded at the beginning of the workshop to complete the survey if they had not already (and provided with the link again in the virtual meeting chat box). Like the PBMU care team, OBCC workshop participants were asked to complete the post-self-assessment survey following the workshop's completion and were sent an e-mail reminder as well.

Workshop participants were also asked to fill out a brief pre/post survey to determine their perceived level of knowledge regarding human trafficking and to gain basic identifiers regarding their role on the care team. No additional personal information or identifiers were acquired from workshop participants. The survey utilized a Likert Scale for participants to rate their knowledge related to workshop objectives (see appendix). Participants also had space to write-in any additional comments they had regarding their knowledge and/or the workshop itself—how to improve the workshop to increase knowledge gained, what went well, what was a barrier, etc.

Following the implementation of the workshop, 45-minute follow-up interviews were held to better understand workshop participants' perceptions of the workshop and its effect on their work skills and interactions with patients. This included exploring participants' experiences with the workshop, its implementation and any foreseen or experienced difficulties, as well as their behavior change since participation. Interviews were recorded and verbal consent was given prior to beginning the recording. The recordings were then transcribed and qualitatively evaluated for reoccurring themes.

Timeline

The IRB review application for this research project was submitted December 2021 and approved January 2021. The workshops were then implemented on 1/19/2021 (PBMU) and 2/16/2021 (OBCC). The pre-self-assessment survey was provided to care team members one week prior to each care team's workshop date. The post-self-assessment surveys were then provided to workshop participants following the workshop's completion. Participants were provided unlimited access to completing the post self-assessment survey link without a final completion date. The quantitative data analysis was completed March 2021.

Follow-up interviews were conducted the during March 2021. The OBCC interview was completed 3/16/2021 and the PBMU interviews were completed 3/17/2021 and 3/31/2021. Recruitment for these

interviews was done during late-February and early-March of 2021 via email sent to all workshop participants. The interviews were then qualitatively analyzed during April 2021.

Data collection

Quantitative Data: Pre/post-workshop self-assessment surveys

Data collection was completed via Microsoft Forms survey platform. Workshop participants were asked to complete pre/post-workshop self-assessment surveys to assess their perceived knowledge regarding human trafficking. These pre/post self-assessment surveys utilized a Likert Scale rating (scale of 1-5) for participants to rate their knowledge of each objective related to the workshop content. Prior to the workshop, participants were asked to complete the pre-workshop self-assessment survey to determine their baseline perceived knowledge related to human trafficking. Requests for completion were made via e-mail and follow-up email reminders. After participating in the workshop, participants were then asked to fill out the same, now post-workshop self-assessment survey, to determine their perceived level of knowledge after participating in the workshop. Reminders to complete the post-workshop self-assessment survey were sent via e-mail.

Qualitative Data: Follow-up interviews

Workshop participants from both care teams were asked to participate in a 30–45-minute follow-up interview 1-month after their team's workshop date. Verbal consent was obtained at the beginning of the interviews and recording of the interview proceeded. Interview participation was voluntary and if participants were interested in being interviewed, they sent an e-mail back mentioning their interest (n=3). Interview dates/times were then scheduled based on the interviewee's availability. Meetings were scheduled via Google Calendar with the video-chat enabled. A reminder confirmation e-mail was sent to the interviewee the day before their interview. The interviewer conducted the interview utilizing a standard interview guide (see Appendix) and interviews were audio-recorded and later transcribed (via the Temi program) and coded (via the Dedoose program) to determine themes.

Data Analysis

Quantitative data analysis: Pre/post-workshop self-assessment surveys

To compare the degree of perceived knowledge change among workshop participants the pre-workshop average perceived knowledge rating was calculated among all completed surveys (N=11) for each workshop objective. The post-workshop average perceived knowledge rating was then calculated among all completed post surveys (N=11) for each workshop objective. Then, the difference between pre- and post-workshop average ratings for each objective was determined and converted into a percent change value (see Table 2A). The same was done to determine the average degree of perceived knowledge change among workshop participants for each workshop section: introduction, education, prevention, community referral organizations, and real-life scenarios and discussion (see Table 2B). Unfortunately, it was not possible to determine whether there was a significant difference in perceived knowledge change between the OBCC and PBMU care teams due to a lack of survey responses. There was a total of 3 workshop participants (1 for PBMU and 2 for OBCC) who completed both the pre- and post-workshop self-assessment surveys. With such a small sample size from the total number of workshop participants (28 for PBMU and 16 for OBCC), any results drawn from these data would have been insignificant and ungeneralizable.

Results

Quantitative: Pre/post-workshop self-assessment

The implementation of the Human Trafficking 201 workshop resulted in 44 total workshop participants (PBMU and OBCC care teams combined). Many participants had previously participated in the initial human trafficking training and other DEI-related trainings or workshops (64%). Only 2 workshop participants (18%) had ever been involved in the SCH Human Trafficking workgroup, so most participants had very little exposure to content related to human trafficking specifically (see Table 1).

Table 1: Combined workshop (PBMU and OBCC) participant details (N=44)*

Workshop participants (N = 44): ARNP, Mental Health Counselor, Psychiatrist, Nurse, Care Coordinator, Mental Health Therapist, Psychologist, Pediatrician (MD/DO), Dentist; Pediatric Dentist, Social Worker, Family Advocate/Case Manager		
[redacted]	Completing Pre-workshop assessment (N=11)	Completing Post-workshop assessment (N=11)
PREVIOUSLY PARTICIPATED IN WHILE AT SCH:		
Prior human trafficking training	6/11 (55%)	5/11 (45%)
Other DEI-related trainings or workshops	7/11 (64%)	7/11 (64%)
SCH Human Trafficking Workgroup	4/11 (36%)	2/11 (18%)

**N=44, number of total individuals who participated in the PBMU or OBCC workshops.*

The "Human Trafficking 201" Workshop did increase perceived participant knowledge around supporting patients suspected of or known to be involved in human trafficking. An overwhelming percent of workshop participants (91%) felt that the Human Trafficking 201 workshop provided them with new skills. No participants felt that the workshop did not provide them with new information/skills which was remarkable feedback that supports the implementation of the Human Trafficking 201 workshop. Participants who completed the post-workshop self-assessment survey also commented that "the thorough overview" added to their learning and "while there are many moving parts to this discussion, I thought the presentation highlighted the most vital takeaways". Additionally, a large majority (82%) of workshop participants felt that the workshop would cause them to change their current behaviors regarding supporting this patient population because of their participation in this workshop. Only one participant felt that their behavior would not change as a result of this workshop and added that this was due to their extensive background in working with this patient population (see Table 2).

Table 2: Post-workshop self-assessment qualitative responses related to workshop evaluation (N=11)*

The Human Trafficking 201 Workshop…		
Provided me with new skills	Yes	10/11 (91%)
	Maybe	1/11 (9%)
	No	0/11 (0%)
See themselves changing current behaviors around supporting HT-patients	Yes	9/11 (82%)
	Maybe	1/11 (9%)
	No	1/11 (9%)

**N=11, number of participants (both PBMU and OBCC) who completed the post-workshop self-assessment survey.*

An increase in perceived participant knowledge was observed for each objective (on average) with a range of 13—42% positive change (see Table 2B in appendix). The largest perceived change in average participant knowledge was observed for objective 15, explaining referral strategies for connecting patients with supports after discharge/leaving outpatient clinic. The smallest perceived change in average participant knowledge was observed for objective 7, explaining how social constructs have caused the human trafficking risk for these patients and how it is not inherent of the individual (see Table 2B in appendix). Other objectives with smaller degrees of average percent change in perceived knowledge include objectives 5, 6, and 9 (all 15%), which ask about identifying/explaining risk factors and increase likelihood of human trafficking involvement, identifying high-risk populations for human trafficking involvement and why they are at increased risk, and describing the provider role in supporting patients: mandatory reporting, informed consent throughout, goal is to build trust and not disclosure. Additionally, objectives related to diversity, equity, and inclusion (DEI) were areas of greater degree of perceived knowledge change; objective 8, which asks about explaining how human trafficking is a DEI-related issue and why it is important to treat is as such, saw an increase of 28% (see Table 2B in appendix).

Table 2A: Percent change in participant perceived knowledge by training sections (N=11)

Section	Pre-workshop average perceived knowledge rating ($\bar{x}$, (O))	Post-workshop average perceived knowledge rating ($\bar{x}$, (O))	Absolute change in perceived knowledge	Relative percent change (%)
Introduction	3.7 (0.1)	4.8 (0.1)	1.1	22
Education	3.6 (0.3)	4.4 (0.1)	0.9	18
Prevention	3.2 (0.4)	4.6 (0.2)	1.4	28
Community Referral Organizations	2.6 (0.1)	4.6 (0.1)	2.0	40
Real-Life Scenarios Activity	2.9 (0.2)	4.5 (0.2)	1.6	31

The average perceived knowledge rating change by section was 22% for content related to the introduction, 18% for content related to education, 28% for content related to prevention, 40% for content related to community referral organizations, and 31% for content related to the real-life scenarios activity (see Table 2A). The community referral organization objectives (14, 15, and 16) all observed the largest change in average perceived knowledge change (38%, 42%, 40% respectively), whereas the introduction and education sections had smaller degrees of perceived knowledge change (see Table 2B in appendix). The real-life scenarios activity section saw the next highest degree of perceived knowledge change, with content related to identifying ways in which the care team can best support the patient in various scenarios (objective 18) and identifying and implementing skills that can support a patient in the moment (objective 19) having percent changes of 36% and 31%, respectively (see Table 2B in appendix). Although there was a large change in perceived knowledge with these sections and their objectives, the post-workshop perceived knowledge rating was still not that high (maximum relative change of 80%) so there is more that could be done with these sections to better address the current perceived knowledge rating.

Qualitative: Follow-up interview themes and quotes

Previous experience with patients suspected of or known to be involved with HT

A common theme that resulted from the interviews was that the content was useful, but interviewees had extensive work experience with HT.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
Previous experience with patients suspected of or known to be involved in HT	**19**
	"Nothing, nothing standard… I think we've had hospital-wide trainings that we've invited people to, we might've done one for residents…"

All interviewees have had some exposure in their current position and prior but still appreciated the training as a refresher. Interviewees discussed various ways in which the training was still useful because they interact with these patients and are often unsure of how to best support them. In addition, interviewees shared that they currently do not have any standard protocol or training that is required for them to participate in. As a result, interviewees did not feel that their teams are adequately skilled to support patients suspected of or known to be involved in HT. Participating in this workshop provided them with additional knowledge for better supporting this patient population.

Repeated content from (initial) Human Trafficking 101 workshop

Many interviewees commented that there was a fair amount of information that was repeated from the previous HT-workshop.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
Repeated information (101) training	**9**
	"…there was enough that if you were brand new to this information, you could catch up really fast, but also enough new stuff that if you had already been, there was more, and it didn't feel like 'uh, I've already done this, like I don't need to do this again.'" *"There did seem like there was a lot of overlap in the 101 and 201. And I don't know how you would do that differently."*

Much of the introductory and educational information was content that they had already been exposed to, and included content on definitions, risk factors, and pathways to HT-involvement. Some interviewees felt that too much time was spent on these sections which could have been better spent focusing on new information. Although there was much repeated content, interviewees shared that it was unavoidable for some of the content (definitions and risk factors) but was still a good reminder and relevant for all care team members regardless.

New areas of knowledge: Protective factors, engaging in HT-conversations, and community referral organizations

All interviewees commented positively on the sections related to HT-prevention and community referral organizations. Interviewees were particularly interested in the content related to protective factors and engaging in conversations around HT with patients and parents/guardians.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
New areas of knowledge	**18**
Protective factors	*"Yeah. This is really helpful. So as much of this as we can get."* *"I would say that the reminder to not just be looking for red flags and warnings and to really look at protective factors, I think that's important right now with just in general with this pandemic and everything that meant for families."*
Engaging in HT-conversations	*"… So just thinking about how I approach this directly with patients, or their caregivers as appropriate, you know, like what are maybe phrases or just ways to approach it that are maybe more likely to be received in a supportive and therapeutic way was helpful."* *"I think this was wonderful. I loved it. And I think we could even spend more time there."*
Community referral organizations	*"I think it's a really solid section. It covers a lot of different areas and has so much good information."* *"This was wonderful. …it was wonderful to dive into the resources more."* *"There are so many organizations and I'm not well versed in who does what, and so it was, it was nice to just get some more insight there."*

They all mentioned that this information was not covered in the previous HT workshop which is currently available to providers and staff. The content related to protective factors came from a social services approach which was a new way to view prevention for many interviewees. Interviewees appreciated this strengths-based approach and shared that it also helped to inform the way in which they can engage in HT-prevention conversations with patients and parents/guardians. Learning how to engage in conversations in a supportive and therapeutic manner was an area in which interviewees gained new information and would have like to spend more time rather than on the introductory content.

Interviewees appreciated the section on community referral organizations because it provided them with a way to make sure patients continued to receive support after discharge. Interviewees explained how this

was an area of need for them and found it useful to spend time discussing strategies for building connections with referral organizations. An area of improvement that was mentioned for this section was to provide actual contact information for an individual who works at the referral organizations mentioned. The interviewee explained that having an actual person to contact rather than a general phone number removes another step for HCPs and allows them to connect the patient with a person directly—provides a bit of a standard referral protocol for a patient who may be involved in HT.

Workshop implementation

Another theme that came from the interviewees was around the implementation of the workshop.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
Workshop implementation	**13**
	"So we have a standing Monday (Monday, noon), multi-disciplinary didactic seminar where different people from different disciplines, some with the PBMU and some from any other service, come and just five talks about topics. It could be really anything. So that's a standing place that we have. That's a great venue for things like this." *"[OUR CLINIC DIRECTOR] promoted it, and it's one of those things I feel like makes employees say, 'well, this is the director of our clinic and she's telling me it's important for me to be there.'"*

All interviewees shared that the workshop topic, date, and time, were communicated to them through e-mail from their department leads. The workshop was not a mandatory, but the department leads shared their strong interest and emphasized attending the workshop. One interviewee shared that they believed that this interest demonstrated by their department lead may have encouraged fellow care team members to attend because it seemed like important content. Additionally, interviewees discussed how HT-content is very much relevant to their care team because they interact with these patients quite often and many care team members may not have the necessary skills to fully attend to these patients and their unique needs.

In terms of any barriers that care team members may have had to attending, it was mentioned that there was a social work-related training going on at the same time as this training on one of the implementation days. This may have deterred some care team members from attending this workshop because of the other

competing training. Additionally, both workshops were held after 3-day holiday weekends which may have affected team member attendance. On a normal week, both care teams have standing meeting times where they invite speakers/trainers, etc. to come discuss a relevant topic with the team but they had to move the meeting due to the long holiday weekend and care team members could have forgotten been confused by this change. Lastly, it was commented that there must be some staff that stay with the patients so not all care team members had the opportunity to attend the workshop even if they saw it as relevant and useful content.

Lack of time

One of the main problems that interviewees had with the workshop was that there was not enough time to explore all the content.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
Lack of time	**7**
More time for real-life scenarios activity and discussion	*"You know, it's so hard with limited time. I mean, I think if there would be a way to have a little more time for case discussion, that would be the only thing I can think of, but it's tough to say that because then something else would have to give."* *"I would always say yes to more time, but I know it's hard to get people to take more than an hour. So I think for, for exposure, for reach more people, I think keeping it to an hour is good…"*

This lack of time made it difficult to further explore many of the topics. Although there was a good amount of new information interviewees felt like they did not have adequate time to discuss more and practice with the real-life scenarios activity. All interviewees expressed an interest in the real-life scenarios activity and discussion but mentioned that this section could have had more of a focus when it came to time management. One interviewee was particularly interested in the real-life scenarios activity and mentioned that it would be helpful to role-play conversations connecting with community referral organizations to feel more comfortable to do this when they need to in the future. Interviewees expressed their understanding that it is difficult to determine where to focus the time especially with the time limit of one hour. Interviewees felt that too much time was spent on the introductory and education sections (repeated content) and more could have been focused on the latter sections with new content on prevention, community referral organizations, and the real-life scenarios activity with discussion time.

Lack of opportunity for behavior change related to HT post-workshop

Another barrier that became evident through interviews was that HCPs may not have had the opportunity to implement the knowledge/skills gained in the time period between attending the workshop and their interview date.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
No opportunity for behavior changes related to HT	**10**
	"I think since the last training, I can only think of like maybe two kids who came onto our unit who have either confirmed or suspected trafficking." *"I haven't had a referral for trafficking, so I haven't really had an opportunity to make a referral."*

Interviews were held about one month after the workshop was implemented and most interviewees (2 out of 3) shared that they had not encountered a patient who was suspected of or known to be involved in HT since the workshop. It was thought that this may be due to the COVID-19 pandemic and the limitations that has put on the HCPs, the continued lack of a HT-screening tool/guide for identifying these patients, or the possibility that they really have not had any patients involved in HT come to their unit/clinic in that month-period.

One of the interviewees said that they had maybe had 2 HT-related cases since the training but was unsure of any behavior change on their end due to the training. Many of the workshop participants who also participated in these interviewees also have extensive experience working with patients suspected of or known to be involved with HT and this interviewee mentioned this as a reason for why it may not have resulted in behavior change for them. Additionally, the interviewee shared that their unit has been doing many trainings related to DEI topics and thought that this also may have had an impact on behavior change. Lastly, the interviewee mentioned that the team working with these patients seemed to work much better than with past cases but that there were many other factors that could have added to this improved collective case management.

Additional areas for improvement

Interviewees had few recommendations for how to improve the workshop for the future.

THEME	TOTAL CODE EXCERPTS AND EXAMPLE QUOTES
Additional areas for improvement	**16**
	"You know, it's so hard with limited time. I mean, I think if there would be a way to have a little more time for case discussion, that would be the only thing I can think of, but it's tough to say that because then something else would have to give." *"I think the biggest, my biggest thought is like having a recording so people can go back and look at it… I think it would be a good way to just capture all of the people that couldn't make it [workshop]."*

The main suggestion was for better time management—either lengthening or spending less time on the introductory and educational section. Interviewees expressed their interest in the real-life scenarios activity which either did not get covered or spent a very short amount of time on. Interviewees found this content to be relevant, new, and useful, and expressed the need to spend more time on this section. Additionally, interviewees thought that recording the workshop sessions would allow for better reach of providers/staff who were unable to attend. It would also allow those who did attend the live workshop to go back and take more detailed notes, rewind, re-listen, and spend more time to familiarize themselves with the content as needed. Lastly, it was shared that providing copies of the presentation slides to participants would have allowed for easier notetaking and absorbing of knowledge/information.

Discussion

Care team areas of focus

Although the workshop evaluation indicated a positive change in perceived knowledge change among participants, it is interesting to note the explanations for these differences. Prior to implementing the workshop, both teams had the chance to share their areas of focus in terms of content. Both teams expressed an interest in learning more about community referral organizations and ways to connect with them. Additionally, both teams wanted to gain real-life situation skills to better serve patients in the moment. Prevention was more of an area of focus for the OBCC care team especially when it came to

facilitating conversations. These areas of focus for care teams supported the conceptual models given that they were noticing missed opportunities for supporting patients who may be involved in human trafficking. This became evident with the percent differences between pre- and post-workshop self-assessment results. The largest change in the average perceived knowledge was observed with the community referral organizations section followed by the real-life scenarios activity section. Prevention was the next greatest average perceived knowledge change, then the introduction, and the education section with the least. The qualitative interviews also supported these trends, with interviewees most vocal about the sections on community referral organizations, real-life scenarios activity time, and prevention (protective factors and engaging in conversations about human trafficking). These were areas that the conceptual model points out are areas of need and places where interviewees felt more time should have been spent. The introduction and education sections were not discussed by interviewees nearly as much as the other sections apart from interviewees noting the repeated introductory content from the (initial) Human Trafficking 101 training. For this reason, it is most likely that there was not as large of an increase in average perceived knowledge change for the introduction and education sections.

Trends in perceived knowledge change

Much of the perceived knowledge change that was observed was related to content on prevention, community referral organizations, and the real-life scenarios activity. It is interesting to see this trend because these sections had the least amount of dedicated time and interview participants said they would like to spend more time exploring. It is most likely that the large changes in perceived knowledge are because it was new information and not necessarily that participants gained long-term knowledge improvement, as evidenced by the low initial ratings and higher post-workshop ratings. It is also interesting to note that the objectives had the greatest change in perceived knowledge. There is also the possibility that the content that was shared in these sections was quite beneficial and workshop participants did note the new knowledge gained. These sections emphasized information regarding ways to build trust with patients, highlight patient/family strengths (protective factors), strategies for connecting

patients with referral organizations, and the importance of trauma-informed care. Participants may have remembered these areas more because it was new content and focused on learning because of its relevancy. The introductory and educational sections had a smaller degree of perceived knowledge change which was most likely a result of repeated information. 45% of participants who completed the post-workshop self-assessment surveys stated that they had previously participated in the initial Human Trafficking 101 workshop. As a result, many of the Human Trafficking 201 workshop participants had already been exposed to much of the content in these two sections. This could explain the smaller percent change in perceived knowledge post-workshop.

Modifications made based on PBMU workshop implementation

There were many things that we learned from the implementation of the workshop with PBMU that we were able to adjust to improve the OBCC workshop's implementation. This mainly revolved around our strategies for engaging participants in completing the pre/post-workshop self-assessment surveys. We noted that participants were not provided enough time to complete the pre-workshop self-assessment survey. The survey was provided to participants one week prior to the workshop being held. It was thought that providing the link once a week ahead would be enough to get plenty of responses, but we only ended up with 11 responses, with only 5 of those also completing the post-workshop self-assessment survey.

To remedy this with the OBCC workshop's implementation, we provided the link to the care team two weeks ahead to the workshop being held and provided the survey link in the chat box of the virtual workshop meeting with a verbal reminder for participants who have not yet completed the pre-workshop survey to do so as we wait for other to join and get started. This did result in more responses from the OBCC team but still only a few. We also provided the post-workshop self-assessment survey in the chat box at the end of the workshop and reminded participants to complete it because this is what we are using to gather information for the data analysis. We also followed up with an e-mail reminder with the post-workshop survey link embedded.

Future changes to allow for matched-pair data analysis

It was unfortunate that not enough pre/post-workshop self-assessment surveys dyads were completed to conduct a matched-pair data analysis. In the future, it is recommended that time be built into the workshop for participants to complete the pre-workshop self-assessment survey before starting the presentation and allow time at the end for participants to complete the post-workshop self-assessment survey. This would increase the chances of obtaining a higher yield of dyads to do an amplified, more valid, analysis of the change in perceived knowledge because of the workshop itself. Additionally, it could be beneficial to provide a longer period (3-6 months) between workshop implementation and conducting the follow-up interviews. This would allow more time for participants to possibly engage with patients suspected of or known to be involved in HT. The one-month period did not provide interviewees enough time to possibly engage with these patients so there was no feedback obtained to evaluate participants' long-term behavior change in relation to engaging with these patients.

Workshop implementation

All aspects of the presentation of the workshop went smoothly with both care teams. Unfortunately, we ran out of time during the OBCC workshop and did not get to complete the real-life scenarios activity and discussion. I was able to explain the activity to participants and give a brief run-through of each scenario, but participants were unable to divide into breakout groups and discuss each scenario together. The PBMU workshop participants did have the chance to divide into breakout groups, but the conversations only lasted about 5-minutes and then we had to come back to close the workshop.

Workshop participants seemed to be engaged in the workshop content during the presentation. Participants in both sessions were utilizing the chat box to ask questions and share comments throughout the presentation. Post-workshop self-assessment surveys indicated that attendees thought the presenter did a great job and was well-organized. An additional comment was that the real-life scenarios One topic that participants had questions about during both sessions was in the Introduction to Human Trafficking

session and was on the definition of child labor. Participants seemed to be confused about what constitutes child labor and we had discussions during both sessions about examples of child labor and how it may be difficult to identify child labor when it coincides with cultural and familial values around being a part of a family and the role older children may play in various cultures.

The mixed-methods data analysis yielded additional opportunities for workshop improvement in the future. There was a demonstrated need to adjust the amount of time spent on the various sections. The overwhelming feedback was that too much time was spent on repeated introductory and educational content and not enough time on new content related to prevention, community referral organizations, and the real-life scenarios activity and discussion. It is difficult to address this concern because much of the introductory content is needed if it is not required for attendees to have taken the "Human Trafficking 101" training prior to this secondary workshop. Interview feedback made it clear that it is not realistic to have providers/staff attend both due to turnover, work schedules, and additional position tasks. If the hospital were to require all providers/staff to attend both trainings, then it would be possible to shorten much of the introductory and educational content (because participants would have already heard that information in their previous training) and focus more on the prevention, community referral organizations, and real-life scenarios and discussion content. What may be more realistic is to change the workshop to a 2-day training or extend the time to one hour and thirty minutes, in order to accommodate all the necessary content.

Limitations

There were several limitations with this evaluation. (1) Data was based on self-report, (2) difficult to control for participant initial HT-knowledge level, (3) few pre/post-workshop self-assessment dyads obtained, (4) few follow-up interview participants, and (5) the individual who implemented the workshop with both care teams also conducted the evaluation, which could have biased the interpretation of the results.

The main limitation to this project is that data is based on self-report of participants. Workshop participants will be providing information related to their perceived knowledge around human trafficking topics. Self-reported data is susceptible to various types of bias which can influence the reliability of the results draw from the data analysis.

Furthermore, it is difficult to control for all participants having the same initial level of knowledge related to human trafficking. As a result, some participants may have greater knowledge than others which can result in varied degrees of change in perceived knowledge unrelated to the workshop itself. We attempted to control this by analyzing the pre/post-workshop self-assessment survey responses via participant pre/post dyads, comparing each individual's pre-workshop question response to the same corresponding post-workshop question response. This strategy assisted in mitigating the baseline knowledge problem but there was still the issue of the degree to which perceived knowledge may have changed. Individuals who may have rated their pre-workshop perceived knowledge higher than other workshop participant's may have had a smaller change in perceived knowledge with their post-workshop response. For this reason, the OBCC data was adjusted for this outlier and was also compared to PBMU perceived knowledge change. There is the possibility that the degree of change for individual participant's perceived knowledge may be misconstrued because of the nature of a Likert Scale reporting method.

In addition, there were few pre/post- workshop self-assessment survey responses received from workshop participants. As a result, it was not possible to analyze the effectiveness of the workshop for the PBMU care team compared to the OBCC care team. The small sample size makes it difficult to generalize the results of this study to the workshop's effectiveness on a larger scale. To have a stronger generalizability, there is a need for a stronger power, which was not achievable with the small sample size (11) that resulted from pre/post-workshop self-assessment surveys. This was difficult to control for because workshop participants were not required to complete both pre/post-workshop self-assessments to participate in the training. It was also noted that self-assessment surveys were not a priority for providers

and staff at this time due to the global COVID-19 pandemic; there were other more pressing tasks for care team members to be attending to rather than completing these self-assessments.

There were also only a few workshop participants who agreed to also participant in follow-up interviews. These interviews served to provide additional qualitative data to support the quantitative data received from the pre/post-workshop self-assessment surveys. It was our goal to conduct 2-3 interviews with each care team. Due to extenuating circumstances (the global COVID-19 pandemic, busy schedules, and interviews having to be held virtually) only three interviews were conducted: two with members of the PBMU team and one with a member of the OBCC team. This could have caused selection bias, in that those who agreed to participate in the interviews may have been more positive in their thoughts about the workshop. Additionally, this limits the generalizability of their comments and the themes discovered during the qualitative data analysis.

Only having one care team member from the OBCC workshop participate in the follow-up interviews makes it difficult to generalize the feedback received from this interview. Additionally, it was better to have two workshop participants from the PBMU workshop participate in the follow-up interviews, but again, this is a small sample and is still difficult to generalize their feedback. Also, the backgrounds of all the follow-up interview participants adds to the lack of generalizability because they are all have extensive backgrounds in human trafficking related work and serve in leadership roles on their teams when it comes to human trafficking education and training for the care teams.

All workshop participants who completed both the pre- and post-workshop self-assessment surveys expressed that they saw themselves changing their current behaviors around supporting patients suspected of or known to be involved in human trafficking because of the workshop. Participants also said that the workshop helped to improve their knowledge of human trafficking and that the workshop provided them with information that will help them to better support patients who are known to be or suspected of being involved in human trafficking. Finally, participants also thought that their behaviors/interactions with patients will changed based on participating in this workshop.

The fact that the individual who implemented the workshop with both care teams also conducted the evaluation could have biased the interpretation of the results. Ideally, the individual implementing the workshop would not be the one also conducting the evaluation, but this was not possible due to the nature of the project. Many precautions were taken to ensure for unbiased interpretations such as utilizing a qualitative data collection method, highlighting both positive and negative participant comments, sticking to the interview guide, and providing all mentioned reasoning and explanations from participants for all themes and patterns that resulted.

Conclusion

Although the data analysis shows that the workshop was successful in improving average workshop participant knowledge regarding supporting patients suspected of or known to be involved in human trafficking, it is difficult to draw any generalizable conclusions due to the limitations of the evaluation.

It can be said that workshop participants found the content of the workshop to be useful in improving their perceived knowledge regarding the topic of human trafficking based on comments provided in the surveys and the follow-up interviews. Participants seemed to find the content related to protective factors and engaging patients and parents/guardians in conversations around human trafficking to be beneficial to their practice. Participants also appreciated the content discussing strategies for connecting with referral organizations to be helpful information for connecting patients and their families to after their engagement with SCH staff to be completed. Furthermore, participants found the real-life scenarios activity and discussion to be useful but needed more time to explore this content.

Future steps for the “Human Trafficking 201 workshop” pilot include testing it with other care teams associated with the hospital to help inform its generalizability. The SCH CDHE team hopes to one day make this training available to all providers and staff associated with the hospital. To make this possible, this training will require additional piloting and data analysis to determine its effectiveness with an array of care teams. With this further piloting, we will also need to determine ways to encourage more pre/post-

workshop self-assessment survey responses. Accomplishing this will assist in acquiring a higher power for the data analysis and improve validity and generalizability of the results.

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Appendix

Workshop Objectives:

Section 1: Introduction to Human Trafficking

1. Define human trafficking.
2. Define the 2 types of human trafficking: labor and sex.
3. Identify barriers related to human trafficking for patients when accessing medical care.

Section 2: Education

4. Describe the various pathways that lead to human trafficking involvement.
5. Identify risk factors that increase likelihood of human trafficking involvement and explain why they increase risk.
6. Identify high-risk populations for human trafficking involvement and why they are at increased risk.
7. Explain how social constructs have caused the risk for these patients and is not inherent of the individual.
8. Explain how human trafficking is a DEI-related issues and why it is important to treat it as such.
9. Describe the provider role in support patients: mandatory reporting, informed consent throughout, goal is to build trust and not disclosure.

Section 3: Prevention

10. Define protective factors and how they help to prevent human trafficking involvement.
11. Explain the basis of trauma-informed care and how it applies to patients suspected of or known to be involved in human trafficking.
12. Explain ways to focus on prevention in conversations with patients.
13. Describe strategies for engaging in productive, human trafficking related conversations with parents/caregivers/guardians.

Section 4: Community Referral Organizations

14. Identify community organizations that can provide support to patients involved with human trafficking.
15. Explain referral strategies for connecting patients with supports after discharge/leaving outpatient clinic.
16. Describe strategies for building care team connection with community referral organizations.

Section 5: Real-Life Scenarios Activity and Discussion

17. Troubleshoot on-the-spot methods for supporting a patient suspected of human trafficking involvement.
18. Identify ways in which the care team can best support the patient in various scenarios.
19. Identify and implement skills that can support a patient in the moment.

Human Trafficking 201 Workshop: Pre/Post Self-Assessment Survey

Please complete the self-assessment using the following scale:

1= No Knowledge
2= Very Limited Knowledge
3= Limited Knowledge
4= Moderate Knowledge
5= Great Knowledge

Section 1 Introduction to Human Trafficking	1. Define human trafficking.	1	2	3	4	5
	2. Define the 2 types of human trafficking: labor and sex.	1	2	3	4	5
	3. Identify barriers related to human trafficking for patients when accessing medical care.	1	2	3	4	5
Section 2: Education	4. Describe the various pathways that lead to human trafficking involvement.	1	2	3	4	5
	5. Identify risk factors that increase likelihood of human trafficking involvement and explain why they increase risk.	1	2	3	4	5
	6. Identify high-risk populations for human trafficking involvement and why they are at increased risk.	1	2	3	4	5
	7. Explain how social constructs have caused the risk for these patients and is not inherent of the individual.	1	2	3	4	5
	8. Explain how human trafficking is a DEI-related issue is and why it is important to treat it as such.	1	2	3	4	5
	9. Describe the provide role in supporting patient: mandatory reporting, informed consent throughout, goal is to build trust and not disclosure.	1	2	3	4	5
Section 3: Prevention	10. Define protective factors and how they help to prevent human trafficking involvement.	1	2	3	4	5
	11. Explain the basics of trauma-informed care and how it applies to patients suspected of or known to be involved in human trafficking.	1	2	3	4	5
	12. Explain ways to focus on prevention in conversations with patients.	1	2	3	4	5
	13. Describe strategies for engaging in productive, human trafficking related conversations with parents/caregivers/guardians.	1	2	3	4	5

Section 4: Community Referral Organizations	14. Identify community organizations that can provide support to patients involved with human trafficking.	1	2	3	4	5
	15. Explain referral strategies for connecting patients with supports after discharge/leaving outpatient clinic.	1	2	3	4	5
	16. Describe strategies for building care team connection with community referral organizations.	1	2	3	4	5
Section 5: Real-Life Scenarios Activity and Discussion Time	17. Troubleshoot on-the-spot methods for supporting a patient suspected of human trafficking involvement.	1	2	3	4	5
	18. Identify ways in which the care team can best support the patient in various scenarios.	1	2	3	4	5
	19. Identify and implement skills that can support a patient in the moment.	1	2	3	4	5

GENERAL QUESTIONS:

1. Which care team are you affiliated with?
    a. Psychiatry and Behavioral Medicine Unit (PBMU)
    b. Odessa Brown Children's Clinic (OBCC)

2. What is your primary role (job title) on this care team?
    a. Advanced Registered Nurse Practitioner (ARNP)
    b. Care Coordinator
    c. Clinical Director
    d. Dentist
    e. Dental Assistant
    f. Dietitian
    g. Director (general)
    h. Front desk staff
    i. Mental Health Therapist
    j. Medical Assistant (MA)
    k. Medical Director
    l. Mental Health Counselor
    m. Nurse
    n. Nutritionist
    o. Occupational Therapist
    p. Office staff
    q. Orthodontist (DDS)
    r. Pediatrician (MD/DO)
    s. Psychiatrist (MD/DO)

t. Psychologist
u. Security
v. Social Worker
w. Speech and Language Pathologist
x. Other: please provide

3. How many years have you been in this role on this team?
    a. Less than 1 year
    b. 1-3 years
    c. 4-7 years
    d. 8-10 years
    e. 11-15 years
    f. 16-19 years
    g. 20+ years

4. How many years have you worked in this role overall?
    a. Less than 1 year
    b. 1-3 years
    c. 4-7 years
    d. 8-10 years
    e. 11-15 years
    f. 16-19 years
    g. 20+ years

5. How many years have you been a part of this care team?
    a. Less than 1 year
    b. 1-3 years
    c. 4-7 years
    d. 8-10 years
    e. 11-15 years
    f. 16-19 years
    g. 20+ years

6. Did you ever take the (initial) human trafficking 101 training?
    a. Yes.
    b. No.

7. Have you participated in any other DEI-related trainings or workshops while in your position?
    a. Yes.
    b. No.

8. Are you currently, or even been, a member of the SCH Human Trafficking Workgroup?
    a. Yes.
    b. No.

<u>ADDITIONAL (POST WORKSHOP SURVEY) OPEN-ENDED QUESTIONS:</u>

1. Did this workshop provide you with new skills and/or information for supporting patients?

a. Yes.
b. No.
c. Maybe.
d. Other: please provide.

2. Do you see yourself changing current behaviors around patients suspected of or known to be involved in human trafficking?
    a. Yes.
    b. No.
    c. Maybe.
    d. Other: please provide.

3. How could this workshop be improved?

4. What helped facilitate your learning in this workshop?

6. Provide any additional thoughts/concerns/ideas you would like to share.

Pre/Post-Workshop Individual Self-Assessment Survey Data

Table 2B: Percent change in participant perceived knowledge by training section objectives (N=11)

Section	Pre-workshop average perceived knowledge rating ($\bar{x}$, (O))	Post-workshop average perceived knowledge rating ($\bar{x}$, (O))	Absolute change in perceived knowledge	Relative percent change (%)
Introduction				
Objective 1	3.7 (1.0)	4.7 (0.5)	1.0	20
Objective 2	3.8 (1.0)	4.9 (0.3)	1.1	22
Objective 3	3.6 (0.9)	4.8 (0.4)	1.2	24
Education				
Objective 4	3.4 (1.0)	4.5 (0.5)	1.1	22
Objective 5	3.7 (1.0)	4.5 (0.7)	0.7	15
Objective 6	3.8 (1.0)	4.5 (0.5)	0.7	15
Objective 7	3.6 (1.1)	4.3 (1.0)	0.6	13
Objective 8	3.0 (1.5)	4.4 (1.0)	1.4	27
Objective 9	3.8 (1.0)	4.5 (0.9)	0.7	15
Prevention				
Objective 10	3.4 (1.0)	4.5 (0.5)	1.2	24
Objective 11	3.7 (1.1)	4.8 (0.6)	1.1	22
Objective 12	2.9 (0.7)	4.6 (0.7)	1.7	35
Objective 13	2.9 (0.5)	4.5 (0.8)	1.6	31
Community Referral Organizations				
Objective 14	2.7 (1.2)	4.6 (0.5)	1.9	38
Objective 15	2.5 (0.9)	4.6 (0.5)	2.1	42
Objective 16	2.5 (1.1)	4.5 (0.5)	2.0	40
Real-Life Scenarios Activity				
Objective 17	2.9 (1.1)	4.2 (1.0)	1.3	26
Objective 18	2.7 (0.8)	4.5 (0.7)	1.8	36
Objective 19	3.1 (0.7)	4.6 (0.7)	1.6	31

RESEARCHER INTERVIEW GUIDE

GREET

1. BRIEF INTRODUCTION

Hello, my name is_____, and I am an intern with the Center of Diversity and Health Equity. I am also a graduate student with the University of Washington School of Public Health.

With this internship, I have been tasked with the implementation and evaluation of the Human Trafficking 201 workshop and have been doing this as my thesis project for my degree. Before we get started, let us go over the consent process and see if you have any questions or concerns.

2. COMPLETE CONSENT PROCESS PRIOR TO STARTING INTERVIEW

The purpose of today's conversation is to understand workshop participants' perceptions of the second human trafficking workshop and its effect on your work skills and interactions with patients. This will include exploring participants' experiences with the 201 training, its implementation and any foreseen or experienced difficulties, your behavior change since. You have been selected to participate in this study because I hope to hear about your personal experience as a part of the patient care team. There are no right or wrong answers to the questions.

Our conversation today will take about 30 minutes. With your permission, I would like to audio record our discussion today. I will take notes but often they are not as complete as when I audio record the discussion. If you want to make a comment that you do not want recorded, just tell me and I will turn off the recorder and restart it when you finish making your comment. Is that okay?

Please remember that anything we say here today is confidential. I will not be asking you any personal questions, only your thoughts about the training and your experience working with patients suspected of or known to be involved in human trafficking. What you share with me will be combined with the information from other participants, so no one will know what you said as an individual. Can you please describe back to me what you understood the purpose of this interview to be? Do you have any questions before we begin?

- START THE AUDIO RECORDER -

Do you provide verbal consent to participate in this interview, yes or no?

I am going to start by asking some general questions related to your work.

1. GENERAL QUESTIONS

- What department/care team are you affiliated with as an employee?
- What is your job title on this team?
    - What is role in this position?
    - What did your training to qualify you for this position look like?
- How long have you been in your position?
- Are you currently, or have you ever been a member of the SCH human trafficking workgroup?
- Did you participate in the initial human trafficking training?
    - If yes, how long ago was your training?
    - Did you find this training useful?
        - If yes, how so?
- Have you participated in any additional trainings or workshops that have helped you to better support patients suspected of or known to be involved in human trafficking?
    - If so, what were they?

2. PREVIOUS EXPERIENCE WITH PATIENTS INOVLED IN HUMAN TRAFFICKING

- Do you have any previous experience working with patients suspected of or known to be involved with human trafficking?
    - If yes, what did it look like?
        - Did you feel prepared and/or equipped for supporting these patients?
            - If yes, what made you feel this way? What were some skills that you had that helped you?
            - If not, what do you think would have improved your ability to better support these patients?
- Have you encountered any difficulties while working with this patient population?
    - If yes, what were they?
        - Do you feel like you had the skills to handle situations like this?
- Are there any specific skills or additional knowledge you wish you had when working with this patient population?

TRAINING-SPECIFIC BEHAVIOR CHANGE

- Do you think the 201 workshop improved your ability to work with patients suspected of or known to be involved in human trafficking?
    - If yes, how so?
        - Were there any skills or concepts that really stuck with you because of this workshop? If yes, what were they?
            - Have you implemented these in your practice?
                - If not, why not? What have some of the barriers been to implementation?
                - If yes, what facilitated your ability to implement them?
                    - Do you think you implemented them successfully?
                        - What did that look like?
- Have your interactions with patients suspected of or known to be involved in human trafficking changed because of this training?
    - If yes,
        - can you identify any specific examples of how your interactions with patients suspected of being involved with human trafficking has changed?
- Have your interactions with patients in general changed because of this training?
    - If yes,
        - can you identify any specific examples of how your interactions with patients in general has changed since this training?
- Have your interactions with fellow care team members changed because of this training?
    - If yes, how so?
        - Can you provide an example?
- Have your interactions with community referral organizations changed because of this training?
    - If yes, how so?
        - Can you provide an example?
- How do you think these changes have impacted your patients' experiences?
    - Have they been for the better or worse?
- Have you encountered any barriers when trying to utilize or implement the skills learned in the workshop?
    - If yes, what were they?
    - How do you think these barriers can be managed so you can use these skills?

4. TRAINING IMPLEMENTATION

- What did the workshop implementation process look like for you with?

    - How was the workshop communicated to you?
        - Was this a good form of communication or would you have preferred an alternative method?
    - Were you given a choice to participate in the workshop?
    - Did anyone ask you if you would be interested or had the time?
- Was there anything that deterred you from participating in the 201 training?
    - How was this overcome?
- Were there any adjustments made (that you know of) so you and your team could participate in the workshop without it interfering with your normal work?
    - If yes, what were they?
    - Was this helpful?
        - If yes, how so?
        - If not, why not?
    - Did this ease your ability to fully participate?
        - If yes, how so?
        - If not, why not?
- What was your motivation for participating in the workshop?
    - What were you hoping to get out of it? Did you achieve this?
    - Did the workshop feel relevant to your work?
        - Did it provide useful information and/or skills for you to use in your practice?
- What were some things you thought went well with this workshop?
- What were some things that could be improved with this workshop?
- What would a successful implementation of a human trafficking workshop look like to you?

5. FUTURE RECOMMENDATIONS

- Do you have any recommendations for how to better implement the workshop in the future?
- Is there any information and/or skills you would like to gain from another human trafficking workshop?

6. CLOSING STATEMENT

That completes the interview. Do you have any final thoughts that you would like to share? Thank you again for your participation. If you find you have any questions, please feel free to contact me.

- STOP RECORDING -

TAPE RECORDER PROTOCOL:

- **ALWAYS TEST DIGITAL RECORDER PRIOR TO CALL**
- **PUT DIGITAL RECORDER ON FLAT SURFACE**
- **PLACE BACKUP DIGITAL RECORDER**
- **RESET DIGITAL RECORDER COUNTER AND PRESS RECORD**
- **START RECORDING**