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*Hospital Health Provider Experiences of Identifying and Treating Trafficked Persons*

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## **Hospital health provider experiences of identifying and treating trafficked persons.**

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## **Hospital health provider experiences of identifying and treating trafficked persons.**

### **Abstract**

Over the past 20 years, human trafficking (“trafficking”) has generated a tremendous amount of public attention throughout the world. The problem has received growing media coverage and increased anti-trafficking activism. Additionally countries have created new policies, laws, and enforcement mechanisms to tackle the problem. This micro level study examined the lived experiences of twenty-two health and allied health workers situated within St Vincent’s Health Australia’s, Melbourne facility, and reports on their identification, assessment, treatment, and outreach to trafficked persons. The results indicated that trafficked persons were predominantly invisible within the health setting. When practitioners did suspect trafficking, they considered themselves as lacking the professional skills, knowledge and/or the clear organisational policy or procedures to confidently identify and manage the complex health needs of the suspected trafficked persons. The findings contribute to St Vincent’s Health Australia’s goal of formulating contextually appropriate policy and practices that will assist in the identification of and response to the health needs of trafficked persons.

### **Implications**

- The health needs of trafficked persons are multiple and interrelated and require health care providers and systems to be skilled in the identification, intervention and treatment of trafficked persons.
- Education and training of health professionals is the cornerstone of the identification, intervention, and treatment of trafficked persons.

Human trafficking, also referred to as modern-day slavery, is defined as

the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. (Office of the High Commissioner for Human Rights, 2000 Article 3 (a)).

Trafficking crosses local, national, and global borders and ranges from sexual exploitation, labour exploitation, criminal involvement, forced marriages, organ trafficking, to forced military service. All forms of trafficking involve the violent exploitation and abuse of human beings and their rights.

Factors such as globalisation, economic and political instability, disease, disintegration of families, and war (Carolan & Simmons, 2016) have increased the numbers of vulnerable populations that expose people to the risk of trafficking. While precise statistics remain elusive (Cannon, Acara, Graham & Macy, 2016), sexual exploitation and forced labour has been estimated at 27 million (De Chesnay, 2013) and 21 million (International Labor Organisation, 2017) worldwide respectively.

In the Asia-Pacific region it is generally accepted that while only a small percentage of irregular migrants are trafficked for exploitation, most victims are irregular migrants who are subjected to exploitation such as forced labour in a country that is not their own but to which they travelled to obtain work (Carolan & Simmons, 2016). In Australia there exists a wide discrepancy between officially detected cases and estimates of the number of trafficked persons. The available aggregate statistics from Australian Government agencies indicate that between January 2004 and June 2011, 184 persons were victims of trafficking (Larsen & Renshaw, 2012). Regardless of the form of their exploitation, people who are trafficked

suffer intense abuse that often results in physical and mental illness (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011).

This article reports on stage one of a two stage project commissioned by St Vincent's Health Australia (SVHA) and carried out by the non-government organisation Australian Religious Against Trafficking of Humans (ACRATH). Prior to reporting the research, the author canvasses the current literature regarding the health needs of trafficked persons and global and national health provider responses to these health needs.

### **The health needs of trafficked persons**

The cumulative harm of each stage of trafficking (recruitment, travel-transit, exploitation, detention and integration or reintegration stages of trafficking) results in adverse and multiple inter-related physical, reproductive, developmental, behavioural and psychological health impacts (Zimmerman, Kiss & Hossain, 2011). These interact with the personal, social-environmental, and contextual systemic factors specific to the trafficked person (Alpert, Ahn, Albright, Purcell, Burke, & Macias-Konstantopoulos, 2014; Banović & Bjelajac, 2012; De Chesnay, 2013; Dovydaitis, 2010; Gibbons & Stoklosa, 2016; Schwarz, Unruh, Cronin, Evans-Simpson, Britton, & Ramaswamy, 2016). Regardless of the reason for being trafficked, an individual's development and life trajectory is negatively disrupted. Many may seek the support of mental health services, physical healthcare services, and social services (Cannon, Arcara, Graham, & Macy, 2016).

### **Invisibility and the health care system**

Health care providers are one of the few groups of professionals likely to interact with victims of trafficking and therefore hold a unique position in their identification, treatment, and referral (Gibbons & Stoklosa, 2016). Notwithstanding this unique, but limited

opportunity to intervene in the cycle of exploitation internationally (Cary, Oram, Howard, Trevillion, & Byford, 2016; Cheshire Jr, 2017; Titchen, Loo, Berdan, Rysavy, Ng, & Sharif, 2015) and nationally (George, McNaughton, & Tsourtos, 2016) many trafficked persons go undiscovered or unrecognised when interacting with health systems. Several factors drive this, these include: the trafficked person's survival-driven priority to often work long hours to support themselves and their families; disconnection from or the absence of accessible mental health services (Lewis-O'Connor & Alpert, 2017); the cumulative physical and mental health impacts of repeated and sustained substance or sexual abuse (Alpert et al 2014; Domoney 2015; Patel, Ahn, & Burke, 2010); the trafficker's adept controlling of the trafficked person (Alpert, et al, 2014); profound patient fearfulness; inconsistent stories; and, resistance to work with law enforcement agencies (Gibbons and Stoklosa 2016).

Systemic and organisational factors that prohibit the identification, treatment, and referral of trafficked persons further contribute to invisibility in the health care system. These include the absence of linguistically matched or culturally sensitive services, limited organisational and practitioner capacity and resources (Davy, 2016); inadequate health provider formal education, identification, screening, and treatment protocols (Yarborough, Jones, Cyr, Phillips, & Stelzner, 2000) and unidentified service needs that extend beyond the health providers' expertise and effective interagency collaboration (Helton, 2016; Titchen, et al 2015). Cheshire (2017) additionally points to the health organisation's surrender of its moral responsibility and over reliance on well-intentioned, under-resourced and ill-informed medical professionals for not taking action. D'amour and Oandasan (2005) highlights media coverage that fails to communicate the severity and complexity of the problem, perpetuates invisibility through the use of images and representations of trafficked persons as either exploited in countries other than the host country or as limited to subjects of particular profiles, for example women trafficked for prostitution.

Juxtaposing invisibility, international literature reports whole of system approaches designed to build organisational capacity identify and treat trafficked persons. These include trafficking-enslavement-training programs and guidebooks that educate in trauma informed responses (Macias-Konstantopoulos, 2016). Other examples of specific screening questions canvas issues relating to safety, physical health and history, living circumstances, employment travel and immigration status, living environment and child specific issues (Alpert et al, 2014; Gibbons, & Stoklosa, 2016), which aim to equip health workers to respond to behavioural and physical “red flags”, by providing safe, trustworthy spaces when further investigating the potentiality of trafficking (Alpert, Ahn, Albright, Purcell, Burke, & Macias-Konstantopoulos, 2014). Additionally, effective programs clearly define stakeholder roles and clearly articulate and reference policies that may be implicated in treatment and referral (Macias-Konstantopoulos, 2016; Schwarz et al., 2016) of trafficked persons.

In the Australian health care system, there is currently limited literature that evidences if and how healthcare providers identify, treat, and refer trafficked persons (Davy, 2015; Macias-Konstantopoulos, 2016), nor is there evidence of any trafficking-enslavement-training programs and guidebooks that can guide a health practitioner’s work. This current study seeks to address this gap and increase understanding of the factors that impede health care providers’ ability to identify a trafficked person who seeks medical attention within Australian hospitals.

### **Research Context**

SVHA has thirty-six facilities comprising of six public hospitals, nine private hospitals, seventeen aged care facilities, three co-located research institutes and one co-located partner facility. SVHA is committed to changing the structures and systems that lead to some people experiencing poorer health outcomes than others because of poverty, marginalisation or vulnerability (St Vincents Health Australia, 2018). It is this commitment that underpinned

SVHA's partnership with and funding of the non-government organisation, Australian Catholic Religious Against Trafficking of Humans (ACRATH). ACRATH is the peak body for 190 religious orders in Australia, working together towards the elimination of human trafficking in Australia, the Asia Pacific region, and globally (ACRATH, 2018). The project was undertaken in SVHA's Melbourne facility. This facility was chosen based on the accessibility and location of the Reference Group members, ACRATH focus group facilitator and researcher.

### **Methodology and method**

The qualitative approach used in this research falls within the constructivist epistemology and postmodernist theoretical perspective (Liamputtong & Ezzy 2005). This theoretical perspective understands that one does not simply encounter "trafficked persons", rather participants construct explanations of trafficking from the multiple beliefs and multiple perspective perspectives they bring to it. Using focus groups as the data gathering method, participants had opportunity to explore and interpret their experiences, perceptions of trafficked persons, and their views of the professional skills, trafficking-enslavement-training programs needed to identify, treat and refer them.

The qualitative research described in this article reports on stage one of the project, stage two is to be reported elsewhere at a later date. The data gathered from the focus groups details the experiences of twenty-two health and allied health workers.

The questions guiding the focus groups:

1. What is your understanding of a "trafficked person"?
2. In your professional duties, have you ever encountered a victim of trafficking?



3. If a nurse or allied health professional at SVHM encountered a trafficked person who what could /would they do?
4. If SVHA provided awareness raising and education about human trafficking for staff, how likely would you be to seek it out and in what form would it be most accessible for you?

Stage one of the project was facilitated by ACRATH's research assistant and note taker and was carried out in SVHA's Melbourne facility. Stage one used focus groups to scope SVHA's health and allied current health professionals' current awareness, knowledge and actions regarding trafficked patients. Stage two, engaged ACRATH in the development, trial and adoption of educational packages for educating and training SVHA workers in the identification, treatment and referral of trafficked persons.

The study received ethics approval from SVHA's Human Research Ethics Committee and was overseen by the SVHA's, Melbourne Reference Group. The reference group comprised of SVHA's Executive Team Member/Mission Leader, Inclusive Health Program Leader, Melbourne and Sydney Chief Social Workers and Procurement Officer and ACRATH's Project Evaluation Officer, Research Assistant and Victoria University Associate Investigator.

The participant's right to discontinue focus group participation without penalty or prejudice was stipulated at the beginning of each focus group. To alleviate any potential risks and discomfort that might have arisen when recalling and sharing personal or professional experiences of work with trafficked persons, participants were given the name and contact details of a SVHM counsellor.

Participant recruitment into stage one of the project involved three phases:

- 1) A flyer widely distributed through the regular staff meetings of the Assessment Liaison and Early Referral Team (ALERT), Emergency Department Team, Nursing Unit Leaders and Allied Health Team called for expressions of interest.
- 2) A General Information Session was conducted for interested staff. This session provided information about the overall project, its context within SVHA's *Inclusive Health Strategy*, the research method, voluntary de-identified participation in the research, *Information and Consent Forms* and opportunity for questions.
- 3) Facilitation of six, 45-minute Focus Group sessions involving 8-10 participants, conducted over three dates in a designated two-week period.

The recruitment strategy yielded twenty-two participants: sixteen social workers, three physiotherapists, two nurses, and one HARP<sup>1</sup> social worker. The researcher acknowledges that the weekday timing of the focus group sessions potentially restricted the participation of those who worked night shifts and thus potentially made the group nonrepresentational of SVHM health and allied health workers.

Focus groups, facilitated by the ACRATH research assistant and introduced by the SVHA's Mission and Social Justice Development Manager, were digitally recorded. Recordings ensured that specific quotes were retrievable at the data analysis stage. An ACRATH note taker was present during each focus groups to document critical feedback. The researcher also added her field notes to the collected data.

Using pseudonyms to protect the identity of the participants, data was analysed and managed through the use of NVivo<sup>TM</sup> (QSR International) computer program, coded and recoded

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<sup>1</sup> HARP aims to improve health outcomes for people who either frequently present, or who are at risk of presenting to hospital, because of chronic disease or complex medical and / or social issues by providing short-term care coordination and education and by linking people to longer term community supports where appropriate.

thematically under the research questions. This involved becoming familiar with the data through carefully reading and rereading units of data and establishing patterns of common and divergent understandings and practices amongst and between participants (Spencer, Ritchie, Ormston, O'Connell, & Barnard, 2014).

The analysis was interested in participants' personal stories and how these personal stories were influenced by larger societal discourses. In this sense the strategy represented the researcher as situated knower, shaping and analysing data and producing knowledge from a particular, partial perspective. The perspective was that of a person producing potentially useful hypotheses about participants' experiences, perceptions and interpretations regarding trafficking and the health carer's identification, treatment and referral of trafficked persons. To ensure that analysis was robust, credible and trustworthy, the researcher's coding and initial analysis was presented to the Research Assistant and Reference Group for feedback and discussion (Neuman, 2006). In this sense, the researcher engaged in "interviewing oneself", drawing on feedback to uncover and correct any researcher biases and any inappropriately presumed relevancies.

## **Findings**

The data presented below reports on stage one of the project. Findings are presented under the each of the questions that guided the focus group sessions.

### ***What is your understanding of a "trafficked person?"***

Overall, data indicated that participants understood what constituted human trafficking and recognised the familial and employment contexts most vulnerable to people trafficking. The general view was that the issue was outside their realm of personal or professional experience and when it was front of mind, their views and perceptions were informed by media

representations.

Participants echoed a human rights (Office of the High Commissioner for Human Rights, 2000) definition of trafficking, understanding trafficking as “when the person is told something else, taken against [their] will, moved between companies and [possessing] no working rights,” as “young women who had been forced into marriage”, and “somebody who has been convinced to move from somewhere to somewhere with a promise of work/housing”, or as “providing someone to someone else in exchange for cash”. The occupations vulnerable to trafficking were identified as domestic work, fruit picking, hospitality industries, sex industry, and mining.

Participants reasoned that it was familial and/or structural powerlessness that maintained people in these contexts. Acknowledging the push and pull factors of global economies, participants maintained that trafficking had become “more economically viable than drug trafficking”. They were also of view that attempts to escape was problematic since “if you leave or make trouble, your family will be harmed”. In the case of forced marriage, participants thought that unawareness was a mitigating reason for people remaining in trafficked circumstances, deeming that “some don’t even realise that they’re in forced marriages”.

Asked about how they formed their views, participants stated that they were largely informed by “reading, news articles” and concluded from the media representations that the issue was “far away and something that happens overseas”. Notwithstanding the media’s role in constructing their views and perceptions, participants argued that the views they held could only be changed through personal and professional contact with trafficked persons and that “until you experience (working with a trafficked person) you don’t understand it”.

Nonetheless, the view that contact with the trafficked brings understanding and that personal

experience influenced their views, there was emphatic warning against professional complacency or the dismissal of the existence of trafficking within Australia or within their sphere of practice. Stating that they “don’t live in a bubble”, that trafficking “happens now in my backyard” and that “modern slavery is alive and well”, participants expressed an urgency for the hospital to address the issue. They maintained that the professional consequence of unfamiliarity and complacency was practice “blindness” and practice “uncertainty about how to proceed” when encountering a trafficked person.

***In your professional duties, have you ever encountered a victim of trafficking?***

Overall, participants variously reported either certainty (“probably”) or unawareness (“haven’t knowingly come across it”) when considering their contact with the trafficked. They also concluded that that they may not been able to “put a name” to trafficking, attributing uncertainty to inexperience and lack of knowledge of the medical, psychosocial or behavioural indicators that may signal trafficking and that may warrant further investigation of the patient’s circumstances. However, drawing on their practice wisdom and skills when dealing with other vulnerable groups, participants could describe factors that could be used to identify, treat and refer trafficked persons

Discussing invisibility, they described the guardedness and resolve of patients who were “not going to make it all that obvious” when interacting with the health system and noted an incongruence between a patient’s narrative and body language as a possible signal that warranted further investigation. Participants suggested that secrecy could also signal trafficking identifying the accompanying adults who purported to be family members and patients “not wanting [the nurse] knowing” a medical history. They also thought that the trafficker’s strategic use of a larger hospital could signal a hope that their victim might get “in and out quickly and anonymously”.

Turning their attention to practitioner interventions, participants recalled incidents signalling the probability of encounters with trafficked persons; patient's "overstaying their VISA", having "no paperwork" and patient referrals made by their colleagues to "immigration agencies". Participants who suspected that they had "most likely" encountered a trafficked person described themselves as registering "a radar go(ing) off" within them. Referring to these "radars" as particularly present when treating patients with complex narratives. They described these patients as "very scared, [supplying] inconsistent information" and disclosing "large debts overseas, working in fields in the sun for long hours with few breaks, and no proper paperwork". Hospital triage notes were also nominated as "hinting at something suspect", particularly those notes that "had information gaps".

Offsetting interpretations that they *may have* encountered a trafficked person, participants indicated that "red flags" were insufficient indicators of trafficking and that it was plausible that a patient's "cognitive difficulties" may also account for some of the behavioural and narrative inconsistencies that they encountered in their patients. Albeit the participants' interpretations for why or why not trafficked persons are recognised, there was a stated reluctance to act on their "red flags". The reluctance was situated in their perception of policy and procedural uncertainty about how to proceed with treatment and referral when encountering trafficked persons.

In contrast to those who had indicated unawareness of contact with trafficked persons, those who were firm in their view that they had knowingly encountered them described the multiple or interrelated health factors that formed the basis of their firm view. Mental health, somatic complaints and overdosing on medication were highlighted as the complex health needs of patients they identified as trafficked. Social workers and physiotherapists described the psychological and contextual factors that combined with the patient's physical factors as "hint[ing]" at trafficking. For example participants described the "very scared" stroke patient

who provided “inconsistent information” as a trafficked person and the mental and physical health concerns resulting from “violent, abusive” spousal relationships and the trauma resulting from “a child marriage”.

As with the participants who had registered “red flags,” those who had encountered trafficked persons believed that they did not have a strategy or hospital policy/protocol to further investigate or act on suspicion of trafficking.

***If a nurse or allied health professional at SVHM encountered a person who had been trafficked, what could /would they do?***

Generally participants indicated that investigating the circumstances of a suspected trafficked victim was not without difficulty for the professionals involved. A lack of clarity around policy and procedures created a reluctance to “ask the question because [workers] don’t know what to do afterwards” and a fear that practice without clear policies may “put the person at risk” of prosecution with immigration authorities. They maintained the belief that they would be “opening a can of worms without the [procedural and policy] information behind it”.

Although the majority of participants’ stated hesitancy to act on their suspicions of trafficking, participants believed that SVHA’s staff were “predisposed to look at people who are vulnerable” and noted that trafficked persons belonged to the group of vulnerable, disadvantaged people that SVHA were committed to serve. They referred to the value of SVHA’s using the trauma informed treatment model and recalled the positive impact of this model on practice with other vulnerable groups. Indicating that they “are trained in things to look for in elder abuse, children at risk, family violence”, they were confident that they could transfer these trauma informed skills and knowledge to work with trafficked persons.

At a systemic level, the view was the need for SVHA to have clear intervention pathways that factored in how individual workers, departments, and multidisciplinary teams could progress

from identification, assessment, intervention through to discharge of trafficked persons. Participants impressed the need for individuals to, “escalate suspicion/things not feeling right, to team leaders” and emphasised the role of interdisciplinary collaboration in cases when a “nurse would make a referral to ALERT board”.

Discussing the circumstances that would mitigate against the stated reluctance to intervene in suspected trafficked cases, participants agreed that training was essential before implementation of any strategy. Proposing that “people get sick, especially if not being cared for”, participants highlighted that the inevitability of encountering a trafficked person and thus their need to be professionally equipped to work with this cohort.

Participants viewed the development of a shared knowledge platform within and across disciplines, and amongst other health provider groups as a priority. They suggested that SVHA, with a strong mission focus and outreach on inclusivity, is well placed to create shared knowledge platforms that shape referral and treatment pathways, systems, and policies for work with trafficked persons. They emphasised the need for education and training packages for all staff, suggesting the use of window displays, and targeted training that incorporated the use of case studies and the development of resources kits/referral kits as a way of building a shared knowledge and skill platform. Participants stressed that any implementation of policies and procedures for working with trafficked people would require a “focus of senior executives and the Board” that assured practitioners that they could confidently meet the needs of the organisation and simultaneously ensure that the vulnerability of the patients was not further compromised or exasperated.

Regarding the type and modalities of education and training, social work participants questioned the efficacy of online learning, opining that “online stuff does nothing” to engage them in deep learning and strongly advised against their use. They suggested that face-to-face



delivery was a more productive learning mode since it provided opportunity to share discipline skills and knowledge as well as providing opportunity to challenge attitudes and beliefs. In contrast, nursing participants were firm in their view that online delivery provided greater flexibility and access to education and training for nurses who worked evening shifts. Although differing in their suggestion of how training could be delivered, all participants argued the need for discipline mentors who were equipped with specialised knowledge about trafficking and who could support frontline practitioners.

Finally, identifying the duty of care owed to those managing the complexity of trafficked patients, participants drew attention to the emotional impact of working with such a marginalised group and the potential vicarious trauma for workers. They were of the view that the work could be distressing and thus they must have an organisational commitment to “background support and resilience training” otherwise workers would be left “carrying around this burden” of identifying and treating trafficked persons.

## **Discussion**

Medical providers in social services are potentially the first point of contact with trafficked persons. Being comprehensively trained to identify signs of human trafficking and intervene while these individuals are in their care is particularly important since it is these professionals who must account for the nuances of trauma and the complications a trafficking experience may bring to the health professional/patient encounter. The findings of this project has efficacy for all institutions and agencies that are likely to encounter trafficked persons and who emphasise social justice as an organising perspective for services and outreach to this cohort.

Additionally the findings of this project affirm the centrality of micro and macro practices and policies that are supportive of the identification, treatment, and referral of trafficked persons.

Findings confirm that the ability to identify, treat, and refer trafficked persons requires individual and organisational capacity building (Baldwin et al., 2011; Gibbons & Stoklosa, 2016; Recknor, Gemeinhardt, & Selwyn, 2017) that moves practitioners and organisations beyond the media and individual created discursive constructions of trafficked persons to an evidence based critique and exploration of the multifaceted issue of human trafficking.

Findings also indicate that participants had more than one sole interpretation, explanation, description, or meaning of trafficking and thus from a postmodern perspective, education and training must include the deconstruction of participant interpretations in order to reconstruct the understanding of trafficking to include the role of the social and cultural context that shape these interpretations.

Affirming previous literature (George, McNaughton, & Tsourtos, 2016), the project found that, with a few exceptions, trafficked persons remained invisible when interacting within the health system. Similar to previous international studies (Alpert et al., 2014; De Chesnay, 2013; Dovydaitis, 2010), this invisibility was aided by professionals who were unaware of the multiple and interrelated symptoms endured by trafficked persons and who were unskilled in the techniques that could be employed to recognise them. In the absence of adequately equipped workers, misidentification and limited preparedness to respond to the needs of trafficked persons will remain a major barrier to effective service provision, as will the professional's ability to *confidently* identify, treat and refer trafficked persons. This reluctance negatively influences the health provider's unique, but limited opportunity to intervene in the cycle of exploitation and role in alleviating the health of trafficked person (Gibbons & Stoklosa, 2016). While the health providers in this project felt "distant" from and generally unable to identify trafficked persons, the burden of disclosure remains with the

trafficked, adding further to this group's marginality, adverse circumstances, vulnerability and invisibility (Alpert et al., 2014).

Reaffirmed as central to capacity building (Davy, 2016; Schloenhardt et al., 2009; Yarborough et al., 2000) was the provision and efficacy of education and training supports, strategies and competencies that build a knowledge and skill base within and across discipline groups, and modalities that employ a variety of methods and strategies.

Recommended as key content to include in education and training is; definitions of and understanding trafficking, understanding victim behaviours, identifying the trafficker/victim, physical/psychological assessment of a potential victim and intervention and referral.

Moderating SVHA's current practice and providing a point of reference and organisational capacity to develop whole of system responses to trafficking is SVHA's culture, ethos, and mission. SVHA's current wholistic, rights based, trauma informed approach to the treatment of vulnerable and alienated populations is transferrable to practice with trafficked populations. As noted in literature (Macias-Konstantopoulos, 2016; D'amour & Oandasan, 2005; Patel et al., 2010), trauma informed practices provide a rich resource when creating policies, practices and protocols that aim to reduce re-traumatisation, highlight resilience and strengths, that promote healing and recovery and that support the development of short and long term coping mechanisms for vulnerable populations, in this consideration, the trafficked.

From an interdisciplinary perspective, the role of social workers and their simultaneous focus on and attention to both the person and the person's environment makes for a unique contribution to the health system's micro and macro practices when working with trafficked persons. The ethics embedded in social work require social workers to engage in social and political actions that seek to ensure that all people have equal access to the resources needed

to meet basic human needs (AASW, 2010). Thus they are well positioned to coordinate case management and the ongoing and multiple services required by trafficked persons within and beyond the hospital site.

Limitations of this study include its location within one branch of SVHA's health facilities, and therefore professionals in other SVHA's facilities may have different levels of awareness, skills and knowledge, nor was there exploration of the previous education, knowledge or training that may have informed participant responses. Nonetheless, this study gives some insight and direction into how SVHA and other health facilities may progress their whole of system capacity to work with trafficked persons and build on the trauma informed approaches currently used with other vulnerable groups. Additionally, SVHA's focus on social justice and its commitment to redress disadvantage cannot be assumed as the focus and commitment of other health providers, therefore transferability of these findings are limited to health providers who privilege social justice in their mission and outreach.

The uneven representation of health and allied health disciplines may also be a limitation. However, while the majority of participants were social workers, the participants were informationally representative, in that data was obtained from persons who could stand for other persons with similar health practitioner characteristics (Babbie, 2013)

### **Conclusion**

The study confirms evidence elsewhere stressing the importance of well-trained, educated, and supported professionals charged to work with trafficked persons. Health care environments that provide support positively change their workers' knowledge and self-reported recognition of trafficked persons. Findings support the need for skills and knowledge that focus on the identification and specific needs of trafficked persons as well as

the needs of the health providers and systems. More explicitly, skills and knowledge must provide workers with step-by-step processes from identification through to discharge and engagement with community services and must ensure co-worker support and supervision if practice is to move towards evidence informed intervention and the current invisibility of trafficked persons addressed.

Finally, the findings of this project reflect the United Nation's (Office of the High Commissioner for Human Rights, 2000) call to identify trafficked persons since "a failure to identify a trafficked person correctly is likely to result in a further denial of that person's rights" (guideline 2).

### **Disclosure Statement**

No potential conflicts of interest is reported by the author.

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