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Examining Commonly Reported Sex Trafficking Indicators From Practitioners' Perspectives: Findings From a Pilot Study

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Abstract

Commonly reported sex trafficking indicators have been disseminated widely by government and non-governmental organizations in trainings aimed to increase identification and referral to resources. However, very little research evaluates such indicators. Drawing from survey responses of 86 social service providers, health care practitioners, and justice system officials in a Midwestern City, this pilot study aimed to examine: (a) the pervasiveness of the commonly reported indicators, (b) the salience of domains of indicators, and (c) the extent to which indicators differ across service populations (U.S.-born minors, U.S.-born adults, foreign born minors, and foreign born adults). The most commonly identified indicators included mental health symptoms of depression (M = 3.82); low self-esteem (M = 3.59); anxiety (M = 3.55); low levels of interpersonal

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trust (*M* = 3.52); sense of fear (*M* = 3.36); feelings of shame or guilt (*M* =3.34); isolation from family, friends, and communities (*M* = 3.3); and fear/distrust of law enforcement (*M* = 3.80). The least commonly identified indicators included exhibiting low English proficiency (*M* = 1.62), previous history of loitering charges (*M* = 1.74), presenting false documents (*M* = 1.85), presence of tattoos or branding (*M* = 1.89), presenting delayed cognitive development (*M* = 1.91), being unaware of one's location (*M* = 1.94), owing large debt (*M* = 1.95), previous history of prostitution or drug charges (*M* = 1.98, *M* = 2.01), and physical evidence of torture (*M* = 2.07). The mental health domain was identified as especially common among U.S.-born adults (*M* = 3.07). Criminal justice involvement was identified as less common among foreign-born minors (*M* = 1.82) and foreign-born adults (*M* = 1.96). The most commonly identified indicators, according to the service providers, health care workers, and justice system officials who work with them, are inconsistent with many of the indicators that are used frequently across governmental and community trainings. Trainings focusing on diverse case examples of trafficking may be important in strengthening identification of sex trafficked individuals, as well as accounting for regional contexts.

Keywords
Sex trafficking, assessment, identification child abuse, intimate partner violence

The U.S. Trafficking Victims Protection Act (TVPA) of 2000 and its various reauthorizations unlocked funding streams aimed to improve identification of human trafficking by ordinary citizens, law enforcement, and within social services through education and training efforts, which typically include information on indicators of human trafficking and related screening tools (Clawson, Dutch, & Cummings, 2006; Yeo-Oxenham & Schneider, 2015). Yet, the commonly reported indicators and related screening tools have not been widely or rigorously evaluated. The present study examines the commonly reported indicators in a Midwestern city from the perspective of practitioners who encounter sex trafficked people to explore: (a) the pervasiveness of the commonly identified indicators, (b) the salience of domains of indicators, and (c) the extent to which domains of indicators differ across service populations (U.S.-born minors, U.S.-born adults, foreign born minors, and foreign born adults).

Background

In response to the TVPA of 2000 and its subsequent reauthorizations, federally funded task forces and coalitions were created to educate practitioners and the public on trafficking risks, indicators, and available resources. By the end of 2005, 17 cities had established Rescue and Restore Coalitions bringing together more than 900 local and national partnering organizations to participate in public awareness campaigns (U.S. Department of State, 2006). Over the next 10 years, trainings led by other government entities and partners, such as the Department of Homeland Security, U.S. Department of Health and Human Services (U.S. DHHS), and Polaris Project grew exponentially. Concurrently, grassroots initiatives and community organizations began addressing trafficking and implemented community education programs and trainings to professionals who may encounter trafficked people.

Collectively, governmental and non-governmental organizations disseminate lists of trafficking indicators and related screening tools in order to increase identification of potential victims (Andretta, Woodland, Watkins, & Barnes, 2016; Macy & Graham, 2012). Sex trafficking indicators typically consist of warning signs commonly referred to as red flags, as well as risk factors. Red flags include observable characteristics (e.g. bruises, anxious presentation, and atypical possession of belongings such as minors with hotel keys), while risk factors include personal/family background history risks (e.g., history of child abuse, involvement in foster care and child welfare systems, and truancy) and history of criminal justice involvement (e.g., history of prostitution or drug charges) (Schwarz et al., 2016).

Despite some differences across organizations, there are striking similarities across the indicators, such as those distributed by the U.S. Department of State (n.d.), Polaris Project (n.d.), National Human Trafficking Resource Center (n.d.), and U.S. DHHS (2012a, 2012b), as well as grassroots and other organizations across the United States. In fact, Macy and Graham (2012) conducted a meta-analysis of journal articles and organizational materials which included human trafficking indicators, and found that most documents "overwhelmingly agreed on typical indicators" including "a) signs the person is being controlled; b) signs the person does not have freedom to exit a job or move; c) signs of physical abuse; d) signs indicating the person is fearful or depressed" (p. 61). This finding suggests that such groups are likely drawing from the same source(s). Macy and Graham (2012) indicated that the U.S. DHHS (2008) appeared to be the initial source, as this group was cited by many of the documents the researchers examined. However, the DHHS source does not provide clarity about their initial data source, nor does it reveal the methodology by which the indicators were developed.

Origins of the Commonly Reported Sex Trafficking Indicators

The earliest documents are guides emphasizing identification, which state that the commonly reported indicators were developed drawing from the legal language of trafficking, and revolved around force, fraud, or coercion (Hughes, 2003) or "coercion, deception, fraud, abuse of power or of a position of vulnerability, control over another person, and exploitation" (International Labor Office [ILO], 2009, p. 2). The challenge with this approach is that legally force, fraud, or coercion are not required in cases involving minors (Hughes, 2003); consequently minors who do not experience force, fraud, or coercion (such as those involved in survival sex or those who are manipulated by a boyfriend pimp) may not be identified using indicators and related screening tools based upon such language. While typical of guides, another challenge with some of the earliest documents is that they do not provide the specific research methodology used to develop the guides, including regional context, sample size and characteristics, as well as data collection and data analysis techniques (Hughes, 2003; Zimmerman & Watts, 2003). Those that do provide research methods are challenged by representing largely international trafficking, emphasizing "transportation, transfer, and destination," or a specific regional context, such as the European Union (EU; ILO, 2009).

Importance of evaluating commonly reported indicators. Well-tested indicators that strengthen identification of potential victims of sex trafficking is essential in order to accurately identify potential survivors and refer them to services. For example, Farrell, DeLateur, Owens, and Fahy (2016) point out that since the TVPA was introduced in the year 2000, only 1,876 federal prosecutions and 450 state prosecutions have taken place. While experts generally agree that trafficking identification is difficult because of the covert nature of the crime, it is also possible that the mechanisms by which victims are identified, the indicators themselves, require maturation. For example, Farrell and colleagues (2016) found in analyzing state-level human trafficking cases and conducting 166 interviews with police, prosecutions, and court staff,

> contrary to the expectation from the literature and the fact that under federal law and across most states minor sex trafficking cases do not require prosecutors to prove force, fraud or coercion, we did not find a statistically significant effect of minor victims on the likelihood of prosecution for state human trafficking crimes or other crimes. (p. 9)

If commonly reported indicators are largely based on the language of force, fraud, or coercion, and officers and service providers are trained to

identify trafficking based on these indicators, then minors who do not experience force, fraud, or coercion may be misidentified. In addition, Farrell and colleagues found that the indicators of human trafficking did not influence whether or not trafficking charges were filed because "contrary to our expectations, indicators of human trafficking did not predict charging of human trafficking offences" (Farrell et al., 2016, p. 12). Such work illustrates some level of disconnect between the indicators and prosecution, warranting further examination of the indicators.

Evaluation of commonly reported indicators. Simich, Goyen, Powell, and Mallozzi (2014) of the Vera Institute developed, evaluated, and validated a screening tool (screening questions reflect indicators) by testing it with potential trafficking survivors ($N = 180$). However, the researchers note that their evaluation was limited by their sample, as 94% were trafficked from other countries into the United States, thus the results may not reflect domestically trafficked populations. Moreover, of the organizations who participated in the study, more than half were immigration-related service providers or exclusively served "foreign nationals." Simich and colleagues (2014) stated that their screening tool should be modified to account for context, and warned that the tool must be adapted for various populations and organizations. Regional contexts may also be important; the evaluation took place in 11 organizations in New York ($n = 6$), Texas ($n = 2$), California ($n = 1$), Colorado ($n = 1$), and Washington ($n = 1$). Ostensibly, trafficking may manifest in unique ways in other regions, such as the Midwest.

Bigelsen and Vuotto (2013) adapted the Vera Institute's screening tool, along with two other tools, to evaluate their effectiveness in identifying domestic trafficking survivors in Covenant House in New York City (CHNY). The researchers found validation for the tool, but only after modifying it to create a new screening tool to identify trafficking among the CHNY population. Specifically, questions drawn from tools provided by the VERA Institute of Justice, the Department of HHS/Rescue and Restore Campaign, and Covenant House Nine Line were selected and modified, and then 11 confirmed trafficking survivors from CHNY provided feedback leading to additional questions. The result was a new assessment tool, the Human Trafficking Interview and Assessment Measure/HTIAM-14 (Bigelsen & Vuotto, 2013). Overall, Bigelsen and Vuotto showed that the existing screening tools needed to be modified to be useful with their population. These appear to be the only studies that evaluate the commonly reported indicators.

Indicators of Domestic Minor Sex Trafficking (DMST). A limited body of work examines indicators specific to DMST in the United States Salisbury,

Dabney, and Russell (2015) provided a list of DMST risk factors drawing from available research studies examining the issue. They compiled a set of indicators, which included (a) having an older boyfriend, (b) tattoos or brands, (c) possession of materials that youth are not likely to afford, and (d) being accompanied by an older male that is not a family member. Similarly, Grace, Starck, Potenza, Kenney, and Sheetz (2012) created sets of indicators of DMST based on case studies of confirmed DMST in schools, and related risk factors, which included (a) new cell phone, (b) increased visits to the health office, (c) often fatigued, (d) frequently tardy, (e) wearing suggestive clothing and accessories, (f) use of suggestive language, (g) frequent altercations, (h) decline in academics, (i) more than one girl dating the same male, (j) fighting over expensive gifts, and (k) self-esteem issues. Such indicators are markedly different compared to previously developed indicators, suggesting potential challenges associated with earlier work, and/or the need for population-specific indicators and related identification and screening tools.

However, the indicators depicted in these studies do not appear to have been widely evaluated. The Sex Trafficking Assessment Review (STAR) (Andretta et al., 2016) is based on the indicators of commercial sexual exploitation of children (CSEC) developed by Grace et al. (2012), Salisbury et al. (2015), and Leitch and Snow (2010). The tool is used to determine whether juveniles may be at increased risk for trafficking, and to share this information with practitioners when referring them to services. Andretta and colleagues' work occurred in the D.C. juvenile court system, and does not measure the relative pervasiveness of indicators. Building from this previous work to provide a stronger evidence base for these tools could potentially strengthen the screening process. As such, the current study builds upon prior research by examining the relative pervasiveness of indicators among various service populations in a Midwestern City.

In sum, there is lack of evidence-based research regarding the widely disseminated indicators of human trafficking. Evaluation research examining commonly reported indicators is significantly lacking. Furthermore, the extant research in this area may only be applicable to particular subpopulations and/or specific geographic areas, specifically urban east coast and west coast areas. Collectively, gaps in the field currently include an overall lack of evaluation research, as well as lack of attention to distinctions by international and domestic trafficking, or minors compared to adults, and research examining the Midwest is particularly lacking in indicators-based data (Schwarz, 2017). This pilot study of 86 respondents in a large Midwestern city attempts to explore these gaps from the perspective of social service, health care, and justice system practitioners who work with trafficked people through the following research questions:

Research Question 1: What is the pervasiveness of the commonly reported indicators?
Research Question 2: What is the relative salience of domains of indicators to service providers?
Research Question 3: To what extent do indicators identified by providers differ across service populations (U.S.-born minors, U.S.-born adults, foreign born minors, and foreign born adults)?

Methods

The study occurred in a southern, Midwestern city. We partnered with a city-wide anti-trafficking coalition, which is comprised of a network of over 35 members representing over 25 non-profit organizations, government agencies, law enforcement, and volunteers dedicated to raising awareness within the community. Coalition meetings provided an avenue to disseminate information about the study to its members. Institutional review board (IRB) approval was obtained for this study.

The Survey

The survey was developed by drawing indicators from peer reviewed journal articles and gray literature (Andretta et al., 2016; Besoplova, Morgan, & Coverdale, 2016; Department of Homeland Security, 2010, n.d.; Grace et al., 2012; Hughes, 2003; ILO, 2009; Macy & Graham, 2012; NHTRC, n.d.; Polaris Project, n.d.; Salisbury et al., 2015; Schwarz, 2017; Schwarz at al., 2016; Simich et al., 2014; U.S. Department of State, n.d.; U.S. DHHS, 2012a, 2012b). After creating a comprehensive list of indicators from these sources, the research team consolidated indicators that held the same meaning but were worded differently. The team then grouped the indicators by coding and organizing them under six key domains: (a) mental health (e.g., symptoms of depression, anxiety, and posttraumatic stress disorder), (b) physical health (e.g., evidence of physical harm, sexually transmitted infections, hospitalizations), (c) restricted behavior (e.g., not knowing date and time, accompanied by a person who does not speak for themselves), (d) criminal justice involvement (e.g., previous history of charges related to drugs, prostitution, loitering), (e) personal and family risk histories (e.g., abuse histories, unstable housing, experiences of underage involvement in sex industry), and (f) restricted access to personal possessions (e.g., identification documents, withheld wages). Three members of the research team were involved in collaboratively coding, discussing, and grouping the commonly reported indicators under the six domains, any discrepancies were minimal and resolved

through discussion. A fourth member of the research team independently reviewed the groupings, and suggested that the criminal justice domain be its own domain, as opposed to falling under personal and family risk histories. The other members agreed, and the domain was added.

The survey indicated that the project aimed to evaluate the commonly reported indicators of trafficking. In order to participate in the study, participants had to respond yes to the following question:

> Do you directly work with people who have experienced trafficking at any point in their lives (defined using the federal legal definition—any minor engaged in commercial sex OR adults involved in commercial sex through force, fraud, or coercion) in social services, law enforcement, or other settings?

Practitioners who provided direct services to sex trafficking survivors were asked to indicate how commonly sex trafficking victims report, experience, or exhibit symptoms of each indicator on a Likert scale (1-5) to determine observed frequencies. Each set of indicators also provided a fill-in-the-blank question for general comments.

It is important to note that participants could check more than one category, as many organizations come across a range of emerging youth or young adults and therefore might serve both age populations or come across both foreign-born and domestic victims (Clawson, Dutch, Solomon, & Grace, 2009). The survey also asked what type of organization their services were based in (i.e., youth serving organization, intimate partner violence [IPV] organization, etc.). Participants were also asked to provide demographic information regarding their age, gender and/or sex identity, sexual orientation, and race and/or ethnicity.

The web-based (Qualtrics) survey was developed in collaboration with members of an anti-trafficking coalition for the purposes of this study. The survey was reviewed by the anti-trafficking coalition executive team, and their feedback was incorporated into the final version.

Data Collection

Data collection took place between April to July 2017. Survey participants were recruited via nonprobability convenience and snowball sampling techniques through the Midwest City's two anti-trafficking coalitions, one domestic and sexual violence network, and specific organizations known to provide services to trafficked individuals in the community. Recruitment strategies for the study included emails to the coalitions' list serves, the domestic and sexual violence network's list serve, and organizational staff members of

organizations known to encounter trafficked people. Emails included a description of the study aims and a link to the survey. Individuals who received the emails were also asked to disseminate the web-based survey to other service providers in the community who serve trafficked individuals.

Data Analysis

All data analysis was conducted in SPSS. Frequency distributions for each of the indicators as well each domain's means were computed for the sample by computing the individual means. In addition, the domain means were calculated for each service population subsample (1-domestic, U.S.-born minors, 2-domestic, U.S.-born adults, 3-Foreign-born minors, 4-Foreign-born adults). For each domain of indicators, internal reliability was determined through Cronbach's alpha scores; all domains generated a Cronbach's alpha of .8 or higher. Given that the questions asked participants to mark whether each indicator was relevant, all missing data and N/A options were coded as 1, indicating the lowest level of reported relevance (as the slider bar in Qualtrics was positioned at 1 as the default). To determine if the domain means differed with each sub-sample, we conducted sensitivity analyses to determine whether the means for indicators differed for the general sample and for subsamples of practitioners who focus on specific populations.

Results

Sample Characteristics

The respondents who completed the survey consisted of 86 participants, while 21 participants indicated that they did not provide direct services to this population and were therefore not invited to complete the rest of the survey. Of the 86, 64% ($n = 55$) worked with U.S.-born minors, 72% ($n = 62$) with U.S.-born adults, 24% ($n = 21$) with foreign-born minors, and 35% ($n = 30$) with foreign-born adults. Seventy two percent ($n = 62$) identified as female, 5% ($n = 4$) as male. Over half of participants ($n = 50$) identified as White, 10% ($n = 9$) as Black/African American, and 2% ($n = 2$) as bi/multiracial. Providers represented organizations in the fields of health care ($n = 19$), prostitution/trafficking ($n = 14$), IPV/sexual assault ($n = 13$), youth services ($n = 8$), and juvenile justice ($n = 5$).

Commonly Identified Individual Indicators

The general findings for the most common 15 and least common 15 indicators are summarized in Table 1. The most commonly identified indicators

Table 1. Fifteen Most and Least Common Indicators Commonly Identified Indicators Among Social Service Providers (Likert-type Scale 1-5).

Variables	Indicator Means	
	Most Common	Least Common
Exhibit two or more symptoms of depression	3.82	
Exhibit low self-esteem	3.59	
Exhibit anxiety	3.55	
Exhibit low interpersonal trust	3.52	
Exhibit a general sense of fear	3.36	
Exhibit shame or guilt	3.34	
Are isolated/disconnected from family, friends, community, and other social networks	3.30	
Exhibit fear/distrust of authorities or law enforcement	3.29	
Exhibit symptoms of attachment disorders	3.20	
Exhibit symptoms of medical neglect.	3.17	
Experience unstable housing/homelessness	3.13	
Experience threats or threatening behavior	3.12	
Involvement with controlling or dominating relationships	3.08	
Have weak family ties/lack of social support	3.07	
Have heightened history of sexually transmitted infections (STIs)	3.06	
Accompanied by an individual that does not let the person speak for themselves		2.20
Have family or friends that have been threatened		2.15
Under the age of 18 and involved in commercial sex industry		2.15
Does not have possession of one's own identification documents		2.12
Lives in the same place where they work		2.08
Exhibit signs of torture		2.07
Have previous prostitution charges		2.01
Have previous drug charges		1.98
Owe a large debt		1.95
Unaware of his or her location, current date, or time		1.94
Exhibit delayed physical or cognitive development		1.91
Have tattoos/branding representing some sort of ownership or membership		1.89
Have falsified documents, identification, or multiple names		1.85
Have previous loitering charges		1.74
Exhibit low English language proficiency		1.62

Table 2. Indicator Domain Means by Population Served (*N* = 86).

Indicator Domains	Indicator Domain Means				
	All Respondents	U.S. Minors	U.S. Adults	Foreign Minors	Foreign Adults
Mental health	3.05	2.90	3.07	2.97	2.12
Physical health	2.67	2.69	2.65	2.69	2.66
Behavioral health	2.64	2.63	2.62	2.68	2.76
Personal history/risk	2.67	2.70	2.56	2.53	2.41
Criminal justice involvement	2.07	1.92	2.11	1.82	1.96
Personnel possession	2.14	2.07	2.11	2.07	2.14

generally addressed mental health symptoms. Signs of isolation or problems with social support and unhealthy relationships were also found to be most common. The least commonly identified indicators generally addressed physical health symptoms as well as signs of restricted movement.

Most Commonly Identified Domains of Indicators

A summary of each domain's means by subsample are presented in Table 2. For the large sample, the most common domain was mental health while the least commonly identified domain was access to personal possessions. Sensitivity analyses revealed some minor differences in two particular domains. The mental health domain was identified as especially common among U.S.-born adults ($M = 3.07$). Criminal justice involvement was identified as less common among foreign-born minors ($M = 1.82$) and foreign-born adults ($M = 1.96$).

Discussion

Least Common Indicators

Our study suggests that individual indicators, including physical evidence of torture, tattoos, and branding were among the least commonly identified indicators. This counters many of the commonly accessible and presented images of trafficking and subsequent trainings and relevant materials. For example, a quick, Google search of sex trafficking reveals numerous images of White, cisgender girls and young women presented in bondage or handcuffs and branded with barcodes. Many trainings that address trafficking include such images and/or use terminology such as "modern day slavery"

to describe the nature of sex trafficking (Gerassi & Nichols, 2017; Gerassi et al., 2017; Nichols et al., 2018). Such images and rhetoric may suggest that sex trafficking occurs under conditions of torture, bondage, or extreme violence and may impact how practitioners think about identifying trafficking victims when they are initially trained. For example, the Southwest Michigan Human Trafficking Task Force uses mannequins exhibiting rope burns and possessive tattoos in trainings provided to practitioners (Wrege, 2017). Yet, the data from this pilot study indicate these are among the less common indicators of sex trafficking. Such findings support the work of some survivors (Sanders, 2015; Smith, 2014), as well as data from the National Human Trafficking Hotline (Polaris Project, 2017), and other qualitative and quantitative research (Dank et al., 2015; Heil & Nichols, 2015; Lutnick, 2016; Murphy, 2018), which indicate that depictions of bondage, torture, and slavery is not relatable to the majority of survivors of sex trafficking.Furthermore, indicators representing extreme isolation, such as being unaware of ones' location, date or time, and being accompanied by an individual who does not let the person speak for themselves were among the weakest indicators. The data would suggest that methods of force, fraud, and coercion are more nuanced than extreme control or confinement. For example, according to the National Human Trafficking Hotline (Polaris Project, 2017), the two primary forms of exploitation included emotional abuse and economic abuse, followed by isolation, threats, and physical abuse. While Polaris Project notes that isolation can include confinement, their data show that many more individuals are trafficked through emotional and economic coercion rather than physical abuse, and isolation more typically involves separating survivors from friends, family, and communities (as discussed below). Taken together, practitioners, such as those in our study, may be less likely to encounter trafficked individuals who experience branding, torture, and confinement/isolation to the point that they are unaware of their location and not able to speak for themselves, and should be trained accordingly.

In addition, the least commonly identified indicators also included exhibiting low English proficiency, presenting false documents, not having possession of identification documents, living in the same place where they work, and owing a large debt. It is important to note that this study took place in a Midwest urban city, which is an underrepresented region in indicators-based research. Our findings suggest that trafficking may manifest differently in specific regions. As international sex trafficking is not as prevalent in the study site, this may explain why indicators related to debt bondage, English-speaking abilities, and identification documents manifested less frequently. In addition, these indicators are very commonly

included in training materials as "red flags," but it is possible that such indicators are more relevant for other types of trafficking, such as agricultural labor trafficking, in which internationally trafficked people are overrepresented and more likely to display these indicators (Hughes, 2003; ILO, 2009). Social service providers encountering labor trafficked populations, who are not concurrently sex trafficked, were not necessarily captured in the present study, given the screening question related to direct work with sex trafficking survivors. Alternatively, the populations in which these indicators do manifest (i.e., those involved in debt bondage) may not be coming into contact with social services in the study site. Overall, regional context and service population may be essential in developing indicators used in trainings and related screening tools. This finding is consistent with Simich et al. (2014) and Bigelsen & Vuotto (2013) who note that screening tools must be adapted to the service population. Consequently, trainings should provide information about modifying screening tools to varied populations to provide a more nuanced and practical approach to screening and identification.

While some work indicates those who have an intellectual disability (ID) may be at higher risk (Reid, 2016), this did not appear as a strong indicator. There are several possible explanations for this finding. First, there are a relatively small number of the population experiencing ID, which may reduce the perception of its commonality among practitioners (Reid, 2016). Second, it could be due to lack of identification of sex trafficking among those with ID and related referrals to social services (Kuosmanen & Starke, 2015). The current study did not determine whether practitioners reported this to be uncommon because it is uncommon for those with ID to be trafficked, or because they are not screening for ID. Some scholars suggest that one of the central barriers to providing adequate support to this population broadly is failure to recognize the disability, because of the misconceptions regarding what constitutes an ID and the time-consuming and expensive nature of a full diagnostic process (McKenzie, Michie, Murray, & Hales, 2012). Within sex trafficking literature, evidence suggests that those with ID reporting trafficking are less likely to be believed, by both service providers and law enforcement (Reid, 2016). Consequently, it is possible that practitioners are not referring individuals with ID to social services or law enforcement, or this indicator appears uncommon due to lack of identification of sex trafficking among those with ID. Future research should explore the extent to which practitioners are aware of cognitive disabilities as a potential risk factor for sex trafficking and whether and how social service providers screen for IDs, particularly in organizations that are likely to encounter sex trafficked people.

Most Common Indicators

The most commonly identified indicators included mental health symptoms, as well as experiencing threatening behavior and controlling or dominating relationships, low levels of trust, lack of family ties and social supports, and social isolation from friends, family, and communities. Such indicators are strikingly similar to those of IPV, and could be reflective of tactics some traffickers and pimps commonly use to build relationships with victims/survivors and prevent them from leaving. Sex trafficking that occurs through an intimate partner has been identified as one of the most common forms of sex trafficking (Lloyd, 2012; Martin, Pierce, Peyton, Gabilondo, & Tulpule, 2014; Nichols & Heil, 2014; Raphael, Reichert, & Powers, 2010; Reid, 2011). For example, the Polaris Project (2013) found that over a third of sex trafficking cases involved a relationship with an intimate partner. In addition, Raphael and Shapiro found that nearly 20% of their sample (n = 222) entered prostitution because of their boyfriends. Many sex trafficked women and girls will describe their affectionate boyfriends as those who provide attention and gifts, before asking them to sell sex in order to support their lifestyles (Heil & Nichols, 2015; Oselin, 2014). Such abuse dynamics are often coupled with survivors' sense of agency in the relationship and isolation from other relationships, rather than the extreme restricted movement reflected in the indicators of trafficking that are more commonly used in trainings. In addition, many of the mental health indicators are also seen among populations experiencing IPV, such as low self-esteem, depression, and anxiety. This suggests IPV service providers should be trained to identify sex trafficking, consistent with the work of Macy and Johns (2011), who noted trafficked people are seeking services at IPV shelters, youth organizations, and other organizations that encounter IPV.

Finally, two of the most commonly identified indicators were related to health care, including heightened history of sexually transmitted infections (STIs) and signs of medical neglect. Such indicators may be particularly useful in health care settings, and can be used as a red flag/catalyst to conduct further screening (Stoklosa, Dawson, Williams-Oni, & Rothman, 2016). This may be particularly relevant for health care organizations that come into contact with low-income and/or high-risk populations, such as Planned Parenthood and urgent care. Future research should explore in more depth what trafficking indicators may be most relevant specifically among health care providers who encounter such populations (Chesnay, 2012; National Human Trafficking Resource Center, n.d.).

Domain Indicators

Individual mental health indicators were the most commonly identified indicators and the mental health domain was also found to be the most salient. This was particularly relevant for practitioners who served U.S.-born adults, in which the mental health domain was more salient. The present study supports the work of Schwarz (2017) who developed a report based on survey data from 722 general service providers in the Midwest and found mental health indicators were among the strongest indicators of sex trafficking. While Schwarz (2017) surveyed all providers, we limited our specialized sample to those who have known experience in working with trafficked people. Despite differences in samples, the findings are strikingly similar. Among both general and specific samples of practitioners, mental health symptoms are found as the most common indicators of sex trafficking.

Collectively, these findings indicate that mental health domain indicators may be more relevant than other domains that focus on restricted behavior and access to personal possessions, which are often focused upon in extant trainings. Mental health indicators may also be viewed as more difficult to identify in short-term settings, rather than more visible physical indicators (e.g., bruises), which are often stressed in trainings. However, depression screenings are recommended for adolescents (ages 12-18) and adults in health care settings, such as primary care (Siu, 2016; U.S. Preventive Services Task Force, 2009). These screening tools may be helpful for practitioners who encounter trafficked individuals as well. In addition, detailed electronic records providing history of an anxiety disorder or depression, two of the strongest indicators, may already be available in some health care settings. Finally, longer term social service programs, including transitional housing and substance use services, may be particularly well-suited to observe mental health symptoms over time. Combined with other indicators, mental health indicators should be considered for identification purposes, as well as referral to related resources (Richards, 2014). Mental health indicators can be viewed as indicators of a problem early in the identification process. The utility of this approach is that it can be embedded within existing screening processes to potentially identify a multitude of various problems, such as trafficking, IPV, child sexual abuse, and more. This multi-tiered approach involves initially screening more potential survivors with broad categories, then passing along this knowledge of risk in the referral process, where service providers can then explore further by using additional indicators and rapport building over time to identify sex trafficking.

While the criminal justice domain was least salient to providers than others across sub-samples, it was also rated particularly low for foreign-born

minors and foreign-born adults. Coupled with fear or distrust of law enforcement and isolation (among the overall strongest indicators), this suggests those who are trafficked internationally may be avoiding justice system interactions, or may be in isolated circumstances inhibiting help seeking in the criminal justice system. Consequently, reports or evidence of interaction with law enforcement may be relevant, but may not be the primary indicator of trafficking among populations who are internationally trafficked.

Implications for Trafficking Assessments

The findings of the present study contrast from the indicators that are currently most-used, which focus on identifying extreme cases of trafficking or the worst case scenarios (i.e., an individual held against their will who experiences extreme restricted movement, branding, and torture). Overemphasizing such training indicators may result in missing large portions of trafficked populations and preventing those at risk of trafficking from being trafficked (Hoyle, Bosworth, & Dempsey, 2011). Collectively, identification trainings that target practitioners should provide nuanced case examples of trafficking and exploitation that highlight the various forms of sex trafficking and related indicators, including highlighting the common overlap with IPV (Hoyle et al., 2011; Kuosmanen & Starke, 2015).

Our study suggests that the indicators most commonly identified by practitioners (e.g., mental health indicators) are inconsistent with those indicators most commonly appearing across trainings. Such indicators are likely to identify a wider body of at risk populations, as mental health indicators overlap with other forms of victimization, such as child abuse, sexual victimization, and IPV. Given the overwhelming evidence suggesting that sex trafficked individuals are difficult to identify, using the most commonly identified indicators from this study may be useful in initially identifying at-risk clients. Once at risk clients are identified, they may require further trust-building to facilitate disclosure. This is consistent with the work of Bigelsen and Vuotto (2013), who found that youth were only likely to disclose trafficking when they were ready to, not necessarily at the time of an intake or initial screening.

Furthermore, social service and health care providers are often pressed for time and given numerous other mandates or protocols to enact. As such, it is possible that a multi-tiered screening system may be most effective for identifying individuals at risk of trafficking. For example, individuals who are screened for trafficking could first use mental health indicators to determine whether they are at risk for trafficking. If an

individual is identified as "at-risk," a provider could then ask detailed questions about their relationships with family, intimate partner, and other social supports while building trust and rapport over time. Importantly, these interactions are likely to require trust building and may be most appropriate for practitioners who can have multiple meetings with clients over time, that is, IPV shelter, transitional housing, and health care social workers (Reid, 2010). Realistically, depending on organizational context, all providers cannot do this for all potential victims. However, a multi-tiered approach to identification may be helpful in determining trafficking, particularly in settings with repeated contact with clients. As this is not possible in short-term contact settings, such as in the emergency room, an assessment of risk and related referral with further prompting by the referral organization may be the necessary response in such settings. The results are consistent with the work of Andretta and colleagues (2016) who suggested initially identifying heightened risk in the juvenile justice system, to then be further explored in the referral process.

Limitations and Further Research Directions

There are a few important limitations to consider. As a pilot study, the current study is limited by its sample size ($N = 86$) and the regional contexts of the city in which it took place. At the same time, Midwestern cities are broadly underrepresented in trafficking related research, including indicators-based work. This study shows which indicators are more or less common in Midwestern regional context. Accordingly, any conclusions should be received with caution. Furthermore, it is possible that a provider who worked with two subpopulations provided an answer that fit the average of their experiences with clients or that reflected one subpopulation over the other. Accordingly, any conclusions that are drawn from comparisons between subsamples are limited. However, the results indicate more work is needed to draw comparisons between varying subgroups. Further replication research should include multiple study sites with varying regional contexts, and engage in purposive sampling to gain representation of varying organizations and service populations for comparative purposes.

The current study did not assess whether or not providers were asking questions related to the 62 indicators compiled in this survey. As such, we do not know if providers engage in screening, are choosing not to screen for some of the indicators presented in this study, or if they are screening and not finding particular indicators to be relevant for their service population. However, all participants of the study had provided direct services to known trafficking victims. Therefore, it is possible that more physically

visible indicators, such as tattoos, branding, and signs of torture (on certain parts of the body) and other obvious indicators, such as unawareness of location and accompaniment by an individual who will not let the person speak for themselves, would have been almost immediately visible without the need for related screening questions. Yet, these indicators were not found to the most commonly identifiable ones. Rather, indicators that would generally require an intimate conversation with a participant to determine whether the individual exhibited signs of depression or anxiety or low levels of interpersonal trust were found to be more common. Consequently, service providers are likely making their determinations based on their experiences working directly with survivors, and the conversations that organically develop between practitioners and clients. Future research should examine whether (and perhaps how) providers ask about or screen for specific indicators.

Conclusion

The commonly reported indicators disseminated at trainings to social service providers, health care practitioners, and law enforcement officials do not have a strong evidence base to support them. Few studies evaluate these indicators, and the small body of research that does shows that related screening tools must be adapted to the service population to be effective (Bigelsen & Vuotto, 2013; Hughes, 2003; ILO, 2009; Schwarz, 2017; Simich et al., 2014). Overall, our findings suggest that the indicators used in existing trainings may require maturation, which necessitates further research to support or negate their use. Our aim in this study was to prompt academics and practitioners to look at the indicators with a critical eye and to call for further research in this area following principles of evidence-based practice.

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