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"Because the resources aren't there, then we fail. We fail as a society": A Qualitative Analysis of Human Trafficking Provider Perceptions of Child Welfare Involvement among Trafficked Mothers

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Abstract

Background Little is understood about child welfare involvement (CWI) in cases where the birth mother has experienced human trafficking.

Objectives The aim of this study was to explore provider perceptions of the impact of CWI for the trafficked mother.

Methods Participants were selected among providers caring for trafficked birth mothers. Semi-structured interviews were conducted with providers and qualitative content analysis was conducted.

Results Interviewees reported reasons for CWI, positive and negative impacts of CWI and provided recommendations for systems improvement.

Conclusion for Practice Recommendations from this exploratory study include mechanisms to support trafficked mothers, train hospital social workers, and systems change. During the prenatal period, strategies to support the trafficked mother may include addressing gaps in social determinants of health, ensuring appropriate medical and mental health care, early screening and referral to substance use treatment services, enhancing community support, and working to develop safety plans for survivors and their families. Enhanced engagement of social workers and all providers to improve understanding of the unique complexity of trafficked mothers is needed. Education should include an understanding that judgement of a caretaker's ability to parent should be current and holistic and not reflexive based on history in the electronic medical record. An exploration of the child welfare system itself should also be undertaken to identify and modify discriminatory laws and policies. Finally, efforts to address social determinants of health in the community and enhance the trauma-informed nature of child welfare referrals could improve the lives of trafficked mothers.

Keywords Trauma-informed care · Child welfare · Human trafficking · Pregnancy · Social determinants of health

Significance

Child welfare involvement (CWI) in cases where the birth mother is a victim of violence has public health impacts. However, no research to date has explored child welfare involvement when the birth mother has experienced human trafficking. This qualitative study demonstrated positive (improved access to services) and negative (stress as well as trauma reactions) impacts of CWI upon trafficked mothers. Furthermore, it puts forth recommendations for change: mechanisms to support trafficked mothers, train hospital social workers, and systems change.

Introduction

Child welfare involvement (CWI) in cases where the birth mother is a victim of violence has public health impacts, affecting families across the United States (Langenderfer-Magruder et al., 2019; Mirick, 2014). Risk factors for involvement of child welfare (CW) services among Intimate Partner Violence (IPV) survivors include substance use, mental health issues, lower educational level, prior personal CWI, and criminal involvement (Hazen et al., 2004; Tutty & Nixon, 2020). CWI lies on a spectrum of engagement from merely investigating an

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allegation, to providing services, to child removal. Studies indicate that CWI is more likely to result in child removal when IPV is involved (Mirick, 2014). While intended as a means of protecting a child, CWI among IPV-mothers may be traumatic and destabilizing to the mother (Juby et al., 2014; McTavish et al., 2019; Sankaran, 2018). CWI can increase risk of abuse towards the child's mother (Ogbonnava & Pohle, 2013; Devoe & Smith, 2003). CWI may reduce help-seeking from IPV survivor mothers (Wathen & MacMillan, 2013). IPV survivors of color and LGBTQ survivors may disproportionately face more undesirable consequences of CWI (Goodman et al., 2019).

The parallels in the experiences of exploitation and coercion inherent in IPV and human trafficking are well established in the literature (Bessell, 2018; Clark et al., 2014; Gavin & Thomson, 2017; Koegler et al., 2020; Menon et al., 2020; Verhoeven et al., 2015). A nascent body of literature is emerging to explore the needs of pregnant trafficked persons (Clark et al., 2014; Collins & Skarparis, 2020; Dovydaitis, 2010; Nightingale et al., 2018; Stoklosa et al., 2017; Tracy & Konstantopoulos, 2012). However, to date, there is no research which has explored child welfare involvement (CWI) in cases where the birth mother has experienced human trafficking.

The aim of this study was to explore human trafficking provider perceptions of the impact of CWI for the trafficked mother.

Methods

Study Design

Given the exploratory nature of our aim, a qualitative study was conducted using semi-structured interviews with care providers of the THRIVE clinic, designed to provide medical, social and behavioral health care services for survivors of human trafficking, including prenatal and perinatal care. (George et al., 2018). This study adheres to COREQ guidelines for qualitative research (O'Brien et al., 2014). Participants were selected among THRIVE clinic providers, all of whom who have cared for trafficked mothers, until saturation was achieved for major themes. Participants were recruited via email and after informed consent was obtained, interviews were conducted virtually using a HIPAA-compliant telemedicine technology without video (Archibald et al., 2019; Mealer & Jones, 2014). This study was conducted in accord with ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments and it was deemed IRB exempt after review by Partners Healthcare and University of Miami.

The semi-structured interview guide comprised two main areas of inquiry in relation to human trafficking survivor mothers (1) positive and negative impacts of CWI. (2) recommendations for improving CWI. The interview was conducted by a member of the study team external to the provider group, a female trainee physician without a formulated opinion on the child welfare system. The audio recordings of the interviews were transcribed for data analysis. Interviews lasted between 25 and 35 min. A unique identifier was assigned to participant interviews. All identifying information was redacted from transcripts to protect anonymity.

Analysis

The study used a directed content analysis approach (Hsieh & Shannon, 2005). A coding structure was developed by [redacted] and [redacted], guided by a review of relevant IPV literature. The transcripts were then independently coded by [redacted] and [redacted], compared for agreement and finalized. Each transcript was reviewed for accuracy against the recording and coded using NVivo software. Member checking was done by sharing the results with the interviewees and verified for accuracy.

Results

Four provider interviews were conducted. Providers had 3–8 years of experience working with trafficked persons. Data saturation was reached for major themes, as noted below.

Exemplar quotes for corresponding themes can be found in Table 1.

Report to Child Welfare

Reports to child welfare (CW) were typically made by a hospital social worker after the mother gave birth. In one case a patient's mother contacted CW, and in another case, a case manager at a shelter contacted CW. Respondents did not note any trends in the demographics of the reporter. Some cases involved CW prior to the birth of the infant. CWI prior to the birth only occurred when they were already involved in a case regarding another child of that mother, such as an ongoing open-custody hearing. Participants did not note any consistency in demographics among trafficked mothers with CWI.

Reasons for Report to Child Welfare

Data saturation was reached among reasons for reports to CW, including the trafficked mother's history of human trafficking, housing instability, substance use, intimate partner violence, mental health issues, and prior CWI. Concern was expressed that CW was notified "automatically," based on electronic health record review of a patient's past, rather than an evaluation of the "whole picture" of the patient's current state.

Table 1 Illustrative quotes of themes related to impacts of Child Welfare Involvement[a] on human trafficking survivor mothers and recommendations for improvement, [REDACTED] 2020

Who reports to child welfare	
Social Worker	"…usually the hot potato falls onto the social worker."- Respondent 4
Timing of child welfare involvement	
Antepartum, if CWI with another child	"If the patient had an extensive history and involvement with the Department of Children and Families and the patient, the patient would have already been flagged since the beginning, so prior."—Respondent 4
Postpartum	"Usually after delivery with what we've seen, those are the most cases that we've had. We didn't have a lot of patients that already had their children with them. So I can't really speak to that. But I know that we had many patients that DCF was involved right after they delivered."—Respondent 1 "For the most part, now, we mostly see it during once they deliver."—Respondent 2
Reasons for report to child welfare	
History of human trafficking	"a lot of them are unaware of human trafficking and what it like, what comes with it and some of the traumas that are associated with that, and I think they just see red flags and get scared and make that initial call instead of having more of an understanding and understanding what it means to go through trafficking and those traumas."—Respondent 1 "…or labeled as human trafficking survivor because that that's supposed to be a diagnosis rather than a rather than a stigma against you. Sometimes it is used against you I feel."—Respondent 3 "a target simply because they were involved in human trafficking, even though the idea is to make sure that the child is safe. But we're already, you know, judging individuals simply from an experience that they've gone through, regardless of what happened to them to get them there. You know what I mean?"—Respondent 2
Substance use and intimate partner violence	"I would say it we would see more substance, but not a significant amount more. And usually when you see DV,[c], there is some substance use as well so that they've overlapped as well."—Respondent 1
Psychiatric history	"They can see that in the system and also that they may have had a history of cutting or a history of going to crisis when they were younger, like some of these girls had, do have a history of going to crisis and have been to [Behavioral Health Facility] and all these other facilities, as well as [Behavioral Health Hospital] while in the foster care system. And so then they I don't know, maybe they're labeled as having behavioral issues."—Respondent 2
CWI with other children	"That previous DCF, if for some reason they either had a removal before they had DCF interaction before and it's in the chart, that I think that there is a lot of cases that got called in because of that."—Respondent 1
Housing Instability	"…one of the requirements to say you're a great parent is to be able to survive, to provide a shelter for your kid."—Respondent 3 "Most common is lack of stability. These are individuals who are either homeless or unable to provide. But the welfare of the child is most important. So is this child going to be safe if there's no permanent housing"—Respondent 4
Automatic judgement based on history in electronic health record	"…sometimes is documented and because we, you know, sometimes with the EMR or the the computer system, some people just cut and paste so it's in more recent notes. But some of those things are very historical. And that person has had stability or a support team and they have developed and they're far removed from that situation, but is not documented as such…., I think it's because of the way as documented … you know, the notes would say prior drug use or so the old red flags are considered the red flags" —Respondent 3

Table 1 (continued)

Lack of holistic picture	"Yeah, like one of my girls, like, I know she was a cutter and she did all of those things. But if you read our notes…she has constantly said in the notes she has not cut herself. She was not thought about suicide. She's in a really great relationship. Things are really positive. It's been this way for this amount of time. There was nothing to show that DCF needed to be called. None of her wounds were fresh."—Respondent 2
General access to resources	"…sometimes it's a situation where it was a positive experience where they actually had access to care that they didn't have before."—Respondent 4
Housing	"…but these are individuals who, if you are homeless now, you have referrals being made for you, for homelessness."—Respondent 4
Substance use treatment	"…if a mom is doing really good and she has progressed a long way through her substance treatment, I think it could be motivation to stay well and to stay sober. But that's a big toss up. I don't think that you can say specifically whether it would go either way."—Respondent 1
	"I don't think DCF is totally bad because if you can't present and do the work, there is safer to keep the kids into in DCF custody. So even in that sense, I've seen where DCF didn't return a kid. But it's also because there's so many obstacles in that person's life that it wouldn't be the best option in the moment."—Respondent 3
Negative impacts of child welfare	
Traumatizing, as prior trauma from CWI	"…you are dealing with people who … may have already been in the system, that don't trust the system, that have had a neglect while in the system. And then they feel like here's the same system that's trying to take away my child, even though so many bad things happen to me while I was there. You understand what I'm saying to you? So I think it can be very triggering for you to hear oh DCF is being called on you."—Respondent 2
	"they feel that their lives as a child was turned upside down when they were removed from DCF or some of their trauma happened while they were in DCF custody. So even the presence of DCF coming based on this one pregnancy in their life, they become stagnated and basically they're frozen. So we have a fight, fight or freeze some freeze because they remember the trauma of what that was like. And so they don't know how, they feel powerless. And some of them do fight really hard because they don't want their children to go down that path that they once went through. But then some of them don't know how to fight."—Respondent 3
Removal of baby	"…think sometimes DCF becomes another obstacle, and while they're trying to put the pieces back together. They're, they're torn because if you give birth to a kid that you really wanted and that kid is removed, you're torn. That's a piece of you."—Respondent 3
Substance use relapse	"I think it really depends on the mom and where she is in her treatment. If she has something triggering like that, like a DCF call and a removal, I think can absolutely make her at a higher risk for relapsing."—Respondent 1
	"But I also believe that forcing someone to do it because you have something that they want isn't ideal because it didn't empower them. It really did not empower them to do it. And so sometimes you get the cases reopened later on because the person didn't fight the drug addiction. It was just fighting the person who had their kid."—Respondent 3
Mental health	"When there is a mention of DCF,[b] I think we see we see out cries for help. We see more crises.—Respondent 4
	"A lot of our patients already have PTSD or some type of depression, anxiety, sometimes adjustment disorder to being pregnant. And I think that that added stressor just heightens those symptoms that they already experience that we're already trying to treat during pregnancy. So I think it just makes the whole situation more difficult."—Respondent 1

Table 1 (continued)

Physical health	"I've seen patients that are even nervous to come to their appointments because they already have this fear that when they go into the hospital to deliver, DCF is going to be called and that their baby is going to be taken away. So most of the time we're able to speak with them and reengage them before it really affects their physical health, but I know that that stress that they feel, especially while they're pregnant, isn't good for them or the baby."—Respondent 1 "If they had a really traumatic experience with child welfare and they were triggered again, some of them don't reengage into services with the clinics or primary care becomes a barrier."—Respondent 4
Interviewee recommendations	
Proactive prenatal approach- emotionally prepare trafficked mother	"To mothers who have not delivered before. I think that it is very concerning to them knowing that they do have this history that you know doctors and nurses may see. And those are the patients that we kind of bring it up with them, like, hey, just to give you a heads up so we can prepare."—Respondent 1
Proactive prenatal approach-secure housing	"So a lot of our women struggle with housing, most of the time we will get them into some type of shelter specifically for trafficking victims. It's not always easy to get, when we are able to get it, I believe it's better for the patients because they can at least say that they're receiving services and that they're having help, especially if it's in a shelter that is for pregnant women as well, because they know that when the mom delivers and she can take baby home, she has everything that she needs at that shelter."—Respondent 1
Proactive prenatal approach-substance use treatment	"So substance use treatment, it's not always easy for us to get our moms in. We do work a lot with some of the other services at [redacted] that can help provide that."—Respondent 1
Interprofessional collaboration	"It would be nice if there, if we knew who the social worker was so that we could speak to them beforehand and maybe even meet the mom beforehand, and have a sit down discussion. So that way they're already aware and they don't all of a sudden see this patient come in and they see this baby and they see this history and they just get panicked. If they knew the mom previously, if they had sat and spoken with us, we could do almost like like a like a little staffing on the case and everything that's happening. So that, and involve the mom there with her so that she can be aware of everything that's happening with her and the baby." —Respondent 3
Training	"So I think one of the biggest things that needs to happen is kind of like an awareness of trafficking, what it does for a person, how they're affected by it, how it's not necessarily somebody gets, you know, pulled from trafficking and all of a sudden they're good. It's something that takes for however long the patient needs to recover from that. And it's not something that will ever really go away for some people. And I think just that awareness of how that works and the trauma that's associated with it. Is something that we need to provide at an educational level to all those people on that floor so they don't look at the chart, see, oh my gosh, all of this has happened, we need to call DCF. [b] Instead, they could see this is what they've been through, this is what they're doing to already get better. They're already engaged in services. Maybe a DCF call isn't necessary at this point."—Respondent 1
Trauma-informed culture and systems change	"There's a difference between being trauma informed and actually applying trauma informed care. you know, saying we're trauma informed and then you're there triggering."—Respondent 4 "We can talk about trauma informed until we are blue in the face, but are we actually applying trauma informed in general? How are you going to provide proper trauma, informed care if I'm burned out? … at the end of the day, what people forget is that trauma informed care about how we interact.. So if I'm looking to engage in a conversation, if I'm not really paying attention to what you're saying because I'm not there, I'm not helping."—Respondent 4

Table 1 (continued)

Improve access to social services	"…I feel like parents don't get a handbook. Right. But you do need some guidance and resources and if the only reason a person isn't getting their child, even if they're doing the work, is because every piece of their little puzzle that needs to be in place isn't in place because the resources aren't there, then we fail. We fail as a society."—Respondent 3

CWI Child Welfare Involvement, *DCF* Department of Children and Families

Impact of CWI

Figure 1 demonstrates the positive and negative impacts of CWI that were reported by interviewees. On the positive side, these included access to services, including housing and parenting skills training, that may not have been available otherwise. Depending on the patient's readiness for change on their substance use journey, the requirements for substance use treatment could be transformative. One respondent defined success related to the child being able to stay with the mother. A success of CWI repeated by respondents was the safety of the child.

On the negative side, data saturation was reached, with all participants noting trauma reactions and increased stress among survivor mothers with CWI. The trauma was particularly profound for those with prior CWI (as a child themselves, or with their other children). The stress of CWI was described as leading to "regression", "self-destructive" behaviors, substance use relapse, more mistrust of the health care system and further decreased engagement with the health care system. Three respondents also stated the removal of the child was a negative outcome.

Interviewee Recommendations

Interviewee recommendations for future improvement included prenatal proactive approaches: discussing with the trafficked mother the possibility of CWI prior to the birth of child; enhancing prenatal communication between hospital social workers and longitudinal providers; and linking the trafficked mother to substance use treatment and housing. Training for hospital providers, including training delivered by people with lived experience such as survivor advocates was recommended. Interviewees also recommended refining post-partum communication strategies between hospital (obstetrics and pediatrics) and outpatient providers. Finally, respondents recommended structural and cultural changes within health systems to promote strength-based trauma-informed care and improved capacity and communication among perinatal providers and CW services in general.

Discussion

This study was single-centered with a limited convenience sample, so its findings are not generalizable. Moreover, data was collected via audio-recorded, non-in-person interview, possibly limiting rapport -building between the interviewee and the interviewer and therefore potentially decreasing the

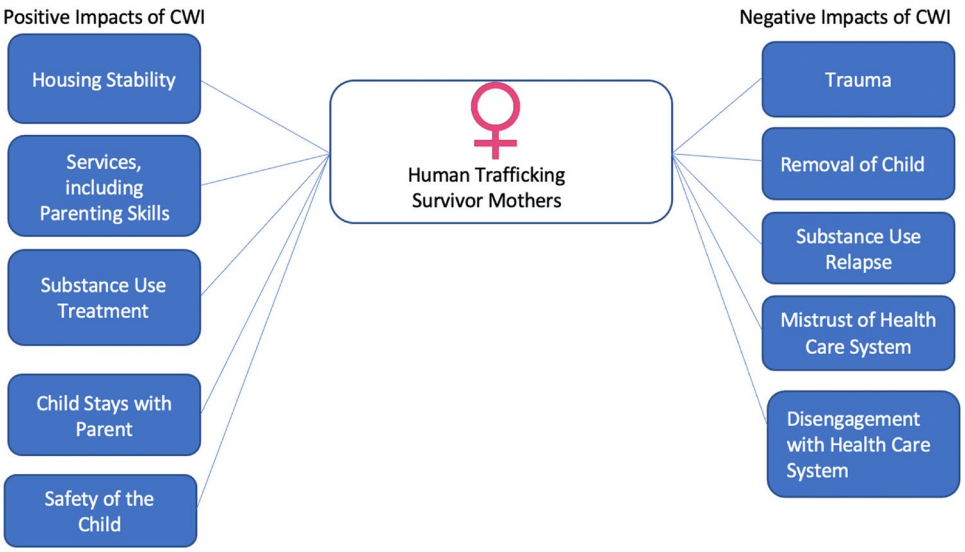

Fig. 1 The impacts of child welfare involvement (CWI) on human trafficking survivor mothers

interviewee's openness in sharing (Archibald et al., 2019; Mealer & Jones, 2014).

Despite the exploratory nature of our findings, our data do mirror what is reported in the public health literature. First, the fact that the reporter to CW lacks a long-term clinical relationship with the caretaker, in this case, the survivor mother, is consistent with the IPV literature. Those with a more holistic view of the entire family may be less likely to make a CW report (Carlson et al., 2019). Respondents also noted reflexive reports to CW based on a patient's history in the medical record, rather than a global assessment of their current state. Stigma reinforced by the electronic medical record has been reported among other populations (Stablein et al., 2015). Stigma associated with a history of human trafficking, unfortunately, is not novel to this study (Richardson & Laurie, 2019). Reports of CWI for substance use are not uncommon (Alexander et al., 2020; O'Rourke-Suchoff et al., 2020). Finally, reports to CW because of housing instability, as we discovered in this study, has been described as a mechanism through which CWI may "criminalize poverty" (Chandler et al., 2020; Newberger, 1983). The types of positive impacts from CWI in our study were also present in the IPV literature (Lippy et al., 2020). Negative impacts, in particular, the trauma from CWI, are also well-described in the IPV literature (McTavish et al., 2019).

Recommendations from our exploratory findings, contextualized in the extant literature, include mechanisms to support trafficked mothers, train hospital social workers, and systems change. During the prenatal period, strategies to support the trafficked mother may include addressing gaps in social determinants of health, ensuring appropriate medical and mental health care, early screening and referral to substance use treatment services, promoting problem-solving and communication skills, providing parenting classes, implementing techniques to decrease parental stress, enhancing community support, and working to develop safety plans for survivors and their families (Alhusen et al., 2015; Clark et al., 2019; Ee & Anderson, 2018; Huebner et al., 2017; Terplan et al., 2015). The respondents also recommended enhanced prenatal communication between outpatient and hospital social workers. Furthermore, enhanced engagement of social workers and all providers to improve understanding of the unique complexity of trafficked mothers is needed (Wolfe & McIsaac, 2011). Education should include an understanding that judgement of a caretaker's ability to parent should be current and holistic and not reflexive based on history in the electronic medical record (Hsieh & Shannon, 2005). An exploration of the child welfare system itself should also be undertaken to identify and modify discriminatory laws and policies (Wolfson et al., 2021). Finally, efforts to address social determinants of health in the community and enhance the trauma-informed nature of child welfare referrals could improve the lives of trafficked mothers.

To date, there are no prospective studies exploring whether mandatory reporting reduces recurrence of maltreatment or improves the well-being of children (McTavish et al., 2017). Future research related to this study's exploratory findings could include interviews with trafficking survivor mothers, representing a diversity of experiences across the country. We recommend involving those with lived experience of trafficking and CWI in the study's design, execution and publication. Effective responses and advocacy for pregnant trafficking survivors and their children requires comprehensive policies and procedures that involve multidisciplinary community input including but not limited to trafficking survivor mothers, advocacy groups, healthcare providers, and child welfare services.

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