BUILDING COLLABORATIVE RESPONSES WITH HEALTHCARE

for Domestic Violence and Sexual Assault Task Forces and Multidisciplinary Teams Addressing Human Trafficking

FUTURES WITHOUT VIOLENCE

TABLE OF CONTENTS

Overview: Why Healthcare?

At their fundamental core, domestic violence, sexual assault, human trafficking (DV/SA/HT) task forces and coalitions work collaboratively and across disciplines to prevent, intervene in, and eliminate violence, abuse, and trauma. The added value of building collaborative responses with healthcare is that coalitions can promote health and well-being, in addition to responding to acute health needs of victims. The healthcare sector is critical to achieve these goals because healthcare providers are often an initial point of contact, or first line responder, for people who are sexually assaulted, in situations of domestic violence, or trafficked; they play a critical role in prevention (recognizing and addressing factors creating individual and social vulnerabilities of people and populations to violence and exploitation); and they are crucial to providing avenues for healing by addressing chronic health consequences of violence, abuse, and trauma.

Furthermore, when DV programs or law enforcement are the first responders for DV/SA/HT, they may find that there are health needs of their clients or victims – partnerships with healthcare can support both the client and responding staff. There is a movement underway for domestic violence programs and healthcare organizations to meaningfully engage and build fruitful partnerships with each other, creating a strong base of community resources and support for people and communities made vulnerable to sexual assault, domestic violence, and human trafficking. Furthermore, several capacity building projects are underway within healthcare systems, particularly within Federally Qualified Health Centers (FQHCs). FQHCs provide primary care, behavioral health, and dental care for underserved communities across all 50 states and territories. It is critical that healthcare systems are part of the collaborative response to address DV/SA/HT – to engage with those at risk, and to provide care for survivors.

About

THE INTERSECTION OF HEALTHCARE

DV/SA is a key social determinant of health and impacts health: At least 1 in four women have experienced IPV and 1 in 7 men have experienced severe physical violence by an intimate partner. [1]

87.8% of survivors in one HT study met a healthcare provider while being exploited. [2]

Health consequences can be severe. The long-term impact of DV/SA includes physical injuries, chronic health, and mental health issues, and high-risk health behaviors. [3]

SA can impact mental health and substance abuse significantly: 13%–51% of women meet diagnostic criteria for depression following SA; 23%–44% experience suicidal ideation with 2%–19% attempting suicide; dependence on alcohol can be seen in 13%–49%; and 28%–61% report the use of other illegal substances. [4]

An analysis of nearly 200 independent studies involving more than 230,000 adult participants found that having been sexually assaulted is associated with significantly increased risk of anxiety, depression, suicidality, post-traumatic stress disorder, substance abuse, obsessive-compulsive disorder, and bipolar disorder. [5]

Male victims of sexual violence experience subsequent mental and physical health problems and were more likely to report poor mental health, poor life satisfaction, activity limitations, and lower emotional and social support than non-victimized men. [6]

Benefits of Healthcare Partnerships for DV/SA/HT Task Forces and Coalitions

- Improved health outcomes for survivors. Good health is a part of healing and helps survivors thrive.
- A pathway to COVID-19 testing, care, and vaccinations for trafficked survivors and their children.
- An opportunity for health care providers to identify and refer trafficked patients to advocacy and legal support offered through the Task Force or Coalition.
- An opportunity for DV/SA/HT coalitions to expeditiously meet the health care needs of victims.
- An opportunity for DV/SA/HT coalitions to be aware of people with vulnerabilities to victimization and to provide prevention and early intervention.

Priority Healthcare Partnerships for DV/SA/HT Task Forces and Coalitions

- Community Health Centers – Prevention, Early and Acute Care, and Long-Term Care
- SART teams – Acute Care
- Emergency Departments (ED) – Acute Care

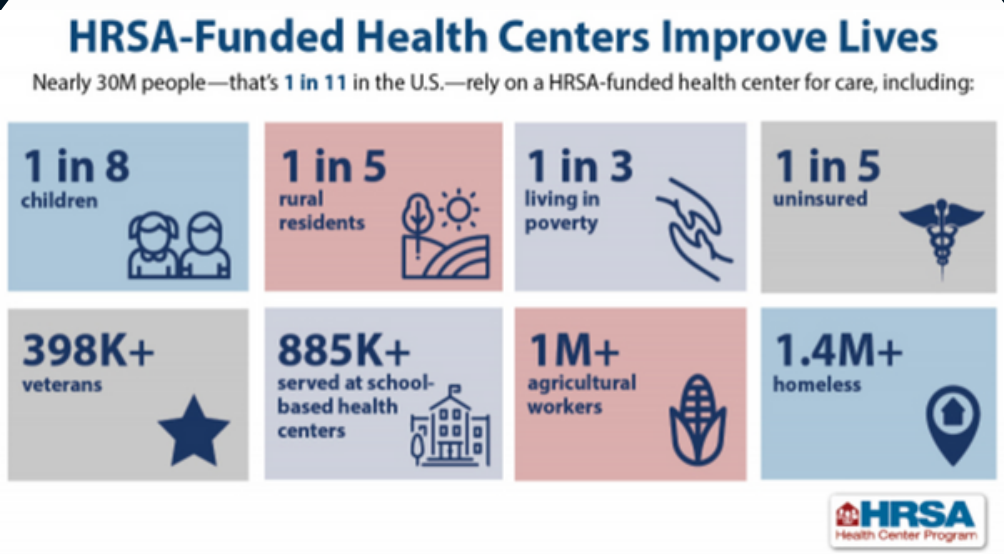
Community health centers provide primary care. They are key partners for DV/SA/HT Coalitions to promote the health and wellbeing of victims/survivors, strengthen prevention and early intervention, increase primary health care access for survivors, and connect survivors with available legal and advocacy support.

About

COMMUNITY HEALTH CENTERS

Community health centers (also known as Federally Qualified Health Center-FQHC) are community-based and patient-directed organizations that deliver free or low-cost comprehensive primary health care services in all 50 U.S. states and territories. There are about 1,400 health centers with over 14,000 clinical sites, serving 30 million patients. Health centers often integrate access to pharmacy, mental health, substance use treatment, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care services. By federal statute, health centers must provide services to Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP) – people who have high vulnerabilities to being exploited and trafficked including migrant farmworkers, public housing residents, and those who are homeless/unsheltered.

Identify a community health center in your area by visiting: https://findahealthcenter.hrsa.gov/



How Health Center "Enabling Services" Can Help Trafficked Survivors:

In addition to primary care, community health centers offer “enabling services”, which are services that help people visit their clinical provider. Here are some of the ways enabling services can benefit trafficked survivors and task force coordination:

- Transportation (such as shuttles, or taxi vouchers)
- Interpretation and translation
- Eligibility and Health Care Enrollment
- Partnerships with Domestic Violence Programs
- Medical-Legal Partnerships with civil legal aid agencies
- Case management and assistance with navigation of social services and justice processes

Opportunities for Partnership with Health Centers during COVID:In addition to medical care, health centers offer:

- COVID-19 testing, COVID-19 vaccinations, and cloth mask distribution.
- The federal government is directly supplying FQHCs with COVID-19 vaccines, specifically to reach vulnerable populations.

Tips to Include Community Health Centers in your Task Force/Collaborative/Coalition:

• Identify your local community health center by visiting: https://findahealthcenter.hrsa.gov
• Identify a champion within the CHC and invite them to your collaborative meetings.
• Visit www.IPVHealthPartners.org for sample MOUs and tools for collaboration.
• Work with the CHC to provide a training to all staff.
• Establish referral processes for survivors once the CHC implements the “CUES” intervention.
• Monitor and evaluate your progress.

Learn more about establishing partnerships with community health centers: www.IPVHealthPartners.org

Sexual Assault Response Team (SART)

A SART is a group of specially trained members of health care, law enforcement, prosecution, and advocacy that work together to provide services to victims of SA, while investigating SA cases for criminal prosecution. [8]

The main functions of SART are to [9]:

- increase intra-agency and interagency collaboration and coordination when responding to SA,
- identify inadequacies and limitations in and among systems,
- ensure appropriate, trauma-informed responses to support victims, and improve offender accountability.

Because the SART is activated in response to reports of SA, they are acute mechanisms for engaging with victims/survivors. The healthcare component is usually limited to forensic examination, and usually completed in a hospital setting (tertiary care). In the acute phase following an assault, a sexual assault forensic examiner's primary role is to perform a medical examination of a victim to address their health care needs, assess for injuries, collect evidence, objectively document findings, and collaborate with other members of the health care team to address the personal health, safety, and emotional well-being of the victim. Additionally, sexual assault examiners are responsible for testifying as fact or expert witnesses, if subpoenaed by the prosecution or defense. [10]

SARTs are also encouraged to collaborate with health care providers in the community they serve. The objective for SARTs collaborating with health care providers is to consistently meet the needs of victims by ensuring:

- victims have access to comprehensive post-assault services in their community and resources to access those services,
- health care providers are aware of options for referral services regardless of a patient's plan to proceed with evidence collection or report to law enforcement, and
- all community providers receive education on reporting options, so victims can make informed decisions.

To ensure quality health care for patients, the SART must be well informed of the available community resources that support recent victims of assault, facilities providing acute care, medical services, evidence collection, follow-up health care services, advocacy support, legal aid and local emergency shelters and the gaps in services that exist in the community.

Emergency Departments:

Emergency departments at hospitals often serve as initial contact with victims of DV/SA/HT. About 14 percent of women treated in the emergency department are for DV-related conditions, and DV leads to at least 1.4 million annual ED visits [11]. Of all assault visits to the ED, 4.2% were SA related, which represents an estimated 143,647 ED visits for SA in 2001 to 2002 [12]. Furthermore, one study of survivors of domestic sex trafficking found that 63% of survivors of domestic sex trafficking reported going to an ED while being trafficked [13].

Building partnerships with the local emergency departments and hospital systems would facilitate the acute responses and help to leverage system change responses by the DV/SA/HT coalitions.

Overview of Different Healthcare Levels That May be Available in Your Community

1. Primary health care is an outpatient, or clinic, level of care where people have initial engagement for physical examinations, preventive care like immunizations and cancer screenings, reproductive care, integrated behavioral healthcare, for urgent care visits for injuries or acute illnesses, and for long-term management of chronic physical and mental health illnesses. Primary care often provides the initial assessments and diagnostics before referring to specialty secondary care levels.

2. Secondary health care is an outpatient, or clinic, level of care where people can access specialist consultations and treatment, and specialty mental health.

3. Tertiary health care is an inpatient, or hospital based, level of care with emergency departments, inpatient surgical care, trauma care, and hospital and intensive care units.

4. Highly specialized health care is usually found at academic medical centers and hospitals, offering experimental treatment, treatment for rare diseases, and participation in research studies.

Examples of Coalitions with Healthcare Partnerships

HEAT Watch, HEAT Institute, and Human Trafficking-Medical Offramps Project, Alameda County, California

The Alameda County H.E.A.T. (Human Exploitation and Trafficking) Watch is a county wide collaborative and multi-system approach to combat exploitation and HT in Alameda County, California, convened and housed under the Office of the District Attorney:

HEAT Watch is a five-point collaborative strategy – a Blueprint -- providing a comprehensive response to effectively combating HT. The five components are: 1) supporting victims 2) robust community engagement; 3) training for first responders and community; 4) vigorous prosecution; 5) education of and advocacy to policy makers. This strategic approach recognizes that the Blueprint is only as strong as the joint involvement and commitment of law enforcement agencies, first responders, service providers, prosecutors, and community members. [14]

As part of the healthcare engagement, H.E.A.T. Watch convenes and facilitates a SafetyNet, meetings of multidisciplinary teams, including healthcare service providers, to provide an immediate response to Commercially Sexually Exploited Children, and to ensure victim safety for youth at the moment of their identification and throughout their potential interface with any system. In parallel to H.E.A.T. Watch, the H.E.A.T. Institute was created to allow Californians to come together and review, rethink, reframe, and redesign how the state responds to HT, recognizing a critical need to align systems and programs, and to create critical infrastructure that provides and funds a comprehensive system of prevention and intervention. Part of the H.E.A.T. Institute funded and guided four local hospitals to develop and implement trafficking response protocols for their emergency departments. Separately, the H.E.A.T. Institute's work with Community Health Center medical providers in Alameda County developed into the Human Trafficking Medical Offramps Project (HT-MO) under the Alameda Health Consortium/Community Health Center Network.

(HT-MO conintued)

The HT-MO supports Federally Qualified Community Health Centers to develop and implement HT response protocols with access to ongoing training and Bedside Advocates. The HT-MO aims to improve immediate support to victims of all kinds of HT, exploitation, and DV. Through this effort medical providers and patients have crises support access and long-term case management and community-based supports including legal, housing, and mental health services. This project also provides trauma-informed practices training to law enforcement and district attorneys.

South Bay Coalition to End Human Trafficking, Santa Clara County and San Benito County, California

The South Bay Coalition to End Human Trafficking (SBCEHT) responds to HT in the counties of Santa Clara and San Benito. The SBCEHT mission is to ensure the protection of victims, the prosecution of offenders, and the prevention of HT and slavery through an effective coordinated partnership. SBCEHT currently engages healthcare in two ways. First, SBCEHT built a collaborative response with the Valley Homeless HealthCare Program (VHHP) to develop organizational protocols, outreach tools, and clinical policies for health record documentation that protects the patient but still communicates the patient's increased vulnerabilities to exploitation, between clinical providers. SBCEHT facilitated a robust collaborative response, resulting in a strong partnership and direct connection between the VHHP and San Jose Police Department Human Trafficking Unit. The solid relationship enabled several options for support and resources for the exploited person – whether health care options, law enforcement needs, or social services response. Second, SBCEHT convened a regional work group, "No Traffick Ahead", amongst neighboring counties focused on healthcare responses. This regional convening brought representatives together to share promising practices within healthcare responses to HT.

Policy Background on Incorporating Healthcare in Responses to DV/SA/HT

The passage of the Violence Against Women Act (VAWA) in 1994, and its reauthorization in 2000, 2005, and 2013, has changed the landscape for victims who once suffered in silence. It is a landmark piece of legislation that sought to improve criminal legal and community-based responses to DV, dating violence, SA, and stalking in the United States. Of note, one of the new focus areas in the 2000 reauthorization was on prevention strategies to stop violence before it starts. The Trafficking Victims Protection Act (TVPA) passed Congress in 2000 and was most recently reauthorized in 2018. In 2013, the US federal government released a five-year federal strategic action plan to address HT from a multi-sector perspective, including healthcare; and a 2013 Institute of Medicine report on child sex trafficking further highlighted this as a health issue. In 2014, the Administration for Children and Families (ACF) developed and evaluated a curriculum on HT for health care professionals. In 2017, the federal government convened a five-year National Advisory Committee on the Sex Trafficking of Children and Youth in the United States, to provide recommendations to Congress, State Governors, and Child Welfare agencies, with a first report/recommendations released in Fall 2020, which included recommendations focused on health care.

Also in 2017, the Health Resources & Services Administration (HRSA) began a three-year plan to address intimate partner violence (IPV) called The HRSA Strategy to Address Intimate Partner Violence. Health care providers across the country are being trained to recognize the signs of DV/SA/HT and to treat individual patients, and at the same time, the healthcare delivery system is undergoing robust transformation to address the social determinants of health, which include violence and safety. More specifically, regarding HT, hospital associations, local medical associations, medical societies, federally qualified health centers, have all embarked upon initiatives to support healthcare providers in prevention, intervention, and long-term care for those at risk, victims, and survivors. With growing momentum, there is a critical window of opportunity to engage healthcare delivery systems with the established and ongoing collaborative responses of the DV/SA/HT coalitions across the country.

ENDNOTES

[1] 2010 CDC National Intimate Partner and Sexual Violence Survey, www.cdc.gov/violenceprevention/nisvs/
[2] Laura J. Lederer & Christopher A. Wetzel The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities, 23 Annals Health L. 61 (2014).
Available at: https://lawecommons.luc.edu/annals/vol23/iss1/5
[3] www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html
[4] Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. Trauma, Violence, & Abuse, 10(3), 225–246. https://doi.org/10.1177/1524838009334456
[5] Dworkin, E., Menon, S. V., Bystrynski, J., & Allen, N. E. (2017). Sexual assault victimization and psychopathology: A review and meta-analysis. Clinical Psychology Review, 56, 65–81. https://doi.org/10.1016/j.cpr.2017.06.002
[6] Choudhary, E., Coben, J., & Bossarte, R. M. (2009). Adverse health outcomes, perpetrator characteristics, and sexual violence victimization among U.S. adult males. Journal of Interpersonal Violence, 25(8), 1523–1541. https://doi.org/10.1177/0886260509346063
[7] https://www.nsvrc.org/sarts/toolkit/2-2
[8] Office for Victims of Crime, n.d., "Glossary of Key Terms," SANE Program Development and Operation Guide. Washington, DC: U.S. Department of Justice. Retrieved June 21, 2017, from LINK
[9] Jennifer Cole and T.K. Logan, 2010, "Interprofessional Collaboration on Sexual Assault Response Teams (SART): The Role of Victim Alcohol Use and a Partner-Perpetrator," Journal of Interpersonal Violence25(2): 336–357.
[10] U.S. Department of Justice, Office on Violence Against Women, 2013, A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents . Retrieved June 29, 2017, from LINK
[11] Davidov DM, Larrabee H, Davis SM. United States emergency department visits coded for intimate partner violence. J Emerg Med. 2015;48(1):94-100.
[12] Saltzman LE, Basile KC, Mahendra RR, Steenkamp M, Ingram E, Ikeda R. National estimates of sexual violence treated in emergency departments. Ann Emerg Med. 2007 Feb;49(2):210-7. doi: 10.1016/j.annemergmed.2006.10.015. Epub 2006 Dec 4. PMID: 17145110.
[13] Laura J. Lederer & Christopher A. Wetzel The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities, 23 Annals Health L. 61 (2014).
Available at: https://lawecommons.luc.edu/annals/vol23/iss1/5
[14] http://www.heatwatch.org/heat_watch/ (accessed May 7, 2021)

Futures Without Violence provides training and technical assistance support to advocates, multidisciplinary teams, and others, as they build collaborative responses to trafficked victims of domestic violence and sexual assault.
Learn more about how we can support you:
https://www.futureswithoutviolence.org/human-trafficking/
Contact us: Learning@futureswithoutviolence.org

This resource is part of a project entitled:
Building Collaborative Responses to Trafficked Victims of Domestic Violence and Sexual Assault.

This project is supported by Grant No. 2015-TA-AX-K029, awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

FUTURES WITHOUT VIOLENCE