Panel 3: Screening to Identify Trafficking Survivors

This panel discusses barriers to identification and strategies for developing, adapting, and using trauma-informed screening tools; referral protocols in diverse settings to promote access to services and ensure better coordination among providers.

Following the PowerPoint presentation is a list of resources suggested by the HHS Health and Human Trafficking Symposium moderators and panelists. The list includes a wide variety of resources, ranging from published research, fact sheets, and tools such as trainings and curriculum.
Screening to Identify Trafficking Survivors

Moderator/Panelists

- **Moderator:** Nicole Greene, Acting Director, Office of the Assistant Secretary for Health, Office on Women’s Health
- **Panelists:**
  - Dr. Wendy Macias-Konstantopoulos, Attending Physician, Massachusetts General Hospital
  - Dr. Makini Chisolm-Straker, Co-Founder, HEAL Trafficking; Emergency Department Physician
  - Mary Landerholm, Action Plan Manager, Laboratory to Combat Human Trafficking
  - Anna Marjavi, Program Director, Health, Project Catalyst, Futures Without Violence
  - Valerie Douglas, Director, Counseling and Runaway and Homeless Youth Services, Center for Youth Services

Learning Objectives

- Describe different approaches to screening for trafficking survivors: Why is it important, and what are the limitations?
- Explore foundational principals that support trauma-informed screening.
- Recount lessons learned from working with particular populations and identify current gaps.

Principles of a Trauma-Informed Approach

- Realizes the widespread impact of trauma
- Recognizes the signs and symptoms of trauma
- Integrates knowledge about trauma into policies, procedures, and practices
- Strives to actively minimize re-traumatization in services
- Supports recovery by fostering:
  - Safety, respect, and acceptance
  - Trust and transparency
  - Peer support and self-help
  - Collaboration and mutuality
  - Empowerment through voice, choice, and emphasis on strengths and resilience
- Respect for cultural, historical, and gender issues/differences

Nicole Greene, Office of the Assistant Secretary for Health, Office on Women’s Health

Dr. Wendy Macias-Konstantopoulos, Attending Physician, Massachusetts General Hospital


Principles of a Culturally Responsive Approach

- Values diversity and inclusion
- Accepts and respectfully navigates the cultural and individual differences that make each person unique, regardless of group membership
- Recognizes the impact these differences have on a person’s experiences, beliefs, attitudes, behaviors, and expectations
- Avoids attempts to become an expert in any given culture, but rather to become an expert in strategies that convey acceptance and support a diversity of needs
- Strives to actively minimize stereotypes and generalizations across a social group based on age, race, ethnicity, religion, language, family background, etc.
- Accepts the responsibility of investing in strategies to decrease or remove barriers (e.g., linguistic services)
- Seeks feedback from the diversity of members served

Definitions

- Screening: Diagnostic instrument applied to an entire (predetermined) population that is used to identify the possible presence of an outcome of interest
- Assessment: Evaluation instrument used by an expert when there is concern for an outcome of interest
- Protocol: Algorithmic set of actions that mobilizes a dedicated team when an outcome of interest or concern arises for that outcome
- Validation: Comparison of a new tool against a logical or gold standard, not expert opinion

Purpose

- Screening: Allows for patient disclosure, regardless of user bias
- Assessment: Activates experts and facilitates purposeful resource allocation
- Protocol: Enables reliable actions, regardless of users
- Validation: Tells the user that the test actually measures what it purports to measure

Existing Gaps in 2018

Validation (tool type, population, setting)
- Greenbaum Tool
  - Screening tool, 13- to 17-year-olds, with high-risk chief complaints to emergency department/health care setting
- Trafficking Victim Identification Tool (TVIT)
- Assessment tool, adults, social service setting
- Human Trafficking Interview & Assessment Measure (HTIAM-14)
- Assessment tool, homeless young adults, social service setting
- Quick Youth Indicators of Trafficking (QYIT)
- Screening tool, homeless young adults, social service setting

Take-Home Messages: The Fundamentals

- Screening is not part of a checklist, and questions should not be read.
- One-size-fits-all screening is not realistic or conducive to disclosure and can cause harm.
- Screening requires active listening and a need-to-know framework.
- Building rapport and earning trust are crucial components of screening.
- For mandated reporters, transparency about the limits of confidentiality is a must and can promote care and move the narrative forward, and minimize the chances of relationship rifts.
- Protocols and resource infrastructure are essential before beginning screening.
Existing Gaps in 2018 (continued)

Comprehensive Tools (screening and/or assessment)
- TVIT (assessment)
- HTIAM-14 (assessment)
- QYIT (screening)

Mary Landerholm, Action Plan Manager, Laboratory to Combat Human Trafficking

Collaboration

Community Reach Center Action Plan

CRC’s identified priorities:
- Training/education
- Screening of victimization
- Capacity building
- Connections to others at the local, state, and national level doing work within the anti-trafficking context

Community Reach Center

Organizational Challenges on Screening

- Questions being asked in the screen
- Placement of questions in the intake process
- Who was screening, when, and how often
- Consideration for wide range of consumers
- Interpretation and language considerations
- Staff training by role within CRC
The Laboratory to Combat Human Trafficking (LCHT) conducted a substantive literature review to better understand and define the key components of promising practices within each of the 4Ps. It was via the Social Ecology Theory that we began to articulate that these Ps happen in specific communities with unique characteristics. We gathered diverse innovative thinkers and began to think together, learn from one another, and adapt our lenses.

What does it mean to combat human trafficking?

Governments and international organizations have declared that an effective response to human trafficking must include these four key elements (US State Department & UNODC):

**GUIDING FRAMEWORKS**

**THE 4Ps**

- **PROSECUTION**
  - Human trafficking protocols and procedures
  - Training and education
  - Task forces
  - State trafficking and trafficking-related legislation
  - Municipal trafficking and trafficking-related legislation
  - Attempted/successful civil and criminal prosecutions of trafficking cases

- **PREVENTION**
  - Training and education programs
  - Awareness campaigns
  - Advocacy campaigns
  - Public and private sector policies
  - Protection services for persons who have experienced trafficking
  - Programs that address root causes of trafficking aimed at universal and selected communities

- **PARTNERSHIP**
  - Private sector
  - Public sector
  - Third sector
  - Protocols
  - Leadership
  - Group diversity
  - Resource leveraging
  - Trust building
  - Sustainability beyond an individual
  - Inclusion of vulnerable population perspectives
  - Effective communication
  - Conflict management
  - Management of competing interests

- **PROTECTION**
  - Social service advocacy & case management
  - Housing
  - Medical services
  - Mental health services
  - Outreach
  - Legal services
  - Training and education programs
  - State laws on victim protection/rights
  - Clothing and food
  - Interpretation/translation
  - Education
  - Life skills training
  - Employment assistance
  - Community re-integration

**Moving Forward**

- Considerations for specific programs
- Staff response at all touchpoints of engagement
- Commitment to engage in systemwide conversation around screening
- Partnership through local stakeholders: Colorado Department of Human Service, Colorado Legal Services, Rocky Mountain Immigrant Advocacy Network, Laboratory to Combat Human Trafficking

**Project Catalyst Local Partnership Goals: Bidirectional Referrals**

- **Warm referral from DV agency to health center**
  - DV Advocacy Partner
  - Improve health and wellness for DV/SAHM survivors

- **Warm referral from health center to DV agency**
  - Community Health Center Partner
  - Improve health and safety through CUES

Anna Marjavi, Program Director, Health, Project Catalyst, Futures Without Violence
Redefining Success: Futures Without Violence

Success is measured by our efforts to reduce isolation and to improve options for safety and health.

Lessons From IPV Screening...

“Success is measured by our efforts to reduce isolation and to improve options for safety and health.”

“No one is hurting you at home, right?” (Partner seated next to client as this is asked—consider how that felt to the patient)

“Within the last year, has he ever hurt you or hit you?” (Nurse with back to you at her computer screen)

“I’m really sorry I have to ask you these questions; it’s a requirement of our clinic.” (Screening tool in hand—what was the staff communicating to the patient?)

The Heart of Being Trauma Informed

What if we challenge the limits of disclosure-driven screening practices?

The Heart of Being Trauma Informed

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The Heart of Being Trauma Informed

Universal Education

Universal education provides an opportunity for clients to make the connection between violence and abuse, health problems, and risk behaviors.

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CUES: An Evidence-Based Intervention

Confidentiality
Universal Education + Empowerment
Support

CUES: Trauma-Informed Intervention

C: Confidentiality: See patient alone; disclose limits of confidentiality.

UE: Universal Education + Empowerment—How you frame it matters
   Normalize activity and make the connection—open the card and do a quick review

S: Support: Identify harm reduction strategies (i.e., address abuser interference with medication or care plan) and offer referral to local program.
   “On the back of the card are 24/7 text numbers and hotlines that have folks who really understand complicated relationships. You can also talk to me about any health issues or questions you have.”

S: Important Reminder

Disclosure is not the goal
AND
Disclosures do happen!

S: Positive Disclosure: One-Line Scripts

- “I’m glad you told me about this. I’m so sorry this is happening. No one deserves this.”
- “You’re not alone.”
- “Help is available.”
- “I’m concerned for your safety.”

Provider recognition and validation of the situation is invaluable.

CUES: Who/When?

- Who does it? Medical assistants, behavioral health providers (MD, NP, PA), or nurses; every health center is different
- Who gets it? All adolescents, female patients, LGBTQ-identified patients
- When? At least annually; with disclosures at next followup appointment; new relationships; or onset of new health issues possibly connected to IPV/HT
### S: Providing a “Warm” Referral

When you connect a patient to a local DV/SA/HT program, it can make all the difference. It may not be safe for them to use their own phone.

“If you would like, I can put you on the phone right now with [name of local advocate], and they can come up with a plan to help you be safer.”

Domestic violence/sexual assault/HT programs have vast experiences working with survivors.

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### Assessments: Lessons Learned

- We are not investigators.
- Create opportunities for strengths to be revealed in assessments.
- Language is important.
- Who is assessing?
- Why are we assessing?

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### Bitter Lesson: Bias and Stigma (Still!)

- “He wants to stay in this lifestyle. He likes it.”
- "He doesn’t want our help.”
- "Why are we helping them if they are the criminals?"
- "If she doesn’t care about her own life, why should we?"
- "Once a whore, always a whore."  
- "Why bother to place her? She is just going to run again."
- "She was an illegal, she was legal, she wouldn’t be in this position."
- “She isn’t going to change.”

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### Hardest Lesson to Accept: People Have Autonomy (Including Youth!)

- We cannot make people do what we want them to do.
- Any cooperation/compliance we get is because they choose to give it to us.
- Youth may not identify trafficking as the source of their problems or the most traumatic thing in their lives.
- Often the part that is the hardest to tolerate is the system’s response to the perceived risk.

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Valerie Douglas, Director, Counseling and Runaway and Homeless Youth Services, Center for Youth Services

Center for Youth Services, Rochester, New York

Hardest Lesson to Accept: People Have Autonomy (Including Youth!)
Hardest Lesson to Implement: Risk Tolerance

System’s responses can result in phone calls, emails, meetings, more phone calls, conference calls, incident reports, investigations, and on and on and on…..

Finally: Are We Assessing for the Right Things?

The things that make someone vulnerable to trafficking are often the same things that make it hard for them to safely and easily get out—and stay out—of trafficking.
RESOURCES

PANEL 3: SCREENING TO IDENTIFY TRAFFICKING SURVIVORS


https://www.ncbi.nlm.nih.gov/books/NBK230550/

