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First, do no harm

DESIGNING A MODEL OF TRAUMA-INFORMED CARE FOR SURVIVORS OF HUMAN TRAFFICKING IN LOS ANGELES COUNTY



Garment workers from El Monte sweatshop. Photo by Rick Meyers, Los Angeles Times

BY ANNIE FEHRENBACHER

ON AUGUST 2, 1995, a police task force led by the California Department of Industrial Relations raided a compound surrounded by razor wire in El Monte, California.¹ Inside the compound, the police discovered 72 Thai garment workers who had been forced to work 18-hour days for less than \$2 an hour.² The workers had been held in debt bondage for more than eight years, sewing tirelessly to pay off the cost of their journey to the United States.³

In the aftermath of the raid, images of the El Monte sweatshop drew international attention and began to galvanize a modern anti-human trafficking movement. Within a few years, human



Apartment building in El Monte where 72 Thai workers were held for 8 years.

trafficking became a priority for governments and human rights organizations alike. In 2000, the U.S. passed the Victims of Trafficking and Violence Prevention Act (also known as the Trafficking Victims Protection Act or TVPA),

the first piece of federal legislation to provide visa benefits for victims of human trafficking.⁴ That same year, the United Nations amended the Convention on Transnational Organized Crime to include the Protocol to Prevent, Sup-

press and Punish Trafficking in Persons, Especially Women and Children.⁵ The UN Protocol was the first global legally-binding instrument with an agreed upon definition of “trafficking in persons” although trafficking remains a

highly contested term among scholars. According to the UN Protocol, “trafficking in persons” shall mean:

*The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.*⁵

Locally, the El Monte case prompted community activists in Los Angeles to form a working group to aid the Thai workers leading to the creation of the Coalition to Abolish Slavery and Trafficking (CAST) in 1998.⁶ CAST was the first social service organization in the United States dedicated exclusively to providing case management and legal advocacy to survivors of human trafficking. Today, CAST is a human rights organization that has been internationally recognized for its dedication to identifying trafficking survivors, educating the community about trafficking, and providing direct services to survivors.⁶

Since its founding, CAST has expanded its services to the operation of a shelter for traf-

ficked persons and the establishment of community partnerships with the Venice Family Clinic and Saban Free Clinic to provide primary care for survivors of trafficking.⁶ Between 2005 and 2011, Dr. Susie Baldwin, Chief of Health Assessment and Epidemiology at the Los Angeles Department of Public Health, worked as a volunteer physician to see eight to twelve trafficking survivors per month who were referred to Saban by CAST.⁷ Unfortunately, because of budget cuts during the recession, the trafficking clinic at Saban ended in January 2012 and has yet to find a new site. This article details my work with Dr. Baldwin at the Saban Free Clinic to document the social and occupational histories of trafficking patients between 2010 and 2012. Our effort to create a collection of case studies regarding the experiences of individuals in post-trafficking health care settings led to the development of a model of trauma-informed care to educate medical personnel providing services to trafficked persons.

Due to the diversity and specialized needs of her patient population, Dr. Baldwin felt it imperative that Saban staff receive training on trafficking and trauma-informed care.⁸ Tracking and referral systems needed to be improved to ensure that trafficking survivors had access to a comprehensive continuum of health services to aid them on their path to

recovery.⁹ Together we sought to identify gaps in health care delivery for trafficking survivors in Los Angeles as well as propose solutions to improve the efficiency and cultural competency of health systems providing care to patients with a history of trauma. Patient characteristics and case studies discussed here were drawn from key informant interviews and experiences recorded during medical appointments at Saban.¹⁰ (Names have been changed to protect the safety and confidentiality of the patients.)

CHARACTERISTICS OF TRAFFICKING PATIENTS

The trafficking patients seen at Saban were diverse in age, gender, national origin, language, and trafficking experience. Patients came from all continents except Australia and Antarctica, and ranged in age from late teens to 66 years of age. A large majority of the patients were immigrants, although persons born in the U.S. who had been trafficked within and outside of the country were also seen. The majority of patients were women; however, the gender distribution was less skewed than often purported in the academic literature, in which trafficking is frequently described as a form of gender-based violence.¹¹ Most patients spoke either English or Spanish—both of which are spoken

by Dr. Baldwin—but interpreters were used in appointments for patients speaking Russian, Korean, Mandarin, Tagalog, and American Sign Language, among other languages.^{6,12}

The forms of trafficking experienced by our patients differed widely, with the most common form being domestic servitude. The types of abuse experienced tended not to be exclusively correlated with a specific type of labor exploitation. For example, sexual abuse was not necessarily more likely among commercial sex workers versus those who worked as nannies, maids, or home health aides.¹³ This observation was particularly important to document to dispel the myth that sex trafficking is inherently more severe or traumatic than other forms of labor exploitation. Assumptions about patients based on the type of trafficking experienced may cause medical staff to overlook or mischaracterize the needs of patients, leading to substandard care.

Our patients experienced varying levels of control and mobility while in a situation of trafficking. Few were forcibly held against their will, but many were subjected to coercion and threats that made them feel psychologically trapped despite no physical barriers. Some lived with their traffickers for several years, while others left or were removed by force, through actions such as police raids, in less than a year.

The health outcomes and barriers to care experienced by our patients often resembled those of other marginalized groups, such as undocumented migrants, exploited low-wage workers, victims of sexual or domestic violence, and survivors of torture.¹⁴ The health statuses of our patients were highly variable and unique to their lived experiences, though some patterns in symptomology were common between patients. Somatization related to past trauma was frequently reported by patients for whom no physical diagnosis could account for symptoms such as phantom pain, dizziness, or incessant nausea.¹³ Although psycho-somatic responses to trauma may have been a shared experience among our patients, the physical expression of the “hurt” and each patient’s interpretation of its causes and consequences were culturally dependent.¹⁵ As a result, Dr. Baldwin could not rely strictly on allopathic medical techniques, which were often ineffective for diagnosing and treating trafficking survivors.¹⁶ Additionally, many had lived far from home for several years and had limited knowledge of their family histories. A reliance on routine medical histories proved insufficient for documenting the experiences of our patients who often revealed crucial details about their health through informal conversations about their social and occupational experiences, rather

than through questions directly posed to them concerning health conditions or symptoms.

After leaving a trafficking situation, patients’ feelings toward their pasts and their traffickers were as varied as the experiences themselves. It was not uncommon for patients to express feelings of remorse or regret for leaving their traffickers.¹⁷ Some expressed that they loved their traffickers or had romantic connections to someone involved in their trafficking. On the other hand, some wished never to speak of or see their traffickers again. Several returned to their traffickers when faced with a hostile economic and social climate towards immigrants in the U.S., while others unknowingly found themselves in exploitative working conditions once again due to limited job opportunities. Finally, some patients in re-trafficking situations understood that they were being exploited but felt compelled to stay for economic reasons, out of loyalty, or because they felt that they were receiving some justifiable benefit.

Many of our patients revealed details of wage theft or new exploitative working and living conditions during their appointments (*see sidebar on page 20 for Maricel’s story*). Although the patients referred by CAST to Saban were presumed to be “free” of their traffickers, many found themselves in situations that mirrored their initial experiences of trafficking. For

CASE STUDY: MARICEL

Maricel is a woman in her fifties who was trafficked from Asia along with many other people from her home country to work in a healthcare facility in Los Angeles. She and the others were eventually discovered and referred to CAST for shelter and rehabilitative services. Maricel received a temporary visa to stay in the United States and find other employment. She eventually found work as an in-home aide providing assistance for an elderly man who was homebound. Maricel was referred to Saban to receive primary care with Dr. Baldwin.

During a follow-up appointment in spring 2010, Dr. Baldwin asked Maricel about her current job. Maricel commented that she was happy working for the man, but she needed to talk to him about getting paid. “How long as it been since you’ve been paid?” Dr. Baldwin asked. “He’s never paid me!” Maricel replied. “How long have you been working for him?” “I’ve been with him for two years, and he’s never paid me.” During this same appointment, Maricel reported excitedly that she had recently finished school to receive her certification as a nurse’s assistant indicating her ability and qualification to obtain stable employment. Nonetheless, she said she didn’t want to leave because her employer needed her and wouldn’t have anyone to take care of him if she were to leave. He had also been providing her with housing in exchange for her free around-the-clock labor. Maricel felt obligated to stay because of the emotional bond she had formed with her employer and a lack of other viable housing options.

many of these patients, Dr. Baldwin was one of the most trusted advocates in their day-to-day lives, so it was crucial that resources for occupational and social services be made available in the clinical setting.^{13,18}

TRAUMA-INFORMED CARE

Despite the progress made by CAST and Saban over the last decade, several social and structural barriers to care limit trafficking survivors in Los Angeles County from attaining a high standard of health. Patient referrals between CAST, Saban, and other safety-net providers were often lost due to staff shortages and the lack of a tracking system to monitor patient progress.¹² Patients routinely missed medical appointments if they were not accompanied by a CAST employee, particularly in the case of first appointments at Saban. Additionally, many patients traveled several hours through multiple means of public transportation just to see a doctor, and they were frequently turned away if they arrived late for an appointment. Finally, some patients preferred complementary and alternative medicine, acupuncture, and mental health services but had trouble finding services that were linguistically, culturally, and financially accessible for them.¹² As a result of these factors, our patients frequently fell between the cracks of the health care and social service system in Los Angeles.

In addition to problems in physical, geographic, and financial access, our patients often faced major psychosocial barriers to obtaining needed medical services. Although the health-care system is meant to aid survivors on their path to recovery and reintegration, many of our patients experienced anxiety in medical settings. Some viewed medical examinations and procedures as invasive or reminiscent of past abuses, such as torture or persistent physical or sexual abuse.¹⁹ Some were uneasy waiting in a room full of people they did not know and trust, while others feared that practitioners would force them to divulge details about their trafficking situations or would not believe their stories.²⁰ Patients were particularly reluctant to attend referral appointments at other health-care facilities after becoming emotionally invested in their relationship with Dr. Baldwin.²¹

Clinical staff lacked training on trauma-informed care which focuses on creating a healing environment from the front desk and the waiting room, to the intake area and the doctor's office, and all the way out the door to the pharmacy.²² Several studies have indicated that within a given clinic waiting room, a significant proportion of patients may have a history of abuse or trauma which may or may not be documented in their medical records.²³ A study conducted by researchers at UCLA and RAND

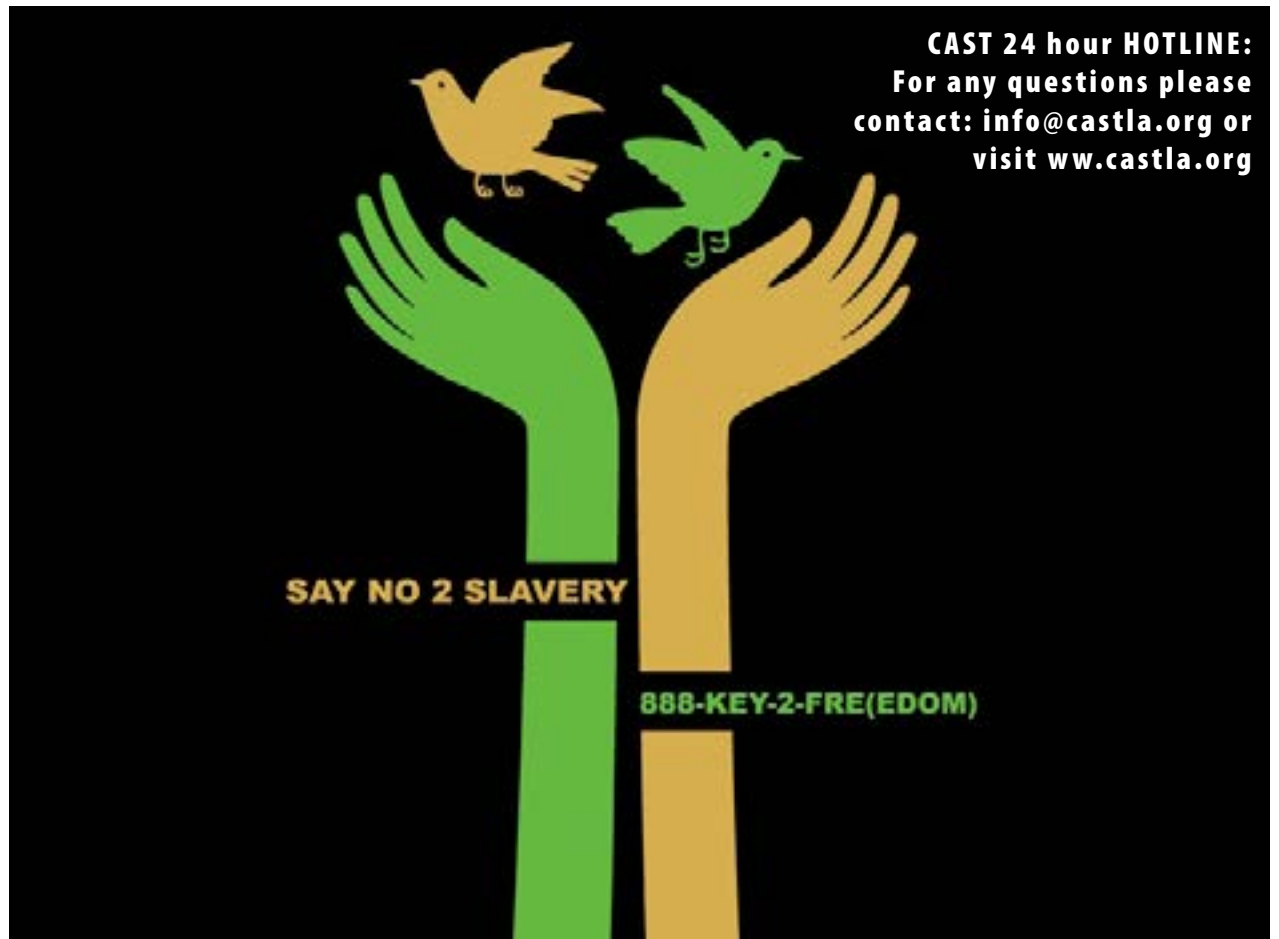




CAST potluck with staff, volunteers, and clients/residents

found that 54% of adult Latino primary care patients reported history of political violence in their home countries, of which 8% reported torture.²⁴ Since the Saban patient population mirrors the study population, it is likely that many patients beyond those seen by Dr. Baldwin may also have experienced traumatic life events.²⁵ As a result, it is crucial that all patients be treated with a level of sensitivity and respect that may not be afforded to them in other aspects of their lives. The clinic should be a place of respite and restoration for patients, not a reminder of the hardships or abuse that may contribute to their need for care.

When a health services organization implements a trauma-informed model of care, every aspect of the management, training, and service delivery must be assessed and modified to incorporate an understanding of how trauma affects the health of individuals seeking services.²⁶ A skilled and compassionate provider can create a comforting environment recognizing the ways in which past traumas may influence patients' behaviors and perceptions of their bodies. However, training on trauma-informed care must incorporate all clinical staff that interact with a patient, including clerical workers, medical assistants, and phlebotomists. Even a brief callous remark or judgmental stare at the front desk can change the course of a patients'



recovery or care, particularly if that patient decides not to return for follow-up as a result of perceived mistreatment.²⁹

Creating a clinical environment in which human trafficking survivors felt safe and respected was crucial to ensuring successful recovery and reintegration of our patients. By viewing the recovery process as a partnership between patient and doctor, we hoped to instill a sense of empowerment in our patients rather

than propagating the perception that patients are merely passive recipients of care. Our work at Saban aimed to create conditions in the health care setting that validated the experiences of each patient and helped them feel a sense of dignity and ownership of their bodies.²⁷

Credits; All photos courtesy of CAST except photo on page 16, which is courtesy of the Los Angeles Times.

NOTES

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