Chapter 20
The Role of Community Health Centers in Addressing Human Trafficking

Kimberly S.G. Chang and A. Seiji Hayashi

20.1 Introduction

There is growing recognition that human trafficking is a health care and public health issue [1] with severe health consequences affecting some of the most vulnerable members of society. Short- and long-term health harms are caused by the conditions of human trafficking and the way people are controlled for labor or sex. While trafficked, people may be deprived of health care and food, are socially restricted, and are coerced into drug and alcohol use and dependence. They are often forced into dangerous, dirty, and degrading living and working conditions; and they are subject to all forms of abuse (physical, sexual, psychological, emotional, behavioral, and spiritual) [2]. The health harms fall into three categories: physical harms such as sexually transmitted infections (STI), injuries, and malnutrition; mental health harms, such as trauma, depression, and anxiety; and social harms, such as criminalization and stigmatization [2–9]. Viewing human trafficking through a public health lens enables social systems of care and protection to reach more trafficked individuals and prevent human trafficking by strengthening both individuals and communities. A public health approach emphasizes prevention, community outreach, and multidisciplinary collaboration, with a focus on addressing social determinants and preventing harms [10]. Community health centers use this approach for all populations, including those at risk of trafficking and with a trafficking experience. Whereas criminal justice and law enforcement systems reach people in the late stages of trafficking, community health and public health systems

K.S.G. Chang (✉)
Asian Health Services, Oakland, CA, USA
e-mail: ksgchang@gmail.com

A.S. Hayashi
Unity Health Care, Inc., Washington, DC, USA
e-mail: aseijihayashi@gmail.com

M. Chisolm-Straker, H. Stoklosa (eds.), *Human Trafficking Is a Public Health Issue*, DOI 10.1007/978-3-319-47824-1_20

have the capacity to extend farther into vulnerable populations, preventing and combating human trafficking earlier, and providing care long after the trafficking ends.

The health care system provides opportunities for interaction and engagement with patients throughout the entire lifespan—from pregnancy, to childhood, through adulthood; from acute emergency care, to long-term, chronic care; from public health community outreach to hospitalizations. All of these points of care are opportunities to prevent, intervene in, start the process of ending exploitation, and begin the healing process for trafficked patients. Studies of trafficked people reveal a wide range of encounters with health care professionals and clinics while being trafficked—between 28 and 87.8 % of survivors had seen a health care professional [2, 11, 12]. As such, primary care professionals and organizations that expand access to care for medically underserved and vulnerable populations play a central role in caring for these patients across lifespans. Examples of these safety net clinics include federally qualified health centers (FQHC), Indian Health Service clinics, free clinics, and others. There are a number of specific types of FQHCs that focus on migrant and seasonal farmworkers, individuals experiencing homelessness, and residents of public housing. This chapter will focus on the variety of FQHCs collectively known as *community health centers* (http://bphc.hrsa.gov).

Community health centers serve a disproportionate share of the nation's poor and uninsured. Most patients are members of racial or ethnic minorities, and millions of health center patients are served in a language other than English [13, 14]. Trafficked persons are often members of society's more vulnerable groups like these [15]. For example, one study found that trafficked individuals in Southeast Asia tended to be poor, young, female, undocumented migrants with low levels of educational attainment [16]. In addition, trafficked persons are more likely to be runaway youth and have a history of trauma or violence [15].

Given that community health centers serve similar populations (and may already unknowingly be serving trafficked patients [17]), developing systems of care within health centers may lead to earlier intervention and prevention efforts. Many health centers have resources and programs in place to care for trafficked persons more effectively than providers in other types of health care settings. For example, many health centers have health care providers and staff that speak the patients' languages or have on site interpreters. Most health centers have social services to connect patients to non-health care resources. Some health centers even have lawyers to assist patients (http://medical-legalpartnership.org). Additionally, health centers have staff to assist patients in navigating the complex health care system with case management and care coordination, a hallmark of a patient-centered medical home. Health centers are now focusing on the integration between primary care and behavioral health, as well as integration of oral health care and primary care, within community health centers.

The United States' vertical organization of the health care system, from a large primary care base to increasingly specialized levels of care, emphasizes the foundational role of community health centers in the prevention, early identification, and acute and long-term treatment of patients who have been labor or sex trafficked. Primary care is the level of a health services system that provides entry into the system for all new needs and problems, provides person-focused (not

disease-oriented) care over time, and provides care for all but very unusual conditions. Furthermore, the primary care level coordinates care, regardless of where the care is delivered and who provides it. It focuses on integrating care into a comprehensive treatment plan for patients (e.g., integration of medical and oral health care) and facilitates system optimization and equity of health status (http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html).

As a large primary care system in the USA, community health centers have multiple opportunities to intercede and identify human trafficking amongst their patients. They are uniquely positioned to be the first point of contact with the health care system for many at risk and trafficked persons. Thus, community health centers can prevent worsening of health issues, but when necessary, refer to specialists, subspecialists, and hospitals. Community health centers also provide many preventative services, health education programs, and community outreach, and therefore, have a great reach into the populations at risk of and affected by human trafficking. Furthermore, community health centers provide continuity of care throughout the lifespan—giving opportunity for long-term engagement with trafficked persons and survivors of human trafficking.

20.2 Discussion

In 2014, 1,278 federally funded community health centers operated almost 10,000 clinics across the USA. These community health centers collectively cared for 22.8 million medically underserved and vulnerable individuals. Of patients served, 71.2 % earned an annual income below the federal poverty level (FPL) and 91.4 % earned less than 200 % of the FPL. Due to the Affordable Care Act, the number of uninsured dropped from 37.5 % (2010) to 27.9 % (2014). Almost two-thirds (62.2 %) of health center patients self-identified as belonging to a racial or ethnic minority group (Black/African American: 23.4 %; Asian/Asian American: 3.8 %; American Indian/Alaska Native: 1.3 %; Native Hawaiian/Other Pacific Islander: 1.2 %; and Hispanic/Latino: 34.9 %). Nearly a quarter (23.2 %) was best served in a language other than English. Individuals experiencing homelessness accounted for 5 % (1.1 million) of health center patients, and residents of public housing comprised 1.9 %. Additionally, community health centers served 892,000 migrant and seasonal agricultural workers in 2014 [18].

Community health centers grew out of the US civil rights movement to eliminate social inequity and promote social justice. The first federally funded community health centers were founded in Mound Bayou, Mississippi and in Boston, Massachusetts in 1965 by two physicians, H. Jack Geiger and Count Gibson, as part of the Johnson Administration's "War on Poverty" [19]. Increasing health care access was also a prime objective of the civil rights movement as exemplified in this statement by leader Martin Luther King, Jr.: "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." Most health centers continue to see their work as a vehicle for social justice. Human trafficking is a human

rights violation, and caring for those trafficked falls squarely within the mission of health centers.

Geiger and Gibson developed the first health centers based on a model called Community Oriented Primary Care (COPC). COPC integrates primary care services with public health approaches. COPC has several distinguishing features that make it especially suitable to care for medically vulnerable populations such as trafficked persons. The first is the use of public health methodologies, such as epidemiology, to define and care for whole populations. Second, patients and community members prioritize health issues and participate in resolving them. Finally, services are not limited to traditional primary care, and may include services aimed at the social determinants of health, such as hunger, housing insecurity, educational attainment, employment, and even environmental justice (http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf).

Geiger studied COPC in a rural South African village called Pholela in the province of Kwazulu Natal, with Drs. Sydney and Emily Kark. The Karks developed the COPC model to combat community-wide health issues like syphilis. They believed that solutions to health problems should be developed and led by community members themselves [20]. The federal statute authorizing the Health Center Program incorporated this community ownership concept, requiring all FQHCs to have a consumer (patient) majority board of directors [21]. This means that board members with understanding of the cultures, languages, and community can identify issues like human trafficking and guide corresponding health services. Further, this promotes the accountability of health centers to the communities they serve.

In addition to community ownership, a distinguishing hallmark of community health centers is the provision of *enabling services*—services that enable a patient to access care. Trafficked individuals can experience numerous access barriers, such as limited English proficiency, health illiteracy, transportation issues, complex physical, mental health, and social needs, among many others. Many community health centers mitigate these barriers through enabling services. These special, non-clinical services facilitate vulnerable patients' access to care, via outreach, case management, translation/interpretation, referrals, transportation, eligibility assistance, health education, environmental health risk reduction, and health literacy [22] (http://www.aapcho.org/wp/wp-content/uploads/2014/06/2014-ES-Best-Practices-Report_FINAL.pdf).

A useful framework to help organize the community health center and health system interface, and the response to trafficked persons, is through a public health prevention model and epidemiologic lens. If human trafficking is considered a disease, and the very real health harms are the symptoms, specific solutions can be crafted to prevent and intervene during different stages of the exploitation [23].

- *Primary prevention* aims to reach people who are not being trafficked, but are at risk.
- Interventions include issue raising awareness in communities, and media or education campaigns.

- *Secondary prevention* tries to reach people in early stages of trafficking, before many health harms may have occurred.
- Interventions include early identification in various settings, like clinics or schools.
- *Tertiary prevention* occurs when a person is being trafficked and is also experiencing physical, mental health, or social harms. This prevention level is late stage and patients usually present in crisis.
- Interventions include acute visits to emergency departments, and are opportunities for an immediate physical intercession, potentially assisting the patient in leaving their trafficked situation.
- And finally, health care presents a unique opportunity to assist and enable *long-term care* for survivors who are no longer being trafficked, or sex trafficked minors who reach 18 years of age and may thereafter be considered sex workers, but may still have serious health consequences from the exploitation. This stage is vital to healing and to preventing revictimization; yet, it is often overlooked in policy and program development of human trafficking organizations.
- Interventions include providing long-term health care and behavioral health care for survivors in the context of primary care (Table 20.1).

There exist models of care for trafficked individuals within community health centers across the country. Because CHCs are grassroots organizations located in the communities they serve, they are well-equipped and informed to create programs specific to the types of human trafficking affecting their patients. As such, there is wide variety in the different programs developed to address human trafficking in health centers;

Table 20.1 Public health model—human trafficking prevention levels [24, 25]

Prevention levels			Health care professional side Disease: human trafficking (HT) Absent: a patient is not being trafficked	Health care professional side Disease: human trafficking (HT) Present: a patient is being trafficked
Patient side	Illness: Health effects/harms, injuries, impairments	Absent: a patient has not experienced health harms from being trafficked	Primary prevention *HT absent* *Illness absent* Example intervention: raising awareness in communities, media or education campaigns	Secondary prevention *HT present* *Illness absent* Example intervention: early identification in various settings, like clinics or schools
		Present: a patient has experienced health harms from being trafficked	Long-term care *HT absent* *Illness present* Example intervention: providing long-term health care and behavioral health care for survivors (who have a history of being trafficked)	Tertiary prevention *HT present* *Illness present* Example intervention: acute visits to emergency departments

some focus on specific populations, such as domestic minor sex trafficking (DMST) or labor trafficking; and interventions vary from after-care, to prevention and early identification. Five different health center models are discussed below.

20.2.1 Asian Health Services, Oakland, California [26] (www.ahschc.org)

Asian Health Services (AHS) is an FQHC founded in 1974 whose mission is to serve and advocate for the medically underserved, including the immigrant and refugee Asian community, and to assure equal access to health care services regardless of income, insurance status, language, or culture. The issues of commercially sexually exploited children (CSEC) and domestic minor sex trafficking (DMST)[1] first emerged at Asian Health Services (AHS) in Oakland, CA, through its youth program and teen clinic. The AHS youth program was established in 1996 to provide reproductive health education in response to increased Asian and Pacific Islander teenage pregnancies in the county. As a result of increased health education and knowledge of reproductive physiology, youth began requesting health services—in response, a confidential teen clinic was started in 1999. In 2001, AHS youth program staff and teen clinic providers noted that some Southeast Asian adolescent patients repeatedly sought reproductive health services for sexually transmitted infection screening and treatment, reported multiple sexual partners, displayed chronic truancy issues, revealed a history of sexual abuse, and exhibited other high risk factors for sexual exploitation [23, 27]. As staff established rapport and built a therapeutic alliance with their patients, some patients disclosed that they were engaged in the commercial sex industry and talked about their health issues and safety concerns. In an attempt to access resources for patients, AHS staff connected with other community organizers in the education and youth development fields; they realized that several of these organizers were also actively seeking CSEC/DMST resources for their students and clients. Together, they created a CSEC/DMST specific program, *Banteay Srei*, in 2004 [23, 27, 28]. AHS utilizes a programmatic strategy to care for CSEC/DMST across all prevention levels:

- *Primary prevention*: education on healthy relationships for the younger adolescent population; and community health education on commercial sexual exploitation of youth;
- *Secondary prevention*: identification of individuals at high risk for commercial sexual exploitation and sex trafficking; and referrals to local service providers which provide additional prevention resources;

[1] The commercial sexual exploitation of children is defined as a range of activities including prostitution, survival sex, child abuse imagery (formerly known as "pornography"), survival sex, sex tourism, mail order brides, stripping or performing in sexual venues. The sex trafficking of domestic minors overlaps with the commercial sexual exploitation of children, but is distinct in referring to exploitation involving a third party exploiter, and in which the child originates from the country in which the exploitation occurs [3].

- *Tertiary prevention*: programming to help trafficked persons and assist them as they transition out of exploitation [3];
- *Long-term comprehensive primary care*: while most support for child-survivors ends once they become adults, AHS continues to care for the patient through adulthood and all life stages, including pregnancy care and pediatric care of children.

AHS' four-pronged programmatic strategy consists of (1) the youth program, (2) a teen clinic, (3) the creation of Banteay Srei, and (4) a school-based health center at Oakland High School. The youth program provides outreach, eligibility assistance, reproductive health education, and navigation of clinical services. The teen clinic provides co-located confidential reproductive clinical services, behavioral health counseling, health education by youth program staff and a peer leader program, and referral resources. The teen clinic routinely and universally screens for sexual exploitation of youth and has implemented a reporting and referral protocol for any youth identified with suspected or disclosed commercial sexual exploitation. Banteay Srei provides youth development and leadership programming specific to at risk or currently sexually exploited girls and young women of Southeast Asian descent; it incorporates programming that highlights and strengthens cultural resiliency. For example, Cambodian interpreters have been included to enable youth to dialogue with mothers, grandmothers, and aunts about the elders' migration and refugee process. For many youth, it is the first time they may hear about their parents' escape from genocide and attendant traumatic experiences; for some, it is the first time they hear the words "I love you" from their mothers in the Cambodian language. *Banteay Srei* also provides case management and care coordination with social services, like reenrolling in school, court advocacy, or connection with shelter support. The AHS school-based health center is at a local high school and health care professionals work with school counselors and educators to identify and help students at risk or suspected of being commercially sexually exploited.

AHS takes their anti-trafficking work further, by conducting research (descriptive investigations of patient population, and development of identification tool); providing trainings for multiple disciplines on human trafficking; and organizing the community to redefine cultural norms, provide resources to at-risk children, and respond to commercial sexual exploitation. AHS also works with local, state, and federal organizations to craft advocacy and policy goals to expand and advance the role of FQHCs in both caring for trafficked persons and preventing trafficking in communities across the country.

20.2.2 Kokua Kalihi Valley Comprehensive Family Services, Honolulu, Hawaii [26] (http://www.kkv.net/index.php/services-and-activities)

Kokua Kalihi Valley Comprehensive Health Services (KKV), an FQHC in Hawaii, has an innovative partnership with the Pacific Survivor Center (PSC). PSC is a Honolulu-based nonprofit organization that focuses on health care and social

services for survivors of human trafficking, immigrant domestic violence and torture (http://pschawaii.org/). Since 2012, PSC has been the State of Hawaii subgrantee for the Department of Justice, Office for Victim of Crime's Comprehensive Services for Human Trafficking Victims Grant. PSC provides and coordinates medical, dental, and mental health services for trafficked individuals and survivors of human trafficking, and provides training for health care providers on caring for trafficked persons. Through the unique partnership between KKV and PSC, domestic and immigrant survivors of sex and labor trafficking receive trauma-informed primary medical services (including family medicine, internal medicine, and obstetrics and gynecology), subspecialty services, imaging and laboratory testing, prescription medications, dental care, and mental health services. In addition, PSC clients have access to ancillary KKV services, which includes interpreters, nutritionists, diabetes and renal groups, and insurance eligibility assistance.

Many clients seen through this partnership are trafficked agricultural workers from Southeast Asia, some of whom suffer from chronic illnesses and infections that have never previously been addressed. At the time of this writing in 2016, PSC is conducting research about the health care and access needs of this population. Other clients include domestic survivors of sex trafficking and those actively being sex trafficked, including both minors and adults; they are provided sexually transmitted infection testing and treatment, immunizations, and standard medical care. These clients also have access to sexual assault forensic evaluations, HIV post-exposure prophylaxis, and specialized sexual assault counseling through collaboration with the Sex Abuse Treatment Center (SATC) (http://satchawaii.com/).

PSC also provides outreach and medical case management for survivors, prevention programs for at-risk youth, and forensic evaluations for survivors, and works closely with other community partners including SATC, Susannah Wesley Community Center (SWCC), and the Hawaii Immigrant Justice Center at Legal Aid (HIJC) to ensure that actively trafficked persons and trafficking survivors' health care, legal, and social services needs are met. These close collaborations allow clients to receive comprehensive services and seamless continuity of care. All services are provided free to uninsured patients.

20.2.3 Institute for Family Health, New York, New York (http://www.institute.org/health-care/services/the-purple-clinic/)

The Institute for Family Health (IFH), among the largest FQHC networks in New York, launched the PurpLE (**Purp**ose: **L**isten and **E**ngage) Clinic on July 12, 2015. The PurpLE Clinic was created to offer a safe and sensitive primary care health home for people who have experienced sexual trauma, including trafficking and other forms of commercial sexual exploitation. The PurpLE Clinic is held weekly on Sundays, offers extended-hours, and is staffed by a family medicine

physician. The clinic is housed in an IFH site in New York City, which is open 7 days a week. The PurpLE Clinic's primary care services mirror the typical primary care services offered through IFH, including routine physical exams, obstetric-gynecologic related care, STI testing and treatment, joint injections, immunizations, hormone therapy, HIV care, and pre-exposure HIV prophylaxis (PrEP).

The PurpLE Clinic also serves as a gateway to IFH's auxiliary services, including mental health care, diabetes team care, case management, dentistry, podiatry, acupuncture, and a prescription assistance program. Additionally, adhering to the FQHC model, the family members, including children of survivors, are also seen at the clinic. All patients meet with case managers for insurance assessment and are placed on a nominal sliding scale fee for clinical care and lab work if they are not insurance eligible. All IFH staff receives education on sexual exploitation and trauma-informed care.

The design and implementation of the PurpLE Clinic was informed by collaborations with local anti-sex trafficking, human rights, domestic violence, and lesbian, gay, bisexual, and transgender (LGBT) focused organizations, and with input from incarcerated sex trafficking survivors on Rikers Island Correctional Facility (New York City's main jail complex). Referrals come primarily from these partners, shelter systems, and through health education and outreach workshops run by PurpLE Clinic staff for community-based organizations. Patients of the PurpLE Clinic have included both sexual violence survivors and their children. Patients have been of all genders, from the USA and abroad, and comprise those currently experiencing or who have previously experienced sexual violence, including human trafficking. Approximately 50 % are undocumented and 50 % are Medicaid enrolled or eligible.

20.2.4 Citrus Health Network, Hialeah, Florida (http://www.citrushealth.org/CHANCE)

Citrus Health Network was established as a community mental health center in 1979 intended to serve the northwest area of Miami Dade County. In 2004, Citrus Health Network, Inc. (CHN), was established as an FQHC and is the only FQHC to receive the Gold Seal of Approval from the Joint Commission in the state of Florida. Over the years, Citrus has expanded to other areas of the state. Services now include primary care, housing assistance, foster care, and case management services. Staff on site include: psychiatrists, primary care doctors, pediatricians, obstetrics/gynecologists, psychologists, licensed clinical social workers, case managers, and peer support staff.

Citrus Health Network has been providing comprehensive treatment services to youth involved in commercial sexual exploitation since 2013. The Citrus Helping Adolescents Negatively impacted by Commercial Exploitation (CHANCE) Program has provided housing and services to 56 state dependent children in Specialized

Therapeutic Foster Care and treatment services to 125 clients in the Community Response team between autumn 2013 and spring 2016. Clinical and support services offered through the program include: medical and mental health assessment and evaluation, individual therapy, family therapy, group therapy, life coaching, certified behavior analysis, and targeted case management.

Commercially sexually exploited youth benefit from integrated care and a full continuum of treatment options. Some youth have required more intensive clinical services than those offered in a community setting due to the severity of their emotional needs. As such, in the spring of 2016 CHN provided services, to 14 youth who have been involved in commercial sexual exploitation, via Florida's Statewide Inpatient Psychiatric Program (SIPP). The network has worked diligently to create a specialized treatment program within the existing SIPP program to meet the unique needs of this population. In October 2015, CHN opened an independent SIPP designed specifically for youth who have been commercially sexually exploited.

The needs of these trafficked clients are extensive and varied. CHN operates a Children's Crisis Unit (CSU) and a Juvenile Addictions Receiving Facility (JARF). Youth who have been sex trafficked are frequently placed in this facility. CHN developed a 24-h training curriculum for direct care staff members working in the CSU, SIPP, and JARF programs. The curriculum emphasizes the importance of a client-centered and trauma-informed approach for this population. Recognizing the many physical health needs of sex trafficked youth, a pediatrician for CHN received specialized training on commercially sexually exploited youth. The primary care physician provides continuity of care to CSEC clients in both the residential facilities and the FQHC setting.

20.2.5 La Maestra Community Health Centers, San Diego, California (https://www.lamaestra.org/medical-legal-social-services/default.html)

La Maestra Community Health Centers began in 1990 and have grown into an FQHC with 12 sites in underserved communities throughout San Diego County. Its headquarters is in City Heights, the most diverse San Diego community located 16 miles from the USA–Mexico border, and one of the largest centers for refugee resettlement in the nation. The majority of residents live in poverty and experience high rates of health disparities and crime. Inadequate access to legal services, fear of the police, and cultural and linguistic barriers make the already vulnerable population of City Heights more susceptible to trafficking, sexual assault, and violent crime.

La Maestra's Legal Advocacy and Social Services department (LMLASS) was established in 2011, to provide education, assistance, and support to people who face rights violations or who are survivors of crime. The majority of clients are victims of domestic violence and trafficking. The legal advocates do not act as attor-

neys, but advocate on behalf of survivor clients; they provide information and referrals that help clients in identifying their rights and options as survivors. Between 2011 and 2016 LMLASS has served more than 1,500 clients; 70 (5%) are survivors of sex or labor trafficking who come from ten different countries. LMLASS' collaborative partners include the US Committee on Refugees and Immigrants, the National Human Trafficking Victim Assistance Program, several law enforcement agencies, and a network of local nonprofits and attorneys providing low-cost legal services, shelter and other assistance.

Trafficked persons are often identified during their clinical visit at La Maestra's health center. Patients may open up to their health care practitioner about issues affecting their health and well-being, or exhibit signs of trauma and exploitation that are recognized by the staff. All clinic personnel are trained by LMLASS to recognize signs of domestic violence and trafficking, maintain confidentiality and safety, and make a sensitive, warm handoff to the LMLASS staff. Moreover, LMLASS' network has helped raise awareness of their services so that trafficked persons, and other agencies, will reach out directly to LMLASS for help. Once a trafficked individual first accesses a service at La Maestra, they are immediately connected to all of the services within the Circle of Care™, including medical, dental, and behavioral health; eligibility assistance; nutritious food and basic necessities; and financial, social, legal, and well-being programs. The Circle of Care™ is a holistic, solution-based approach to providing programs and services; it was created because complete family wellness requires more than just medical services. La Maestra's team works collaboratively to identify the total needs of patients and attend to them through preventative care, education, treatment, and referrals to other needed services. In this way, the Circle of Care™ addresses the social determinants of health, ultimately guiding patients and their families to a state of well-being and self-sufficiency. Thus, La Maestra serves as a "one-stop shop" with many services in a comprehensive health home, preventing the loss of victimized patients before their needs can be addressed, and empowering survivors to rebuild their lives.

20.3 Conclusion

Human trafficking affects the most marginalized members of our communities, both through individual vulnerabilities and social factors facilitating the context for exploitation to occur. Due to historical factors, and the philosophy and mission of health centers, CHCs are located in at-risk communities across the country. As such, community health centers are well positioned to care for people anywhere in the cycle of exploitation and abuse—from primary prevention of trafficking in vulnerable patients and populations, to early identification and urgent treatment of acute health consequences, and to long-term care of sequelae of being trafficked. In many health centers, integration of co-located medical and behavioral health care provides "one-stop" care for patients.

Community health centers utilize a prevention framework, due to their origins as a community-oriented primary care model, breaking down the separation between public health and medical care. They do this through effective provision of enabling services, which help patients to access care. Trafficked persons can benefit from these comprehensive services and this model of care, throughout the stages of exploitation and trafficking. Furthermore, community health centers are located in the neighborhoods where their patients reside and are thus geographically positioned to provide care for exploited patients.

Models of care for trafficked persons in health centers exist and new ones are developing as awareness of human trafficking as a public health and health care issue increases. Models can be comprehensive and include prevention programs, or they may be specialized and tailored to address the multiple health issues of trafficked persons. Regardless of the type of human trafficking care models developed, community health centers also have a unique role and responsibility to identify early, intervene, and help to reframe the issue of trafficking for affected individuals, from a criminal justice framework to a public health perspective. One study showed that using a screening tool in a community health center could help to identify domestic minors who are sex trafficked [17]. Once patients are identified, or suspected of being trafficked, institutional response protocols will vary depending on local and state legislation, and available resources. Community health centers are at the center of care coordination for patients with complex medical, behavioral health, and social needs; CHC's are well positioned to include patients who have been trafficked, in these existing case management and care coordination programs.

While, at the time of this writing, the prevailing criminal justice framework focuses on prosecution and punishment of traffickers, the community health care system focuses on the health and well-being of patients who have been trafficked, and on prevention and early intervention. When the goals of the health and judicial systems align, trafficked patients are willing participants in the prosecution of traffickers; however, sometimes the goals of these systems are at odds. When trafficked patients are not willing or are unable to participate in the prosecution of their traffickers, they can be criminalized, excluded from services, or further traumatized by the very systems meant to help them. A restructuring of system responses, where survivor services and prevention efforts are separate from criminal justice system goals and outcomes, is essential to prevent further marginalization of these patients. For example, when an undocumented survivor of trafficking is unable or unwilling to participate in the prosecution of their trafficker(s), the survivor should not be excluded from services and needed health care. From a health care perspective, this patient would still suffer adverse health consequences from their trafficking experience, so treatment and services should be available, regardless of the case's legal proceedings and outcomes.

In conclusion, a public health framework, which includes a comprehensive primary care health delivery system, and an emphasis on FQHCs as the building blocks of a robust safety net for trafficked persons, provides a system of care and protection that can be both just and effective in healing patients.

20.4 Recommendations

This chapter's recommendations center on facilitating and creating robust programs in community health centers (CHCs) to prevent human trafficking and to care for patients who have been victimized by this crime. It is essential to support CHCs because they are privy to trends and issues affecting their local populations, and human trafficking health care responses require geographically and culturally relevant strategies.

1. Create comprehensive, wrap-around *care teams* in community health centers across the nation focused on reaching out to and providing care for survivors of human trafficking.

   Care teams are essential components of effective community health centers. No longer is health care dependent on a sole health care clinician. As a severely marginalized population, survivors of human trafficking face tremendous barriers in accessing health care. Community health centers have always been at the forefront of addressing those barriers. Care teams would include outreach workers, peer educators, social workers, therapists, case managers, interpreters, and clinical staff like doctors, physician assistants, nurses, nurse practitioners, and medical assistants. Each community health center may develop care teams specific to the needs of their populations, and would utilize different sets of personnel depending on the types of survivors whom they encounter and to whom they provide care. A point person on the care team should be an advocate for the patient, who provides outreach and care coordination, including facilitating communication between law enforcement and social services. Behavioral health and oral health personnel should be included in care teams and programming of services.
2. Create human trafficking specific *programs* within health centers to address the physical, mental health, and social harms that result from being trafficked.

   Community health centers have a track record of developing care programs for specific conditions, such as HIV or diabetes. There are also health centers focused on social conditions affecting health, such as homelessness, or migrant farm work. Public health-framed human trafficking programs, like Banteay Srei of Asian Health Services, should be created for survivors of different types of human trafficking, with an emphasis on culturally relevant strategies to help those affected heal and fulfill their human potential. Programming should address all stages of human trafficking, from primary, secondary, and tertiary prevention, to long-term care.
3. Ensure *language accessibility* for trafficking survivors and *cultural competence* by professionals throughout community health centers.

   Community health centers provide a model for how to care for vulnerable populations. Their history originates in civil rights and health equity work; their emphasis on language access and cultural competency in care models is fundamental to properly serving human trafficking survivors. Language access is critically important for communication with survivors, particularly given survivors'

loss of agency, experienced deprivations and restrictions, and the risk that traffickers may attempt to sabotage communications between providers and trafficked patients. The importance of trained interpreters who adhere to principles of confidentiality and trauma-informed care is essential, particularly for minority communities where overlapping social networks between patients and traffickers may exist.

4. Ensure that non-clinical *enabling services* for patients to access care is provided in all community health centers.

   According to the Health Resources and Service Administration's Bureau of Primary Health Care, "enabling services" are defined as non-clinical services that do not include direct patient services but increase a patient's access to health care. Enabling services should be part of a holistic human trafficking health care response model. Enabling services are a hallmark of the community health center model and should be reimbursed by insurance providers.

5. Incorporate *trauma-informed care* training and develop trauma-informed systems, throughout community health centers, and in other sectors.

   All trafficked individuals have experienced some form of trauma. Understanding this is crucial, not only in the design of community health centers, and training of their staff, but also for other non-clinical systems that touch trafficking survivor lives. A robust public health response lies not only in the health care system. Professionals from other sectors working with trafficked persons must be knowledgeable and aware of the physical, mental, emotional, and psychological effects of human trafficking, and how to work with and engage survivors. When professionals appreciate how to partner with those affected and are equipped to approach survivors from a trauma-informed perspective, those survivors will be better supported, and more able to begin a healing process to transition out of the control of the trafficker and dangerous situations.

6. Develop *health care specific funding streams* for comprehensive human trafficking programs in community health centers.

   Funding streams for health care programs should be separate from the criminal justice system. The goals of the two systems are different. Keeping health care provision and maintaining the integrity of health care goals and the needs of the patient at the forefront of health care services is paramount.

References

1. Chon K. The Power of framing human trafficking as a public health issue. Office of Trafficking in Persons, Administration for Family and Children, U.S. Department of Health and Human Services. 2016. Office of Trafficking in Persons: http://www.acf.hhs.gov/programs/endtrafficking/resource/publichealthlens. Accessed 26 Apr 2016.
2. Baldwin S, Eisenman D, Sayles J, Ryan G, Chuang K. Identification of human trafficking victims in health care settings. Health Hum Rights. 2011;13(1):E36–49.

3. Institute of Medicine; National Research Council. Confronting commercial sexual exploitation and sex trafficking of minors in the United States. Washington, DC: The National Academies Press; 2013.
4. Zimmerman C, Yun K, Shvab I, Watts C, Trappolin L, Treppete M, Regan L. The health risks and consequences of trafficking in women and adolescents. Findings from a European Study. London: London School of Hygiene and Tropical Medicine; 2003.
5. Felitti V, Anda R, Nordenberg D, Williamson M, Spitz A, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. Am J Prev Med. 1998;14(4):245–58.
6. Dovydaitis T. Human trafficking: the role of the health care provider. J Midwifery Womens Health. 2010;55(5):482–7. doi:10.1016/j.jmwh.2009.12.017.
7. Isaac R, Solak J, Giardino A. Health care providers' training needs related to human trafficking: maximizing the opportunity to effectively screen and intervene. J Appl Res Child. 2011;2(1):1–33.
8. Crane P, Moreno M. Human trafficking: what is the role of the health care provider? J Appl Res Child. 2011;2(1):1–27.
9. Willis B, Levy B. Child prostitution: global health burden, research needs, and interventions. Lancet. 2002;359:1417–22.
10. Todres J. Moving upstream: the merits of a public health law approach to human trafficking. Georgia State University College of Law, Legal Studies Research Paper No. 2011–02. 89 N.C. L. REV. 447. The Social Science Research Network Electronic Paper Collection. 2011. http://ssrn.com/abstract=1742953. Accessed 1 Aug 2016.
11. Lederer L, Wetzel C. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Ann Health Law. 2014;23(1):61–91.
12. Family Violence Prevention Fund. Turning pain into power: trafficking survivors' perspectives on early intervention strategies. San Francisco, CA: Family Violence Prevention Fund; 2005.
13. National Association of Community Health Centers. A sketch of community health centers chartbook 2014. Washington, DC. 2014. http://www.nachc.com/client/Chartbook_2014.pdf. 25 Nov 2015.
14. Lewis VA, Colla CH, Schoenherr KE, et al. Innovation in the safety net: integrating community health centers through accountable care. J Gen Intern Med. 2014;29(11):1484–90.
15. NHTRC: National Human Trafficking Resource Center. 2015. The Victims: https://www.traffickingresourcecenter.org/what-human-trafficking/human-trafficking/victims. Accessed 1 Aug 2016.
16. McGregor Perry K, McEwing L. How do social determinants affect human trafficking in Southeast Asia, and what can we do about it? A systematic review. Health Hum Rights. 2013;15(2).
17. Chang K, Lee K, Park T, Sy E, Quach T. Using a clinic-based screening tool for primary care providers to identify commercially sexually exploited children. J Appl Res Child. 2015;6(1), 6. http://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?article=1235&context=childrenatrisk. Accessed 1 Aug 2016.
18. US Department of Health and Human Services Health Resources and Services Administration. 2014 Health Center Data. http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014. Accessed 1 Aug 2016.
19. Massachusetts Leaguve of Community Health Centers. History of Community Health Centers. http://www.massleague.org/CHC/History.php. Accessed 17 May 2016.
20. Mullan F, Epstein L. Community-oriented primary care: new relevance in a changing world. Am J Public Health. 2002;92(11):1748–55.
21. USC 254b: health centers. http://uscode.house.gov/view.xhtml?edition=prelim&req=42+usc+254b&f=treesort&fq=true&num=20&hl=true. Accessed 17 May 2016.
22. US Department of Health and Human Services Health Resources and Services Administration. Health center program terms and definitions. 2015. HRSA: http://www.hrsa.gov/grants/apply/assistance/Buckets/definitions.pdf. Accessed 25 Nov 2015.

23. Chang K, Sy E, Vo T, Nguyen S, Thaing M, Lee J, et al. Reframing our response: a new approach to care for commercially sexually exploited children. San Francisco Med. 2014; 87(1): 21–22.
24. Kuehlein T, Sghedoni D, Visentin G, Gérvas J, Jamoule M. Quaternary prevention: a task of the general practitioner. Prim Care. 2010;10(18):350–4.
25. Chang K. Integration of primary care and behavioral health for human trafficking survivors in patient-centered medical homes. Institute of Violence, Abuse & Trauma: 20th international summit & training on violence, Abuse & Trauma across the lifespan. San Diego, CA. 2015.
26. AAPCHO education brief on human trafficking in FQHCs. http://www.aapcho.org/wp/wp-content/uploads/2015/10/AAPCHO-Human-Trafficking-Education-Brief_103015.pdf. Accessed 1 Aug 2016.
27. Sy E, Quach T, Lee J, Yang NI, Thaing M, Chang K. Responding to commercially sexually exploited children (CSEC): a community health center's journey towards creating a primary care clinical CSEC screening tool in the United States. Int J Soc Sci Stud. 2016;4(6):45–51. doi:10.11114/ijsss.v4i6.1576. http://redfame.com/journal/index.php/ijsss/article/view/1576/1627. Accessed 1 Aug 2016.
28. Brown P. In Oakland, redefining sex trade workers as abuse victims. New York Times. 2011. http://www.nytimes.com/2011/05/24/us/24oakland.html. Accessed 1 Aug 2016.