SAFE HOUSE
PROJECT

Interagency Collaboration for Emergency Housing

March 2022

SAFE HOUSE
PROJECT

Purpose

Human trafficking survivors seeking emergency placements encounter numerous barriers to care that can lead them to return to their trafficking situation or attempt to seek rehabilitation on their own. This leads to increased revictimization rates, lack of access to imperative resources, and an inappropriate and ineffective continuum of care. Continuum of care is a concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care. Interagency cooperation between emergency service providers equips the organizations with the necessary resources and information to serve survivors while navigating potential barriers to care. This includes survivor placement, sharing of resources, and a comprehensive understanding of available services to ensure each survivor served has access to safe housing and holistic care.

Problem

Barriers to care for emergency placements can prevent human trafficking survivors from receiving the necessary start to the continuum of care which can impede their ability to access other aspects of restorative care. This can include obstacles that are medical in nature, location-related, and program-related. Without addressing these barriers, trafficking survivors are left without the restorative care imperative to their healing, health, and well-being.

When seeking restorative care, some survivors require accommodations for physical disabilities, many of which were caused by their trafficking. A Loyola University study found that as many as 45% of survivors have chronic health conditions related to their trafficking. The Department of Health and Human Services also notates the commonality of chronic conditions in human trafficking survivors. These disabilities, such as deafness, blindness, mobility limitations, or an increased need for medical supervision, can impede their ability to be placed into emergency programs. Survivors may need interpreting devices, text to speech tools, mobility accommodations such as wheelchair accessibility, and other tools or building design elements. Their participation in programmatic elements may be contingent on the presence of these accommodations. Without them, care becomes inaccessible to an entire demographic of survivors.

Severe psychiatric disabilities are incredibly common in human trafficking survivors, including Dissociative Identity Disorder[1] (13.2%,) Borderline Personality Disorder (13.2%,) and suicide attempts (41.5%.) Other severe psychiatric conditions such as schizophrenia and disorders with psychotic symptoms require specialized care. Care should include medication management, specifically from a licensed psychiatric practitioner, as well as ongoing therapy with a licensed clinician specializing in a modality relevant to the survivor's diagnosis.

[1] Dissociative identity disorder (DID) is a mental health condition where an individual has two or more separate identities. Each personality has different preferences and controls the individual's behavior at different times.

SAFE HOUSE
PROJECT

There are few programs equipped to accept survivors with severe psychiatric disabilities and the programs that do have capacity limitations in order to best meet the needs of each survivor in the program. While this limitation is a best practice in survivor care, allowing the program to fully meet the needs of the survivors they are serving, it also creates a barrier to care. When a survivor requiring specialized care due to these diagnoses is looking for placement, it is a common occurrence that the few programs offering beds to these survivors are at capacity, leaving the survivor with nowhere to go.

Developmental disabilities are a large vulnerability to trafficking, meaning that there are also survivors with developmental disabilities. These disabilities require specialized care such as occupational, speech, and physical therapy. Survivors with developmental disabilities may also require higher levels of supervision and an increased need for flexibility of scheduling. These accommodations often require additional partnerships and staffing needs that a program must have access to before accepting residents with developmental disabilities. These programs are often presented with the same problem as those serving other disabled survivors: more survivors in need than there are beds.

As many as 84% of sex trafficking survivors report substance abuse during their victimizations, leaving the need for medical detoxification among the most common needs a survivor has when entering the emergency phase of the continuum of care. Detoxification requires an array of medical equipment to safely facilitate, along with 24 hour monitoring of the survivor by trained medical professionals. Many emergency programs do not have the staffing and equipment necessary to accept survivors in active addiction, nor do they have partnerships with local hospitals or rehabilitation centers. This leaves an entire demographic of survivors without access to restorative care.

With so few emergency programs operating in America, physical location can also be a barrier to care for survivors. Before any restorative care can take place, the survivor must get to the program. For survivors leaving trafficking situations in other states, they often arrive at programs via plane or bus. Many survivors are reliant on the program's ability to pay for travel, as they likely do not have the resources themselves. Survivors must also navigate airports and bus terminals, maintain their safety during travel, and arrange transportation to the program itself once flight or bus routes are complete. This experience alone, before any kind of therapeutic services are received, can feel daunting and impossible for a traumatized survivor. Programs that do not offer assistance with travel leave survivors vulnerable, which often leads to revictimization or returning to their trafficker.

A related barrier to getting to programs is specific to minors. If the minor is in state custody, only programs with interstate compacts can accept them from the state they live in. These programs are few and far between and the number of beds they offer is extremely limited. If there are no beds available for these minors, they are left in foster homes, acute psychiatric facilities, or even juvenile detention, which cannot provide the care they need to heal.

For survivors who need assistance exiting their trafficking situation, new barriers arise. They must be connected to resources that can facilitate physical extraction and transportation from the location they are being trafficked. In some instances, survivors are able to make their way to a safe location for pick-up, like a gas station, convenience store, or clinic, which decreases the safety risks associated with an extraction. In other cases, survivors require direct extraction. In lieu of law enforcement assistance to perform an extraction, there are a limited number of trained operators in the country who can help extract a victim. Using trained operatives is key to keeping everyone safe. Regardless, extractions are a considerable expense and require coordination between agencies to ensure that, once extracted, the survivor is immediately provided a victim advocate, assessed, and transported to a safe location.

Human trafficking specific emergency programs are limited across the country. The ones that are available are generally located near a metropolitan city, decreasing access to survivors in rural communities. If a survivor is identified by local law enforcement or a local agency, they are often placed into a domestic violence or homeless shelter.

Should a survivor be admitted to a trafficking-specific program with available beds, transportation services, partnership with medical resources for detoxification, and any other necessary resources to support the survivor, there are still additional barriers.

Programs must have adequate staff to care for residents efficiently while avoiding high turnover rates and employee burnout. They must have enough staffing to meet the needs of each resident. Programs need funding readily available to meet any specialized need a survivor may have. These resources must all be available not only upon admission of a survivor, but for as long as the resident will need that specific resource.

Without access to restorative care, survivors' options become limited. They can choose to stay in their trafficking situation. Doing so leaves the survivor in immediate danger and continuing to be traumatized and exploited. The survivor may have chosen to leave but, upon facing barrier after barrier, returned to their trafficker. This may discourage further attempts to leave. Finally, the survivor may choose to escape their trafficking situation and heal on their own. While this is the best option of the three, it unfortunately is not likely to be successful as 80% of the time the survivor will return to their trafficker. Barriers to care risk the lives of men, women, and children being trafficked every day.

Solution

Cooperation and collaboration between programs, law enforcement, local and state agencies, and other non-government organizations ensures survivors have access to the necessary resources for restorative care following exit from their trafficking situation. A united anti-trafficking industry is capable of

overcoming barriers to care for survivors of human trafficking to ensure every survivor has access to safe housing and holistic care. Each area where there are barriers to care must be addressed.

A network of emergency programs that are familiar with the operations, capacity, and capabilities of other programs allows for survivors to receive necessary restorative care. Partnerships between organizations working toward the same goal can be a solution to several barriers to care. If a program is unable to meet the needs of a survivor, being familiar with other programs allows them to refer the survivor to a program that is equipped to meet their needs. The same is true for when a program that would be allowed to meet the needs of a survivor is at capacity and must refer out. Programs that collaborate with one another may share or borrow resources or tools such as interpreting or text to speech devices. This allows a program with an open bed and appropriate staffing to accommodate a survivor they may not have previously been able to admit. For survivors with higher supervision needs, programs may choose to refer them to a program with a higher staff to resident ratio, information available thanks to interagency collaboration.

Partnerships with other organizations and agencies is also imperative to providing the best possible care to survivors. Programs may have contracts with organizations that provide medical services they do not, such as medication management, specialized therapy, and medical detoxification. Partnerships with local law enforcement and other non-government organizations allow programs to seek assistance with extraction and safe transportation for survivors.

Widespread collaboration creates a list of resources that can be provided to survivors, law enforcement, and healthcare systems in the area to help ensure no survivors fall through the cracks and do not receive services.

When human trafficking survivors have access to emergency placements to begin their healing in the continuum of care, they are empowered to make decisions toward their freedom, including choosing to leave their trafficking situation and stay out. Survivors admitted to emergency programs with strong collaboration and cooperation practices have all the resources they need to begin their healing.

Methodology and Implementation

Cooperation and collaboration between programs can assist in bridging gaps between survivors and the services they need. Programs offering different resources and services working together ensure that each survivor has all of their needs met.

Some ways in which programs can collaborate are as follows:

- Provide program partners with a list of disqualifiers for each program. For example, if a long-term care program cannot accommodate severe psychiatric disabilities such as

schizophrenia or Dissociative Identity Disorder, the program informs their partners so the partner working on placing a survivor with those diagnoses knows that program cannot accommodate.

- Building relationships with area resources that can provide services the program can not accommodate. For example, if an emergency program is not capable of providing medical detoxification, they form a partnership with an area rehabilitation facility to provide that service, after which the survivor is admitted to the program.
- Keeping programs up to date on any changes within the program's capabilities. For example, updating partners if a program has open beds, hires new staff to accommodate for disabilities, or changes policies such as program participants being allowed to smoke on campus.
- Ensuring local resources are aware of organizations offering services. For example, notifying local law enforcement, rescue hotlines, and area hospitals of services offered by a program so if these resources encounter someone being trafficked, they can refer them to appropriate services.

Emergency care is vital for stabilization and assessment of a survivor to help them make an informed decision about their healing journey. When organizations collaborate, it provides greater opportunity for individualized care to be provided to survivors, as well as improves efficiency for the industry at large when programs are operating in their core competency. When each of us uses our strengths for service, partners to decrease barriers to care, and comes to the table with a heart of service, survivors have access to the restorative care they need and deserve.