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# Evaluation Report of Survivor Advocates in Healthcare Program

## For CommonSpirit Health and Office for Victims of Crime, US Department of Justice

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## Executive Summary

Human trafficking is a global crime that involves the exploitation of people through forced commercial sex or other forms of labor. It is a severe violation of human rights that affects over 27 million people globally. One context to engage and support survivors of human trafficking is in the healthcare environment. Throughout the United States, efforts have been underway for 10 -15 years to train healthcare providers to increase their ability to identify trafficked persons, provide trauma-informed healthcare, and refer to appropriate community resources. Healthcare providers and agencies play a unique role in anti-trafficking work, given that they are among the few entities that intimately engage with people experiencing trafficking and can offer them education, options, and opportunities for assistance.

To aid in identifying survivors of human trafficking in healthcare settings, CommonSpirit Health aligned Dignity Health's Human Trafficking Response Program with Catholic Health Initiative's Violence Prevention Initiative to form the Violence and Human Trafficking Prevention and Response Program. This aim of this program is to ensure trafficked persons are identified in the healthcare setting and are assisted with victim-centered, trauma-informed care and services.

The current project is an expansion of a 2018 pilot study exploring the efficacy of utilizing human trafficking survivors as advocates to aid hospital patients experiencing human trafficking. The potential for trafficking survivors to act as advocates in direct service provision remains largely unexplored and can contribute valuable experience and insight to anti-trafficking efforts, supporting both healthcare providers and trafficked persons.

### *Methodology*

The Office of Women's Health (OWH) at the Los Angeles County Department of Public Health (LAC DPH) served as evaluator for the Office for Victims of Crime (OVC) funded Survivor Advocates in Healthcare program, which provided CommonSpirit/Dignity Health Hospitals funding to enable two local community based organizations (CBOs), the Coalition to Abolish Slavery and Trafficking (CAST) and Journey Out, to hire bedside Survivor Advocates to respond to Los Angeles County medical centers when clinical staff suspected a patient may be experiencing human trafficking. This evaluation assessed levels of achievement, and challenges faced, in meeting the aims of the OVC-funded project. This evaluation also informs the project's goal to develop guidelines for expanded employment of Survivor Advocates who can work with both community-based organizations and hospital systems.<sup>1</sup>

The evaluation consists of a mixed methods study exploring responses of staff working with survivor advocates using quantitative and qualitative data collected from hospital and CBO personnel. Additional data was collected, from survivor advocates, about patients served through the program. We also aimed to collect data from patients who received services from CBOs after their hospital visit, but received insufficient responses.

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<sup>1</sup> The current project began in February 2020, but the COVID-19 pandemic resulted in sudden and long-lasting changes to the program's implementation.

## *Results*

A total of 169 patients from 38 different hospitals across Los Angeles County were referred to a Survivor Advocate. For the patients for whom gender was known, a majority were cisgender female (88%) and 73% spoke English as their primary language – notable given the cultural diversity in Los Angeles. The Survivor Advocate confirmed 72% to be trafficked for commercial sex, 3% were determined to be experiencing labor trafficking, and for 24% of patients, the type of trafficking could not be determined. A survey conducted with hospital staff indicated improved confidence after working with a Survivor Advocate. Confidence was gained across the board – in recognizing signs of both labor trafficking and sex trafficking, and in responding to patients who may be experiencing sex or labor trafficking. Respondents also noted an increase in their comfort levels of respecting patients’ decisions to not accept assistance, which is a critical skill that even Survivor Advocates themselves may struggle with. The survey indicated better engagement from patients suspected of trafficking when an SA was involved in their care. Healthcare staff noted some challenges they face in connecting potentially trafficked patients with support services, most commonly difficulty placing patients with special needs for mental or physical health, and needing assistance from a SA when the SA is unavailable.

Overall, the inclusion of survivor advocates in hospitals appeared to have been well-received by hospital staff, and their value to the anti-trafficking movement was also well-recognized by CBO colleagues. More specifically, qualitative analyses showcased three primary themes. Firstly, Survivor Advocates quickly became a celebrated, valued, and integral resource for hospital and CBO staff. Their firsthand experience of trafficking was invaluable in offering support to patients, and clinicians greatly appreciated the presence of SAs and their willingness to provide training and resources. On the CBO side, they provided crucial insights on community outreach and internal processes such as documentation and screening tools. Secondly, the Survivor Advocate program made a sizeable organizational impact in its contribution to benefitting both hospital staff and patients. Hospital staff received extensive training on providing supportive care, which facilitated change in staff perspectives and attitudes towards patients. The third theme to emerge was the challenges that arose over the course of the program across all contexts, providing opportunities for continued growth and improvement which can inform future iterations of program implementation. COVID 19 presented a challenge, shutting down Los Angeles County at the beginning of the funding period and changing the hospital environment for much of the grant timeline. Perhaps the most prevalent challenge was noted to be providing support to patients with complex challenges – mental health needs, substance use disorder, housing needs – which uncovered systematic problems in resource finding and reflected the need for community resources that center intersectionality. Finally, at one CBO, findings revealed the need to explore how to better empower Survivor Advocates and integrate their input into decision-making.

## *Discussion*

During the three-year project time frame, Survivor Advocates saw 169 patients across more than 30 hospitals. Compared to the pilot project, in which 148 patients were served over 18 months by one SA, the program’s success was limited, due to the onset of the COVID-19 pandemic in March 2020, which

severely disrupted hospital and public health operations. Despite the delayed implementation and optimization of the SAs in Healthcare Program, evaluation results speak to the importance and value of integrating Survivor Advocates into a hospital setting.

Most of the patients referred to the Survivor Advocate identified as (cisgender) female. Men only accounted for 4% of referred patients, and an even smaller percentage were gender minorities. Male identifying individuals face the common misconception that they are only perpetrators and never victims, or that trafficking among them is far less common than it is in women. Many men may not even realize that they are experiencing a crime, let alone recognize that they are being trafficked. Men being exploited may not share their situations with healthcare providers or others in positions to assist, and may struggle to see themselves reflected in the Survivor Advocates that otherwise could provide a way out of their circumstances. In a similar vein, gender minorities are often overlooked despite being disproportionately impacted by trafficking and affected by common precursors to trafficking, but hospital staff identified three trans or gender non-binary people experiencing trafficking during this grant period.

Compared to labor trafficking, sex trafficking was far more commonly identified in the project period. In a medical setting, labor trafficking also tends to be more difficult to identify, since there may not be any overt physical or emotional signs or obvious workplace injuries. Survivor Advocates in health care could play an important role in expanding health care providers' understanding of labor trafficking presentations and in establishing rapport with individuals experiencing trafficking in sectors other than commercial sex.

Most patients referred to the SA during the study period presented to the hospital with multiple complaints, the most common ones reflecting mental health issues, violence, and trauma. These presentations vary from the more diverse patient presentations catalogued in emergency departments that used a screening tool to identify patients at risk for trafficking. Discharge outcomes were documented for 80% of patients, including 15% who left against medical advice and 28% who were placed at a shelter of some kind.

Qualitative findings included universal praise of the Survivor Advocates in Healthcare program by both hospital and CBO personnel. SAs fulfilled the promise to better engage patients, establish rapport, and increase the acceptance of community aftercare services by patients in the four CommonSpirit hospitals. They were perceived as professional, hard working, effective, and indispensable by healthcare providers who worked with them. Data demonstrate how the SAs catalyzed the provision of trauma-informed care, operationalizing the principles of safety; trustworthiness; peer support; collaboration (particularly in decision-making about referrals and reporting harm); and empowerment, voice, and choice. The support SAs provided patients directly manifested these principles, while their presence in the hospital and interactions with clinical staff modeled trauma-informed behavior and appropriate survivor engagement. On the CBO side, SAs were valued for their ability to build rapport with and advocate for their clients, their initiative, and diversity of skills.

Perhaps the most prevalent challenge was noted to be providing placement for patients with complex challenges – mental health needs, substance use disorder, housing needs – which uncovered systemic problems in resource availability and reflects the need for investment in community resources that center intersectionality. Finally, at one CBO, findings revealed the need to explore how to better

empower Survivor Advocates and integrate their input into day-to-day decision-making as well as higher level planning.

Overall, this evaluation found that the Survivor Advocates in Healthcare program achieved its primary aims, and general consensus among people involved is that it should be maintained, expanded, and scaled.

## Table of Contents

<b>Executive Summary</b> .....	2
<b>Introduction &amp; Background</b> .....	8
<b>Research on Survivors as Advocates</b> .....	<b>9</b>
Attentiveness to Well-being of Survivors as Advocates .....	10
<b>Pilot Study</b> .....	<b>10</b>
Patients .....	11
Survivor Advocate .....	12
Programmatic Challenges .....	12
Impact on Survivor Advocate .....	13
Staff .....	14
External Challenges .....	14
<b>Methodology</b> .....	14
<b>Overview</b> .....	<b>14</b>
<b>Design</b> .....	<b>15</b>
<b>Materials and Procedures</b> .....	<b>15</b>
<i>Characteristics of Patients Served by the Program</i> .....	15
<b>Participants</b> .....	<b>18</b>
<i>Inclusion Criteria</i> .....	18
<i>Exclusion Criteria</i> .....	18
Data Security .....	18
<b>Results</b> .....	19
<b>Quantitative Analyses</b> .....	<b>19</b>
Patient Data .....	19
Survivor Advocates in Healthcare Hospital Staff Survey (via SurveyMonkey).....	27
<b>Results: Qualitative Analyses</b> .....	<b>32</b>
Theme 1: Survivor Advocate Role.....	32
Theme 2: Organizational Impact.....	42
Theme 3: Challenges and Growth Opportunities .....	53
<b>Summary of Qualitative Results</b> .....	87
<b>Discussion</b> .....	<b>89</b>
<b>Recommendations</b> .....	<b>101</b>

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<b>References .....</b>	<b>105</b>
<b>Appendices .....</b>	<b>110</b>



## Introduction & Background

Worldwide, 27.6 million people are victims of human trafficking where they are compelled or coerced to engage in forced labor, with 17.3 million exploited in the private sector, 6.3 million in forced commercial sexual exploitation, and the remainder in forced state-sponsored labor (International Labour Organization, 2023). In the United States, human trafficking consists of using force, fraud, or coercion to compel a person to engage in work or service, or inducing a minor to engage in commercial sex regardless of the use of force, fraud, or coercion (United States Department of Homeland Security, Blue Campaign, 2023). According to a 2021 report, the National Human Trafficking Hotline received a total of 51,073 signals (e.g., phone calls, texts, emails, tip reports, etc.) about or related to human trafficking in the United States (National Human Trafficking Hotline, 2023). Of these, 5,257 (10.3%) signals were reported in California – the highest across all 50 states – with Texas a distant second with 3,534 (6.9%), followed by Florida with 2,894 (5.7%).

Though millions experience human trafficking, as a hidden crime, identifying people impacted by it presents a challenge. One of the most effective places to engage and support victims of human trafficking is in the healthcare environment (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Barrows & Finger, 2008; Chisolm-Straker, et al., 2020; Family Violence Prevention Fund, 2005; Polaris Project, 2023; Tracy & Macias-Konstantopoulos, 2017). When trained, healthcare providers significantly increase their ability to identify trafficked persons, provide appropriate healthcare, and refer to appropriate community resources (Loa, et al., 2022). It is essential healthcare providers and systems maintain awareness of community agencies that provide support to survivors of human trafficking and other forms of violence (Baldwin, Miller, Maclin, Williams, & Stoklosa, 2023).

In a survey report published by the Coalition to Abolish Slavery and Trafficking (CAST), over half of human trafficking survivors indicated they accessed healthcare services at least once while they were being trafficked and 40% believed there was something their doctor could have done to assist them in getting out of their trafficking situation (Lumpkin & Taboada, 2017). However, 97% of survivors stated they never received education or resources about trafficking from a healthcare provider; only one respondent out of 55 reported a health care provider identifying them as a trafficking victim. This survey—and peer reviewed literature—emphasize the need for programs providing resources to trafficking victims in healthcare settings (Chisolm-Straker, et al., 2016; Lutz, 2018; Shandro, et al., 2016).

To identify survivors of human trafficking in healthcare settings, CommonSpirit Health aligned Dignity Health's Human Trafficking Response Program with Catholic Health Initiative's Violence Prevention Initiative to form the *Violence and Human Trafficking Prevention and Response Program*. This program aims to ensure trafficked persons are identified in the healthcare setting and are assisted with victim-centered, trauma-informed care and services. CommonSpirit adopted a system-wide Abuse, Neglect, and Violence policy guiding each acute care facility to implement procedures assisting staff in identifying and supporting survivors of abuse, neglect, and violence, including human trafficking. Key components of the policy include staff trainings on human trafficking and trauma informed care, as well as use of the PEARR (Provide Privacy, Educate, Ask, Respect, and Respond) Tool. CommonSpirit Health and its partners, HEAL Trafficking and Pacific Survivor Center, created the PEARR Tool to guide staff in how to offer victim assistance to patients in a trauma-informed manner. An internal educational module about

the PEARR steps was made available to all CommonSpirit Health staff including physicians, volunteers, and contract employees through the learning portal, My Journey, beginning in March 2020.

Also in 2020, a new grant was awarded to CommonSpirit Health by the Department of Justice to expand the Survivor Advocate model piloted in 2018-2019 (discussed further below). The goals of this model were to 1. Increase the engagement and support of survivors of human trafficking who are identified in emergency departments, labor and delivery units, and other hospital-based settings, and 2. Support healthcare personnel in their work with potential survivors of human trafficking.

Evidence supports the effectiveness of Intimate Partner Violence Survivor Advocate programs in healthcare settings (Decker, et al., 2012; García-Moreno, et al., 2014; Rivas, et al., 2015; Sullivan & Goodman, 2019; Tirado-Muñoz, Gilchrist, Farré, Hegarty, & Torrens, 2014; Trautman, McCarthy, Miller, Campbell, & Kelen, 2007; Young-Wolff, Kotz, & McCaw, 2016). The success of IPV Survivor Advocate programs provides support for the implementation and study of human trafficking Survivor Advocate programs.

## Research on Survivors as Advocates

Survivors as advocates have relevant lived experience and are professionally trained staff providing support, connections to resources, safety planning, and intervention to a target population (e.g., survivors of intimate partner violence, IPV). The current project is a novel approach exploring the efficacy of utilizing human trafficking survivors as advocates to aid people experiencing human trafficking. The potential for trafficking survivors to act as advocates in direct service provision remains largely unexplored and can contribute valuable experience and insight in anti-trafficking efforts, supporting both healthcare providers and trafficked persons.

In intimate partner violence studies exploring the use of survivors as advocates, evidence indicates survivors as advocates report their personal background or family experience is a driving factor in their decision to pursue advocacy (Wood, 2017) and that organizational factors contribute to their well-being through mechanisms validating their survivor identities (Wilson & Goodman, 2021).

Advocates identifying as survivors of human trafficking may benefit clients by providing a crucial source of empathy in communicating commonalities with clients and understanding their responses (Wood, 2017). As such, connections made between clients and survivors as advocates can be useful in linking clients with appropriate services. Survivors express how valuable it is to receive service from another person who has first-hand trauma and recovery experience (Wilson & Goodman, 2021).

Further, human trafficking survivors as advocates can provide more meaningful engagement, as they can offer mechanisms to receive and act on critical feedback on behalf of both the organizations they work with, and the trafficked persons they provide assistance to (Ash & Otiende, 2023). Lived experience coupled with professional training provides survivors as advocates an unparalleled understanding of trauma. Through this understanding, survivors as advocates are keenly aware of the impact trauma may have on a client's health and attitudes, allowing advocates to successfully guide survivors to resources, helping them regain power over their lives and fostering emotional stability (Sullivan & Goodman, 2019).

There is also an important distinction to be made between advocates for survivors of human trafficking and survivors of human trafficking as advocates, the latter being the focus of the current project. Advocates for survivors of human trafficking do not necessarily have direct lived experience in human trafficking or exploitation. However, survivors of human trafficking as advocates, referred to as *Survivor Advocates (SA)* henceforth, are advocates with direct lived experience of human trafficking.

### Attentiveness to Well-being of Survivors as Advocates

Even though survivors as advocates report improved sense of well-being through helping other survivors, research from the domestic violence field demonstrates survivors working as advocates can also potentially experience harmful effects on their mental health. As such, survivors as advocates may experience tension, burnout, and vicarious trauma. As an example, IPV survivors as advocates shared witnessing survivors' experiences of abuse mentally affected them and that seeing others' injuries could remind them of their own attacks (Sullivan & Goodman, 2019).

Survivors as advocates often tend to stress about their self-evaluation; they have a sense of doubt if they are suitable for the role of an advocate and if they have said the right thing or provided support to the client. (Importantly, advocates without lived experience sometimes experience the same self-doubt). Survivors as advocates can find it difficult to meet their client's expectations due to limitations in their scope of practice, lack of long-term engagement with clients, and difficulty helping clients of various backgrounds and experiences far different from their own (Mihelicova, Wegrzyn, Brown, & Greeson, 2021).

For example, in one study, a survivor in an advocate role described the challenges associated with a client needing more certainty than the advocate could provide:

*"It almost felt like she wanted the answer that if she connected with the [organization] and their legal services that they would be able to like find the [perpetrator] and I told her I, I'm not sure if they could do that...and so it was really hard 'cause I felt like...she was wanting an answer that I couldn't give her."* (Mihelicova, Wegrzyn, Brown, & Greeson, 2021)

Nonetheless, because survivors as advocates are trauma-conscious and capable of meeting survivor needs, they hold promise of improving trauma informed care to trafficked persons in hospital settings and successfully linking survivors with social, legal, and other community-based services. Given the high number of trafficking cases in Los Angeles County, application of this model to human trafficking survivors in Los Angeles County could improve care and outcomes for an extremely vulnerable and hidden population.

### Pilot Study

In 2018, Dignity Health Hospitals in Los Angeles County initiated an SA pilot program in partnership with CAST to improve healthcare staff's ability to provide services and community referrals to patients identified as victims of human trafficking in the hospital setting. The Los Angeles County Department of

Public Health Office of Women’s Health (LACDPH OWH, aka OWH) served as evaluator of the SA program, collecting quantitative and qualitative data to determine whether it is effective to utilize a human trafficking SA to enhance trauma informed responses for patients who may be impacted by human trafficking. In provider surveys and interviews, the pilot program was consistently described as beneficial to hospital staff members and patients, and having an SA on-call was influential in identifying trafficking victims and linking patients with services.

## Patients

During the pilot project period, from June 2018 through January 2020, CAST received 179 calls from health care providers in Los Angeles County. This compared to 79 calls or referrals to CAST from healthcare agencies during the previous 19 months. Of the 179 total referrals, the SA served 146 unduplicated patients at 20 different hospitals. Patients referred to and served by the SA were 96% cis-gender female.

Forty-eight (33%) of the patients referred to the SA were confirmed as trafficked by an attorney. Because CAST is only able to serve people who meet the legal definition of victims of severe trafficking in persons, confirmation of this status by an attorney is a prerequisite for receiving services. In the context of this hospital-based program, determining this legal status— which requires that the potentially trafficked person answer many personal questions unrelated to their medical care— presented a challenge. In many cases, patients who interacted with the Survivor Advocate were reluctant to see an attorney. In other cases, the attorney could not show up or make it to the hospital in time. As a result, these patients could not be confirmed as trafficked and thus were unable to receive the services they potentially needed at that time. Even for patients who did meet with the CAST attorney, many barriers prevent people from disclosing their trafficking situation, particularly in an acute care setting, including fear, shame, language barriers, not understanding that one is experiencing abuse, and a lack of trust in medical providers, legal professionals, and other authority figures.

Among the 48 confirmed to be trafficked, 42 were classified as sex trafficking survivors, two as labor trafficking survivors, and four as survivors of both sex and labor trafficking. In the pilot patient population, there were also patients misidentified as trafficked who were involved in (consensual) commercial sex work, suggesting the two were being conflated.

Patients confirmed as trafficked presented to hospitals for a variety of reasons. The most common reasons patients presented to the hospital were for “Physical Injury/Pain” (n=11), “Physical Violence” (n=7), and “Drug Related” reasons (n=6). Seven of the survivors’ presenting complaints were unknown to the SA. The leading indicator for patients confirmed as trafficked persons was “prostitution” with 15 patients (21%) sharing their engagement in commercial sex.

Those not confirmed as human trafficking victims had similar indicators of potential human trafficking as those who were confirmed, though the top three indicators varied: “Account Indicative of Sexual Assault and/or Harassment” (15.3%), “Accounts or Indicators of Physical Violence” (14.1%) and “Prostitution” (9.2%).

Relatively few immigrant patients were referred to the SA during the pilot period and few cases of labor trafficking were suspected or identified. Patients experiencing labor trafficking may be less likely to

present with indicators that are recognizable in an acute care setting, such as markers of physical and sexual violence, than are survivors of sex trafficking.

There were 39 trafficked patients who accepted CAST service referrals, with nine declining all services. Patients who became CAST clients received a combination of shelter, legal, and case management services from the organization. Within the emergency shelter, 12 survivors received an average of 30 days of service. Case management services were offered to 6 survivors, who received an average of 109 days of service. Twenty survivors took advantage of legal services and each received an average of 531 days of service. Other patients accepting referrals were discharged to various locations including maternity homes, Whole Person Care (a Los Angeles County Department of Health Services program), substance abuse treatment programs, or returned home with family or friends.

### Survivor Advocate

In both follow-up surveys and qualitative interviews of hospital staff, it was clear how significantly the SA's skills and performance contributed to the success of the program, benefitting patients and hospital staff.

The SA received both excellent satisfaction ratings and glowing reviews from hospital personnel. Hospital staff described the SA as professional, attentive, empathetic, dedicated, knowledgeable, responsive to staff inquiries, and as providing valuable and respectful engagement with patients. Similarly, patients shared high praise, expressed their thankfulness and how instrumental the SA was in helping them escape their trafficking situation and connecting them with helpful community resources and organizations (e.g., CAST).

### Programmatic Challenges

During its first year the pilot SA in Healthcare program was rife with interpersonal conflict on the CBO side and lack of organizational management. Challenges centered on the lack of role clarity and structure at CAST related to the responsibilities of the SA and the goals of the program.

Although the project was structured to support a community-based organization's (CBO's) response to trafficking survivors identified in hospital settings, the Survivor Advocate spent the majority of her time within one hospital, directly supporting health care staff, both functioning and identifying as a hospital employee. This model of service provision had an extremely very positive impact for hospital personnel and patients and allowed the SA to thrive in an environment where she felt appreciated. However, many hospitals would not be as open to having staff from an outside agency roam freely in the emergency department or on hospital floors, potentially limiting replication of this model. Strong relationships between hospitals and CBOs employing Survivor Advocates would need to be built and nurtured to allow CBO-based advocates access to hospital patients at the level observed in this pilot program.

In the hospital setting, integration of the SA into care was facilitated by hospital leadership, resulting in acceptance and inclusion of the SA. This ultimately, successfully increased the number of patients clinical staff referred to the SA, but the increase challenged CAST's limited emergency response resources, especially given the brief time available to respond to the hospital before a patient would be discharged from the emergency department or inpatient setting.

Dissonance between CAST personnel and the Survivor Advocate was created when case management staff were negatively impacted by the Survivor Advocate's complaints and concerns at their internal meetings, spaces in which staff previously were able to debrief cases and support one another nonjudgmentally in their work with challenging clients. It is unclear whether the Survivor Advocate's lack of understanding or familiarity with the stressors faced by case managers, her perspective, personality, trauma, or other issues led to this conflict, but it was not adequately resolved during the pilot time period. [Notably, evaluation of the OVC grant-funded project, as described below, does reflect greater support for Survivor Advocates at the CBOs and better-defined roles and structure for the program.]

An additional challenge in the pilot period was the identification of labor trafficking, as 95.8% of the cases identified in the pilot study involved sex trafficking. Two factors may have contributed to decreased identification of labor trafficking: 1. The SA's own personal experience as a survivor of sex trafficking and the guidance she provided hospital personnel about sex vs. labor trafficking, 2. An underdeveloped understanding related to the identification of labor trafficking on part of hospital staff.

### Impact on Survivor Advocate

One concern and goal of the SA program was to develop a model protecting and maintaining the SA's health and safety. Survivors as advocates can often be exposed to secondary trauma or re-traumatization through interactions with patients, which may impact their ability to effectively perform or maintain their role, especially in the long term, without proper mental health support. In their interviews, CAST staff members shared their appreciation of the need for survivors working in direct service roles to have access to trauma-informed environments and recognized the need of the SA to have a steady support system. While CAST staff also shared concerns about the SA's well-being, interviews did not reveal that the organization implemented any systematic measures to mitigate traumatic exposures, provide support for the SA's mental health, or encourage self-care.

Another concern the pilot program highlighted was a need to set appropriate boundaries regarding workload for the SA. Hospital staff had a sense that the SA was an around-the-clock resource rather than available just during her scheduled work hours, compounded by the SA fielding calls outside of her work hours on her personal phone. Staff also showed limited knowledge of the existence of the 24/7 CAST hotline and became dependent on the SA for support. The underutilization of the hotline potentially allowed the need for more coverage to go unnoticed; while CAST staff did notice the SA's difficulty stopping work, they were unable to prevent her from taking on an unmanageable workload.

As the program became more well-known within the hospitals and the caseload increased, the SA reported being physically and mentally taxed at the prospect of not being able to respond to all potential trafficking cases due to both geographical and temporal restraints. The SA acknowledged the potential for re-traumatization from her work but reported that the work gave her a sense of satisfaction and fulfillment. While she did have regular meetings with her supervisor(s), as mentioned above, there was not a formalized system in place to manage trauma reactions. Without structure, support and guidance for the person in the SA role, the SA faces risks to their health and wellbeing, which could hinder the program's sustainability.

## Staff

In addition to the work provided by the SA, CommonSpirit Health provided formal education to hospital personnel, including the “Human Trafficking 101” module. Results from the pilot project indicate the presence of the SA, and the education provided to staff both formally and informally, improved staff understanding of human trafficking, particularly sex trafficking; their recognition of signs of (sex) trafficking; their compassion for patients potentially impacted by trafficking; their ability to assess patients for trafficking; and their comfort with linking patients with resources outside the hospital. Social workers, nurses, and physicians began to identify signs of trafficking in more patients, and survivors were more receptive to services.

## External Challenges

The two primary external factors evidenced in the pilot study impeding responses to trafficked patients centered on 1. Issues related to program funding and, 2. Post-trafficking housing logistics (e.g., emergency housing/shelter). Expanding on the first issue, CAST staff commented in interviews that the rushed timeline to apply for funding, program planning, and implementation can often hinder the successful rollout of a program. Expanding on the second issue, resources to provide housing and shelter for trafficked patients proved to be a struggle as most housing was already at capacity (or unavailable) or patients were unable to find suitable placements due to the physical injury which brought them into the hospital.

# Methodology

## Overview

The Office of Women’s Health (OWH) at the Los Angeles County Department of Public Health (DPH) served as evaluator for the Office for Victims of Crime’s (OVC) Survivor Advocates in Healthcare program, which provided two bedside Survivor Advocates to respond to Los Angeles County medical centers, primarily CommonSpirit/Dignity Health Hospitals, when clinical staff suspected a patient may be experiencing human trafficking.

The evaluation assessed levels of achievement, and challenges faced, in meeting the aims of the OVC-funded project, which included:

- 1) to improve identification of potential trafficking survivors and acceptance of referrals to specialized community-based services;
- 2) to gather evidence on the overall satisfaction among community-based service providers who employ Survivor Advocates and among CommonSpirit Health staff who work with them; and

3) to describe the aggregate demographics, presenting complaints, indicators of abuse and/or trafficking, and diagnoses of patients suspected of being survivors of trafficking by CommonSpirit Health personnel.

The evaluation also informs the project's goal to develop guidelines for expanded employment of Survivor Advocates who can work with both community-based organizations and hospital systems.

## Design

This project is an expansion of the pilot program discussed earlier in this report. The current project began in February 2020, but the COVID-19 pandemic resulted in sudden and long-lasting changes to the program's implementation, as Survivor Advocates were unable to provide support to patients in crowded and high-risk hospital environments during the first year of the pandemic.

The evaluation consists of a mixed methods study, including:

- Quantitative survey data collected from hospital personnel who worked with Survivor Advocates, along with free text responses
- Qualitative data from hospital and CBO personnel who worked with Survivor Advocates, and Survivor Advocates themselves, collected through semi-structured interviews
- De-identified data collection, by Survivor Advocates and CBO supervisors, of patients served through the program
- Quantitative data collected from patients who received services from CBOs subsequent to hospital visit through the CARE measure

## Materials and Procedures

### *Characteristics of Patients Served by the Program*

Using data collection tools created in consultation with Dignity Health/CommonSpirit, Journey Out, and CAST, SAs recorded information for all patients referred to them by hospital staff. Data were de-identified before sharing with the OWH research team. Information collected included service date (first date of contact with the patient), demographic characteristics (age, gender, race/ethnicity, primary language spoken), reason(s) for the hospital visit, patient characteristics that triggered referral to the SA, SA observations of referred patients, type of human trafficking noted by SA, other conditions noted aside from human trafficking, services needed by patient, referrals and services offered to and accepted by patient, and discharge outcomes.

Aggregated patient data were analyzed using SAS 9.4 (SAS Institute, Cary, NC) and Excel (Microsoft, Seattle) to provide descriptive statistics on patient demographics, as well as all relevant indicators and service information captured by the SAs.



### *Hospital Staff Surveys*

Research team members invited CommonSpirit Health clinical staff who had engaged with a Survivor Advocate to complete an online survey, hosted by SurveyMonkey (San Mateo, CA), that took less than ten minutes to complete. Survey recruitment for hospital personnel occurred initially via email from the Chief Nurse Executive Officer (CNEO) at each hospital, which included an attached PDF flyer about the survey. The flyer included a QR code that staff could scan with their cell phones, which took them to the online information sheet and survey. Research team members also attended staff meetings and team huddles to remind staff about the survey invitation email from the CNEO and share a copy of the flyer. A statement of informed consent was included at beginning of the survey, and the first survey question asked personnel for their consent to participate. Participants who consented to the survey could stop taking the survey at any time. Staff who never interacted with a Survivor Advocate should have screened out upon answering the second question of the survey.

Due to low survey response, CommonSpirit research personnel acquired a list of patients who were referred to a Survivor Advocate during the study period from the two CBOs and using this information, searched the electronic health record (EHR) system to locate the names of providers and staff who were involved in the patient's care. A co-investigator then forwarded the initial CNEO survey recruitment email to each of these providers with a message advising them that they had been identified as a provider who may have interacted with a Human Trafficking Survivor Advocate in the past while caring for a patient, asking them to please consider completing the attached survey. Several more responses were entered following this outreach.

The survey (Attachment A) measured staff's level of interaction with the Survivor Advocate(s); their impressions of patients' receptivity to the Survivor Advocate and referrals; and changes since working with the Survivor Advocate in their perceived level of confidence in: (1) recognizing signs of sex and labor trafficking in patients; (2) responding to patients who may be trafficked for sex or labor; their comfort level in respecting patients' decisions to not accept assistance; and challenges faced in connecting potentially trafficked patients with support services outside the hospital. The survey also collected staff's basic demographic information. The survey was conducted from May 4, 2022 to December 31, 2022. We used SAS 9.4 (SAS Institute, Cary, NC) to conduct descriptive analyses of the dataset.

### *Hospital and CBO Staff Interviews*

A sample of hospital staff who engaged with Survivor Advocate(s) or were familiar with the Survivor Advocate program were invited to participate in a one-time 30-60 minute interview about the program. Interviews occurred between April 4, 2022 through December 21, 2022. The team used slightly different scripts to interview clinical personnel vs. hospital leadership, including Human Trafficking Task Force leads (Attachments B and C). Recruitment for interviews for hospital personnel occurred via email from the CNEOs with an interview information sheet attached. Research team members also reminded staff of the invitation to participate during staff meetings and team huddles. Any clinical staff who sat for an interview and had not completed the quantitative survey were invited to complete that as well.

A sample of CBO staff who interacted with the Survivor Advocate, and the Survivor Advocates themselves, were also invited to participate in a one-time 60-minute semi-structured interview about

the Survivor Advocate program (see Attachments D and E). Recruitment for interviews for CBO staff (including Survivor Advocates) occurred via email from CBO supervisors with the interview information sheet attached.

Qualitative interviews consisted of 10-12 questions and aimed to describe program challenges, successes, results, perceptions of the program's strengths and weaknesses, advantageous characteristics and skills of a Survivor Advocate, functionality of work relationships within community-based organization and hospital teams involved in the Survivor Advocates' work, and recommendations to improve the program. Interviews were conducted with personnel seated in a private setting at the hospital, service agency office, or other workplace using HIPAA compliant Zoom software (San Jose, CA). Interviewers informed interviewees that interviews would be digitally audio recorded and transcribed, but that interviewees would remain anonymous aside from their general role and whether they were hospital or CBO-based. If a person's role alone could identify them, such as an employment title, we would use alternative labels (such as "lead" or "administrator") to de-identify them in any results or reports. Participants could stop participating in the interview at any time.

We originally performed thematic analyses of qualitative interview data with Dedoose software (Manhattan Beach, CA) using an inductive framework, based on the information we found in the data and not on an *a priori* hypothesis. During our second or third review of qualitative data, we used a deductive framework, examining the text for evidence similar to or different from observations documented during the pilot study. We used an experiential orientation, capturing what participants described to make sense of what occurred, and a realist approach, where we assume respondents told the truth and did not explore underlying motives or incentives (Braun & Clarke, 2006).

### *CARE Measure*

Survivors who sought follow-up services at CAST or Journey Out following a Dignity Health/CommonSpirit hospital visit were to be invited to complete a short, anonymous questionnaire, the "CARE Measure 5Q Visual" at or following their first appointment with the CBO (Attachment E for English version). The Consultation and Relational Empathy (CARE) Measure is a patient-rated experience measure of practitioner empathy that uses a simple visual scale assessment (Mercer, Watt, Maxwell, & Heaney, 2004). The CARE Measure was translated by CommonSpirit Health certified translators into Spanish, Mandarin, Russian, Tagalog, and Korean. Clients were to be invited to complete the short survey at in person visits, via mail with a self-addressed stamped envelope to return it to the CBO, or through a link sent via electronic mail by CAST or Journey Out. The survey required less than three minutes to complete.

Unfortunately, due to lack of in-person appointments with clients for most of the study period, staff turnover, and misunderstandings, CBO staff did not distribute the CARE Measure to their clients in a timely fashion. In total, only three surveys were received by the evaluation team, precluding analyses of these data.

## Participants

### *Inclusion Criteria*

- 1) Patients identified by hospital staff as potentially trafficked for labor or sex and who received assistance through a Survivor Advocate from February 1, 2020 through December 31, 2022.
- 2) CommonSpirit Health staff in emergency departments, labor and delivery units, behavioral health units, and other hospital-based settings who offer assistance to patients who may be experiencing labor or sex trafficking.
- 3) CommonSpirit Violence and HT Prevention and Response (VHTPR) Initiative leaders, including Human Trafficking Task Force members and other hospital leaders and stakeholders.
- 4) Staff at the Coalition to Abolish Slavery and Trafficking and Journey Out, two community-based organizations that provide services to survivors of human trafficking, as well as survivors of sexual exploitation (at Journey Out), including Survivor Advocates.
- 5) Patients who schedule and attend follow-up appointments with the Coalition to Abolish Slavery and Trafficking and/or Journey Out.

### *Exclusion Criteria*

- 1) There are no exclusion criteria for hospital staff or CBO staff.
- 2) Minor patients (<18 years of age) who became clients at either CBO were not to be asked to complete the anonymous CARE questionnaire.
- 3) For the CARE measure, CBO survivors who speak a language other than English, Spanish, Chinese, Korean, Russian, or Tagalog may have been unable to complete the form or provide comments.

### *Data Security*

All electronic data files related to the study were stored electronically on DPH OWH password protected computers, on a secure Los Angeles County server, in a locked suite accessible only by LACDPH staff. Only OWH study personnel approved by the CommonSpirit IRB could access the secure digital folder where research materials and data were stored. Anonymous Survey Monkey responses were stored on the secure Survey Monkey platform, again, accessible only to OWH research staff.

Patient data collected by Survivor Advocates were password protected and sent to OWH research staff via encrypted email.

Semi-structured interviews were recorded with HIPAA compliant Zoom software on secure, HIPAA compliant, password protected devices at Dignity Health/CommonSpirit offices, then transferred to a password protected File Transfer Protocol (FTP) site only accessible by Dignity Health researchers, OWH research staff, and OWH's contracted, secure, HIPAA-compliant transcription service (TSI Transcripts; La

Quinta, CA). All transcripts and audio files were processed by TSI without including any identifying information and were stored securely on a password-protected server. TSI staff transcribed the audio files and generated a typewritten electronic file of each interview.

Anonymized interview transcripts (assigned only a participant number) were uploaded to Dedoose (Manhattan Beach, CA), a secure, password protected qualitative data analysis application for coding and analysis by OWH researchers.

All data files are to be destroyed five years after the end of the study, once the final Survivor Advocate Program Model Training Manual is completed and any manuscripts resulting from the project are published. Hard copies of data will be shredded via DPH OWH contracted shredding service, and electronic copies of data will be wiped from password protected hard drives after five years. Similarly, electronic data will also be deleted from CommonSpirit Health servers five years after the end of the study.

## Results

### Quantitative Analyses

#### Patient Data

Patients referred to Survivor Advocates (SAs) ranged in age from 17 to 62, with an average age of 31. Patients were overwhelmingly female at 88%, with only 4% identifying as male. Patients evaluated for trafficking identified primarily as African American (26%), White (24%), and Hispanic/Latinx (21%).

Most referred patients spoke English as their primary language (74%), followed by Spanish at 7%. While 68% of patients indicated the United States as their country of origin (68%), 16% mentioned other countries including Brazil, Finland, China, and Guatemala, to name a few. The country of origin was unknown for the remaining 16% of patients.

**Table 1: Patient characteristics**

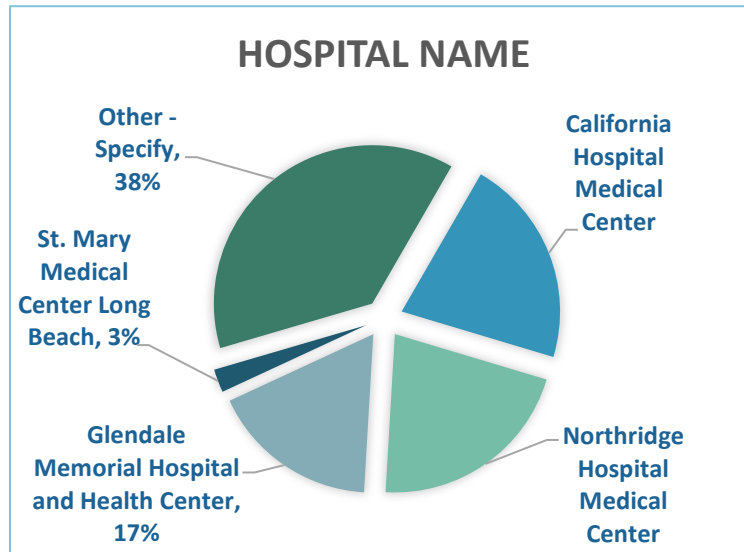
Age		
Mean	30.68	
Median	29	
Minimum	17	
Maximum	62	
	n	%
Gender		
Female	149	88%
Male	7	4%
Trans female	2	1%
Non-binary/Genderqueer	1	1%
Prefers not to state	10	6%

Race/ethnicity		
White	41	24%
Hispanic, Latinx, or Spanish	36	21%
Black or African American	43	25%
Asian	5	3%
American Indian or Alaska native	1	1%
Multiracial	11	7%
Some other race; specify	2	1%
Missing	30	18%
Primary Language Spoken		
English	124	73%
Spanish	12	7%
Chinese (Cantonese or Mandarin)	1	1%
Korean	1	1%
Russian	2	1%
Portuguese	1	1%
Mongolian	1	1%
Multiple languages (English, Spanish, Portuguese, Lucumi)	1	1%
Unspecified	26	15%
County of Origin		
United States	115	68%
Unknown	27	16%
Mexico	7	4%
Honduras	4	2%
Colombia	2	1%
Antigua and Barbuda	1	1%
Armenia	1	1%
Brazil	1	1%
Cuba	1	1%
Canada	1	1%
China	1	1%
Finland	1	1%
Guatemala	1	1%
Korea, Democratic People's Republic of	1	1%
Mongolia	1	1%
Russian Federation	1	1%
Serbia	1	1%
Trinidad and Tobago	1	1%
Ukraine	1	1%

The Survivor Advocates served a total of 169 patients across 38 different hospitals, 62% of which were within the Dignity Health system. California Hospital and Northridge Hospital each contributed to 21% of

referred patients, and the remaining 38% of patients were referred from hospitals across Los Angeles County.

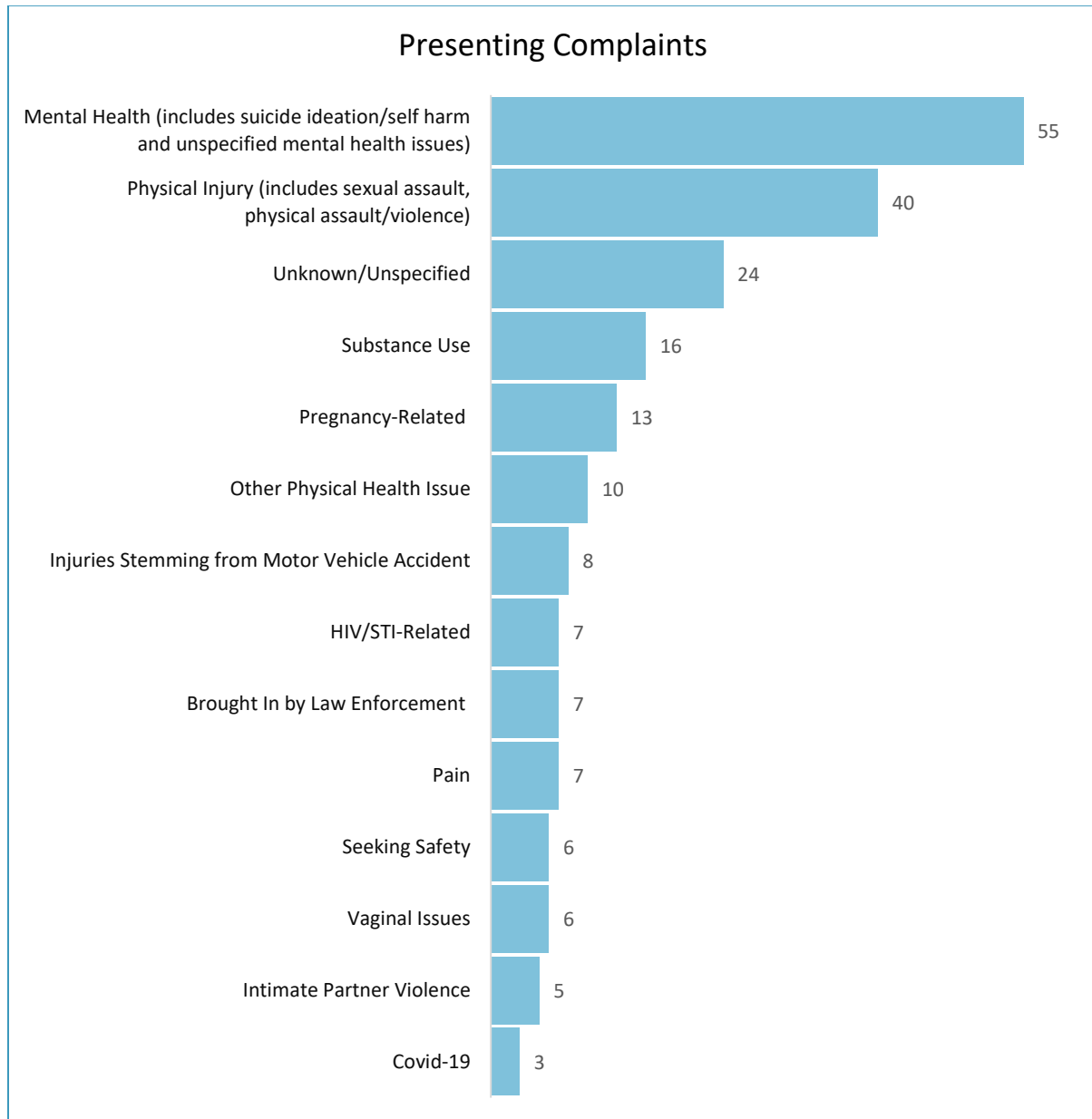
**Figure 1: Hospital Name\***



*\*See Appendix G for hospitals outside of the Dignity Health System*

Most patients referred to an SA presented to the hospital with more than one health issue. Mental health problems were the most common reason for the hospital visit, with 55 unique complaints including suicidal ideation, anxiety, and unspecified mental health issues. There were also 24 individuals whose reason for presenting to the hospital was unknown to the SA or otherwise not detailed in the final database. Appendix H provides examples of each presenting complaint category.

**Figure 2: Presenting complaints for patients referred to Survivor Advocates for suspicion of trafficking**



After their medical needs were tended to, patients were referred to the SA for further assessment. Multiple reasons for referral were documented for most patients referred to SAs, including engagement

in the sex trade, sexual assault, violence, and suspicion by law enforcement. Notably, the most common reason for referral was self-identification by the patient as a person who had experienced human trafficking.

**Table 2: Reasons for referral to Survivor Advocate\***

Referral Reason	n	%
Self-identified	40	17%
Prostitution/Sex trade	20	9%
Substance use	18	8%
Sexual assault	15	6%
Mental Health	15	6%
Escaping bad situation	13	6%
Law enforcement suspects HT	12	5%
Violence/assault	12	5%
Unknown	11	5%
Provider suspects HT	10	4%
Exploitation	10	4%
Abandonment/neglect	9	4%
Pregnancy	7	3%
Fear	7	3%
Previously Identified as Human Trafficking victim	7	3%
Held against will	6	3%
Sexual Health	5	2%
Homelessness	5	2%
Self-Harm	4	2%
Intimate Partner Violence	4	2%
Suspicious Injury	3	1%
Parent suspects HT	1	0%
<b>Total</b>	<b>234</b>	<b>100%</b>

*\*The total number of referral reasons exceeds the total number of patients because many patients had more than one reason to be referred. Appendix I details examples of each referral reason.*

Because of schedule and time limitations for the Survivor Advocate, as well as the impact of the COVID 19 pandemic, 65% of patient consultations were initiated over the phone. However, Survivor Advocates indicated that they later had an in-person visit with the patient either in the hospital or as part of the intake process once a patient accepted assistance. They assessed both physical and emotional presentations for the patient to determine if the patient was trafficked, and what type(s) of trafficking each patient may have dealt with. Sex trafficking was more prevalent (73%) than labor trafficking (4%) and for 24% of patients, Survivor Advocates were unable to determine the type of trafficking.



**Table 3: Trafficking Type**

	n	%
Sex Trafficking	122	72%
Labor Trafficking	5	3%
Not Sure	41	24%
Not Trafficking	1	1%

**Table 4: Visit type**

	n	%
In-Person	37	22%
Videoconference	11	7%
Telephone; audio only	110	65%
Unknown	11	7%

The Survivor Advocates documented signs and symptoms of trafficking that hospital personnel reported to them in the context of patient referrals (Table 5). Through conversations with the patient, Survivor Advocates recorded behaviors, statements, and other visual indicators that a patient may be a trafficking victim. Additionally, they provided expert evaluations of the patient, noting common indicators of human trafficking observed in the patient (Table 6).

**Table 5: Patient indicators of human trafficking that triggered referral to Survivor Advocate, as documented by Survivor Advocate\***

Patient Indicator	n	%
Account of force, fraud or coercion by family, partner, or friend	29	13%
Forced Sex Work	25	11%
Self-Identified	21	9%
Assault/Abuse	17	8%
Disengaged	14	6%
Seeking Support	12	5%
SA did not have contact with patient	12	5%
Sexual Assault	12	5%
Commercial sex trade/Prostitution	10	5%
Fear	8	4%
Held Against Will	6	3%
Substance Use	7	3%
Not Enough Information Provided	6	3%
Patient Does Not Need Services	6	3%
Intimate Partner Violence	6	3%

Mention of Different Locations/Migration	6	3%
Threats	5	2%
No Access to Documents/Money	4	2%
Escape	4	2%
Forced Labor	3	1%
Mental Health	3	1%
Abduction	3	1%
Stalking	3	1%
<b>Total</b>	<b>222</b>	<b>100%</b>

*\*Patient indicators exceed the total number of patients because many patients displayed multiple indicators. See Appendix J for examples.*

**Table 6: Survivor advocate observations of patients suspected to be trafficked\***

Survivor Advocate Observations	n	%
Fearful	28	11%
Self-Identified	20	8%
SA did not have contact with patient	16	7%
Disengaged	16	7%
Anxious	16	7%
Assault/Abuse	15	6%
Requests Support	11	4%
Hypervigilant	10	4%
Not Trafficked	9	4%
Distressed/emotional	8	3%
Not Enough Information Provided	7	3%
Previously Assessed for Human Trafficking	7	3%
Forced Commercial Sex	7	3%
Substance Use	7	3%
Money/Documents Withheld	7	3%
Non-Cooperative	6	2%
Controlling Behavior	6	2%
Threats	5	2%
Branding	5	2%
Guarded/Defensive	5	2%
IPV	5	2%
Trauma	5	2%
Confused	5	2%
Restricted Movement/Held Against Will	4	2%
Escape	4	2%
PTSD	4	2%

Sexual Assault	4	2%
Mental Health Issues	4	2%
<b>Total</b>	<b>246</b>	<b>100%</b>

*\*Survivor Advocate expert observations exceed the total number of patients, because more than one indicator was noted in some patients. See Appendix K for examples.*

Discharge outcomes were recorded for most patients (80%), most of whom were discharged to a shelter. Over one in five (21%) were discharged to family or friends, and 9% left against medical advice.

**Table 7: Discharge Outcomes**

Discharge Outcome	n	%
Discharged to shelter	47	28%
Discharged to family or friends	35	21%
Referred to shelter/housing	25	15%
Unknown	33	20%
Left Against Medical Advice	14	8%
Connected to case manager	14	8%
Declined shelter	1	1%

Part of the Survivor Advocate’s assessment included common resources and referrals that were provided to the patient. CAST provides a variety of services in-house, including shelter, legal services and case management. Additional services not provided by CAST are often referred out to partner organizations. Journey Out offers case management, peer support and basic needs to their clients, and addressed most of their clients’ other needs through referrals to other organizations.

**Table 8: Services offered to and accepted by survivors**

Service	Offered	Accepted	Yield
Shelter	84	28	33%
Legal	95	58	61%
Case Management (with CAST or JO)	91	65	71%
Other services	77	68	88%

For 57 patients who continued services with Journey Out and CAST, time spent in specific services was recorded. Time spent in shelter and case management services was recorded for 53 survivors. More than half utilized shelter services (60%) and case management (58%), with 3 in 4 survivors needing shelter services for two months or less. Survivors remained in case management for an average of 119 days.

Journey Out recorded additional outcomes (basic needs, transportation, mentorship, emotional support) for the 27 survivors they worked with. Almost all (96%) received provision for their basic needs

(food, clothing etc.), and about 1 in 4 needed this service for more than more than 4 months. Notably, all clients accepted survivor mentorship and support services, though half utilized these services for 2 weeks or less. About 1 in 4 clients needed these services for over 6 months.

**Table 9: Long term outcomes for patients who became CBO clients**

<b>Type of Service</b>	<b>Clients served</b>	<b>Avg days in service</b>	<b>Min (Days)</b>	<b>Max (Days)</b>
<i>Emergency Response</i>	26	23	2	153
<i>Legal</i>	26	222	78	410
<i>Basic Needs</i>	27	82	1	425
<i>Transportation</i>	27	77	1	475
<i>Survivor Mentorship</i>	27	98	1	475
<i>Emotional Support</i>	27	98	1	475
<i>Shelter</i>	53	28	1	327
<i>Case Management</i>	53	119	1	557

#### Survivor Advocates in Healthcare Hospital Staff Survey (via SurveyMonkey)

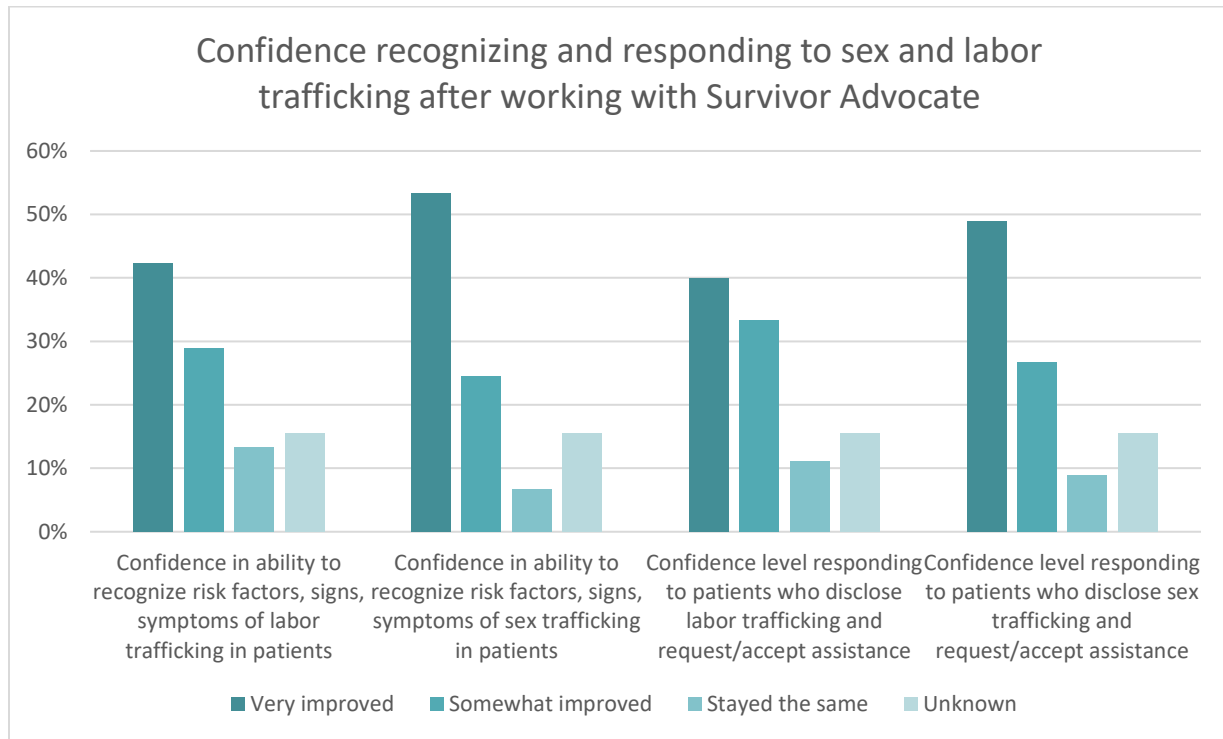
A total of 66 hospital staff consented to an online survey designed to detail experiences interacting with the Survivor Advocates. However, 33% of them did not continue with the survey past the consent stage. Of the 45 (66%) that completed the survey, a majority (38%) had consulted a Survivor Advocate only once, while 14% had worked with a Survivor Advocate more than 7 times. Respondents were primarily female (73%), most were staff at Northridge Hospital Medical Center (36%) and California Hospital Medical Center (29%), and 64% had spent over 10 years in their profession. Clinical social workers and Hospital Administrators/Managers were most represented, at 32% and 25% respectively. Many respondents had interacted with Survivor Advocates from both organizations, though most (49%) had worked with CAST. Nearly one third (31%) of respondents had interacted with a SA from both CAST and Journey Out, and 11% had interacted with a SA but were not sure which organization the SA was from.

**Table 10: Characteristics of Staff Respondents**

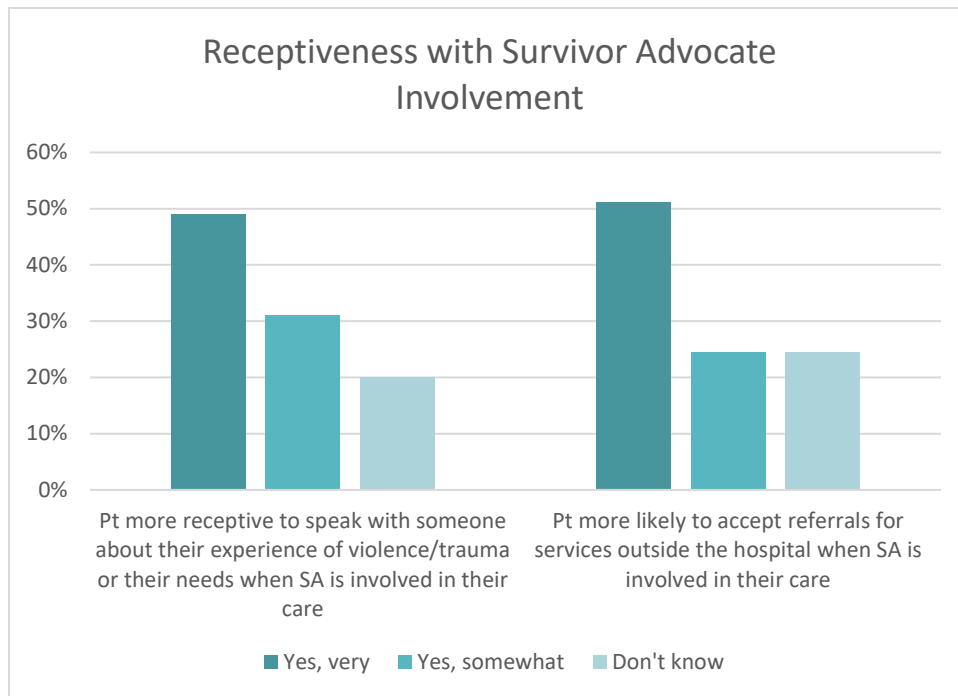
Characteristic	n	%
Gender		
Female	33	73%
Male	9	20%
Missing	3	7%
Role in Hospital		
Role - Clinical Social Worker	17	32%
Role - Admin or manager	13	25%
Role - Registered Nurse	10	19%
Role - Other specify	4	8%
Role - HT Taskforce Lead or Hospital HT Lead	3	6%
Role - Physician, NP, PA, CNM	2	4%
Years of experience in profession		
3-5 years	2	4%
6-10 years	11	24%
11-15 years	14	31%
16 or more years	15	33%
Missing	3	7%
Name of hospital		
Northridge Hospital Medical Center	16	36%
California Hospital Medical Center	13	29%
St. Mary's Medical Center - Long Beach	8	18%
Glendale Memorial Hospital and Health Center	5	11%
Missing	3	7%
CBO Interactions		
Interacted with only CAST	28	60%
Interacted with only JO	14	30%
Interacted with SA but CBO is unknown	5	11%
# of consults with SA		
1	17	38%
2 - 3	12	27%
4 - 6	10	22%
7 - 10	3	7%
More than 10 times	3	7%
Years worked with SA		
2018	13	29%
2019	19	42%
2020	15	33%
2021	18	40%
2022	18	40%
Year Unknown	8	18%

Over 70% of the respondents noted that their ability to recognize risk factors, symptoms or signs of trafficking had improved after working with the Survivor Advocate, though confidence in recognizing sex trafficking was higher than that of recognizing labor trafficking. Similarly, over 70% noted improved confidence in responding to patients who disclose trafficking. Notably, half of staff members reported that patients were very receptive and more likely to accept referrals when an SA was involved.

**Figure 3: Confidence after working with Survivor Advocate**

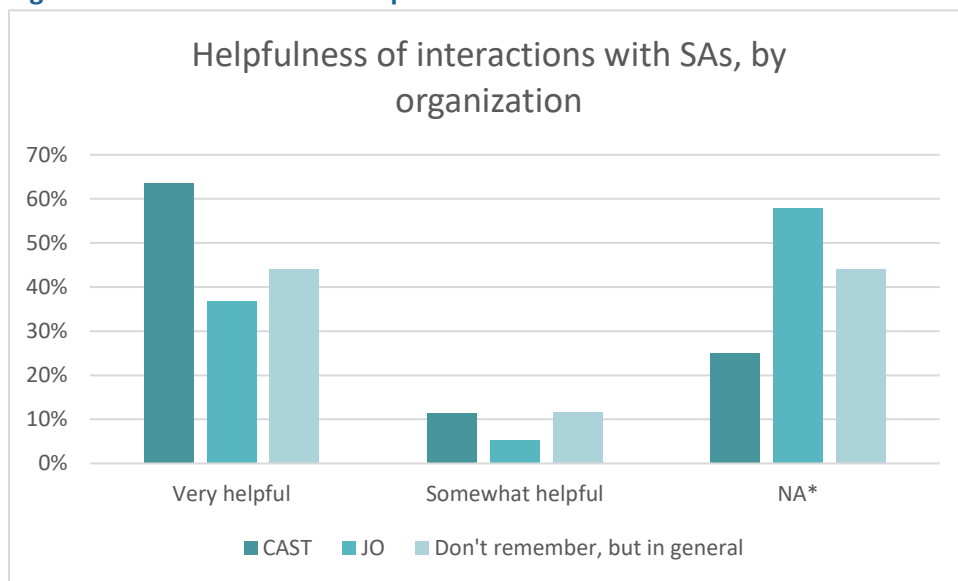


**Figure 4: Patient receptiveness when working with Survivor Advocate**



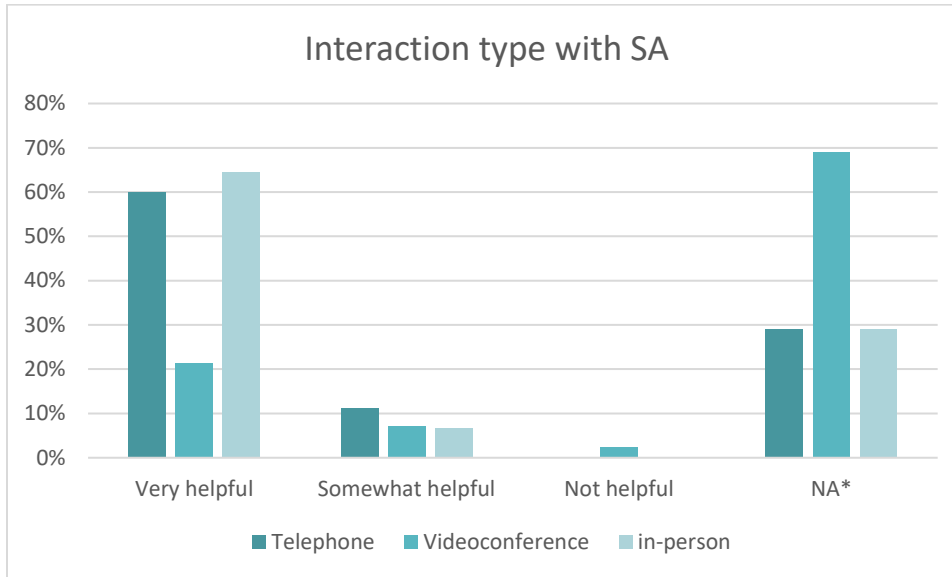
Overall, all staff reported that working with SAs was very or somewhat helpful, regardless of the organization they were involved with. In-person and telephone interactions with the SA were found to be most helpful, with a few individuals (2%) indicating that videoconference interactions were not helpful. However, it is important to note that this question specifically measures impressions by the staff based on exposure and engagement, rather than the actual performance of the SAs.

**Figure 5: Survivor Advocate Helpfulness**



\*Skip patterns ensured that all respondents to this question had interactions with an SA; as such, we are unable to interpret what the "NA" response indicates.

**Figure 6: Method of interaction with Survivor Advocate**



\* “NA” responses indicate that the hospital staff person had not used that means of communication with a survivor advocate.

Hospital staff reported a few challenges in working with the Survivor Advocates. At 17%, the two most common challenges were unavailability of a SA when needed due to an off-shift and difficulty in placing patients with unique mental health or physical health needs, followed by patients refusing to speak with the SA or leaving AMA, both at 16%.

**Table 11: Challenges faced by Hospital Staff working with Survivor Advocates**

Challenge	n	%
Need SA during shift where SA is unavailable	15	17%
Difficulty placing patient with special needs (mental health, physical impairments)	15	17%
Patient refuses to speak with SA	14	16%
Patient leaving AMA	14	16%
None of the above	12	14%
Long wait on hotline/phone to reach SA	5	6%
Difficulty placing patient due to them being male	4	5%
Difficulty placing patient due to them being cis-female	4	5%
Difficulty reaching SA scheduled to work	2	2%
Difficulty placing patient due to them being trans, non-binary or gender non-conforming	1	1%
Obtaining placement for a patient in the middle of the night (after hours)	1	1%



## Results: Qualitative Analyses

Qualitative analyses conducted across interviewees from hospitals and community-based organizations, including survivor advocates, revealed three primary themes:

1. Survivor advocates quickly became a celebrated, valued, and integral resource for hospital and CBO staff
2. The Survivor Advocate Program made a sizeable organizational impact in hospitals, through its benefits to both hospital staff and patients; and survivor advocates were valued for their skills and the roles they played at the CBOs
3. Challenges arose over the course of the program across all contexts, providing opportunities for continued growth and improvement, which can inform future iterations of program implementation.

Overall, the inclusion of survivor advocates in hospitals' responses to patients experiencing trafficking was very well-received by hospital staff, and their value to anti-trafficking efforts in the community were also well-recognized by CBO colleagues. We explore each of these themes in detail, here, and provide a summary of the results at the conclusion of the full qualitative results section.

### Theme 1: Survivor Advocate Role

The first major theme demonstrates the impactful role and presence of the SAs in hospitals and in community-based organizations. Interviewees consistently provided responses evidencing how the SA expertise, experience, and engagement were exceedingly helpful and beneficial to both staff and patients/survivors (heretofore referred to as 'patients'). Ample examples were shared how the SAs reliably educated and supported hospital staff and also collaborated with CBO staff. Interviewees shared they (and their colleagues) were thoroughly impressed with their SA's conscientious awareness and respectful incorporation of resources for patients. Additionally, SAs also shared their perspective related to the SA program, followed by interviewee accounts pertaining to the integration of SAs into the hospital context.

### Hospital Perspectives

This section below covers perspectives of hospital staff related to the SA role, program goals, and educational experiences between SAs and hospital personnel.

### Survivor Advocate Role and Program Goals

Hospital leadership and staff shared clear understanding of the SA role, the goals of the program, and how they utilized Survivor Advocates to support patient care. One leader described the purpose as

“...having someone that is able to connect with potential victims of trafficking that we’ve identified here in the hospital who can provide education, who can provide supportive services, and case management when the patient consents to those services and while they’re here in the hospital.” [ID 14] A nursing leader described, “My general understanding of the Advocacy program is just like an extra layer of support and like a lifeline for these people in our community, because they are the unseen and the unspoken for, unrepresented because nobody’s paying attention.” [ID 21]

Leadership from another hospital expressed:

“I think the aim for the program was really making the human trafficking victims comfortable to have conversation with somebody who has gone through a similar problem in the past. A person who could truly help them navigate through the system to get some help. A person who is, in collaboration with the staff, understands the symptoms or signs when you do have a human trafficking victim that comes in, and how to get help, how to connect them to the survivor advocate when needed and as needed. So, it is a multi-fold approach: one being staff being aware that there is a presence of survivor advocates who can help them out in that situation, second being present for the victims and being there to help them and walk them through the process of getting some help.” [ID 24]

Hospital staff valued the connections SAs had with patients and what they could offer them. “...having that survivor advocate not only is good for the patients in terms of that interpersonal relationship, but as an expert in the field itself linking them to resources, so that’s my understanding of why we have that program and what it’s designed to do.” [ID 12] They understood that the SAs served as a type of specialist whom they could call on for support with specific patients. A social worker explained, “I would say like they’re kind of in the hospital system, the other specialists, right. I could be like the ED doctor but I have to call in a specialist to help me figure out a patient, how to help them, how to treat them, how to do their disposition. And I think that’s what the survivors are like for me at least in the ED.” [ID 07] Leadership concurred with this framing:

“We heavily lean on our advocates because they are, they’re a phone call away and it is such a relief to know that we have a specialist. Just like if you had a cardiac injury or a neurological deficit, you’d want to go to the specialist to take care of that issue, right? So, it’s the same feeling that we know we have somebody who is specialized in the field. They’ve experienced it so they know firsthand, and they just connect with our patients right away.” [ID 21]

Another social worker noted the specialized and complementary assistance the SAs provided, “...survivors are so dedicated and because that is pretty much their specialty, they have more time and more resources to really attend to these patients and they are a phenomenal supplement to what we have here at the hospital.” [ID 03]

A hospital lead shared the practical benefits for staff of regularly encountering the SA:

“I think it's helpful for the [hospital] staff when they interact with the survivor advocate, or, you know, like in a huddle or in a team meeting to be able to feel comfortable, to ask the advocate, you know, ‘What’s the best approach?’ if I don’t know. You know, sometimes you’re new to the situation. You might not know how to approach the person, even though we’ve got, you know, tools and procedures, and we do that. It still can be scary for the for the provider as well. So,

having some help and some hints because see, you know the survivor advocates it's just that, they're survivors. And, having been a survivor, who knows better to how to approach somebody that's a potential victim than a survivor." [ID 28]

Hospital personnel especially admired the connections that SAs were able to make with patients.

"So, the survivor advocates just have a whole next level of, one, understanding and knowing what the patients are going through, and to be able to kind of better interact with them, and patients feel more understood, I think, by a survivor advocate than a nurse, or a doctor, or a social worker, so they are more willing to open up to those people." [ID 16]

Social workers also noted the relatively easy rapport the SA developed with patients. "Just having someone who has been through it I think they were willing to open up and be more vulnerable because they knew that she understood them at a different level." [ID 10] Another social worker appreciated that SAs could share their experiences with patients as part of their role: "And, whereas in social work sometimes we're often said don't share too much of yourself with the patient, where the advocate can, and that makes a difference." [ID 07]

One noted that the connection with an SA could be an important step forward for people experiencing trafficking:

"I think that starts building that rapport that there are still good people in this world even though you've seen so much ugliness, I think that's what survivor advocates are, kind of the start of healing for these men and women. But yeah I'm going to help you I'm not going to hurt you, and that's the start of them getting a new life. Because I have no doubt that they think that the world's a very ugly place." [ID 07]

Hospital personnel valued the SAs' awareness of important resources for their patients, particularly with regard for placement after discharge from the hospital. A social worker noted, "They bring us...obviously resources which constantly changes [sic]...it doesn't matter how much education you get, you won't know what resources are out there and these individuals because they deal with it daily they are pretty up to date with it" [ID 03], while a social work supervisor commented, "I think they're more in tuned with the services out there and they become more savvy about what's there and how quick they can find a shelter and placement for our patients." [ID 04] A social worker in another hospital appreciated how the SA worked with them to place patients, "...they're giving you the information and they're also working at the same time calling facilities and shelters and trying to connect the pieces...pull out resources that I didn't know existed." [ID 09]

Another shared her thoughts about the program's importance more generally, in the context of this evaluation:

"So, hopefully having some of this evidence will help move the program elsewhere. It's really good, it's a hard thing for hospitals to detect. You know every time we have these cases, and we go through it I'm always amazed at how many times these patients have been in our emergency rooms and yet none of these red flags were picked up. And there's so much work to be done in training staff and it's a bigger process that has to change to get these things recognized. So, every little step that we add goes a long way. I think the biggest step that we have is the survivor advocate and I think it's just unique, it's one of a kind, there's no amount of clinical training that

I or my colleagues can get that can replicate a survivor advocate. So, I hope this helps move things forward at other hospitals still.” [ID 12]

### Survivor Advocate Role: Educating Hospital Personnel

Hospital leadership and staff all shared the importance of the SAs’ role in educating hospital personnel. The SAs, through their presence and interaction with clinical staff, supplemented the existing, standardized training that the CommonSpirit hospital system provides as part of their Violence and Human Trafficking Prevention and Response Initiative. One social worker described that training:

“It was a training for the entire hospital. So, that’s how we were able to see images and listen to stories and learning how to act with patients. You’re not just going to say, ‘Are you being trafficked?’ You can’t say that. There have got to be other ways. So, we all received training in person. And I think online.” [ID 22]

In addition to occasionally participating in formal training sessions, the SAs typically educated staff through advising and consulting on individual patient cases and informally sharing information about the SA program. A Human Trafficking Task Force and hospital leader noted the impact of a person with lived experience providing such education: “...but having that training from a survivor is very different than if a non-survivor were to offer that same information and education. Their expertise, their experience brings life to a subject that sometimes people still believe isn’t happening in our community. [ID 16] She further described how the training occurred:

“I’ve brought them into huddles where they can answer questions for staff. They’ve helped to kind of guide our education for our staff as well, for general education as well as kind of the focused or in person, having them round through the department and really interact with the staff.... talk to them about who they are and their position, what they do, and then again answer any questions that they have. [ID 16]

Task force and hospital leadership at another hospital echoed the account of introducing SAs to hospital staff and allowing them to provide informal education. “We have some education sessions along with those survivor advocates for our departments. I helped them do a table in the cafeteria, socialize their presence, introduce them to our taskforce members, introduce them to the staff on different units, and then help them to provide education to the staff.” [ID 24] Leadership at a third hospital discussed similar opportunities, noting, “You need to hear things from the person who is doing the work. Then you need to hear what they’re doing and how they’re doing it. Why they’re doing it. It’s very important.” [ID 28] Another leader shared the impact of the SAs’ sessions on health care providers.

“You know just yesterday we had a meeting with some physicians... the physician was very honest and he said, ‘Sometimes I think that human trafficking happens way over here, out there, out there, and I forget that it’s right here in our community.’ So, when we have our survivor advocates rounding on the different units, giving talks, you know, whether it’s to the staff or we’ve had them speak during human trafficking awareness month, or providing education, it makes a big difference.” [ID 14]

Front line staff appreciated education provided by the SAs as well. “Just being educated on it, you know, like it’s definitely helped me open up my eyes and things that I don’t even know that existed in cities or locally here, and how impactful it really is, you know, and how often they can be liked dismissed. So, that education component was very helpful.” [ID 11] A seasoned nurse shared:

“Going to conferences and different things, I had heard about human trafficking and how to recognize and how to identify if somebody might be or is high-risk to become a trafficking victim. But I think working with the advocates, I got to see a whole different side of it...I’ve learned so much from them...about some of the subtle red flag signs that I could pick up on. Things that I never would have thought of in the past, I now know are consistent with trafficking labor or sex trafficking... They have taught me, and I’ve been able to identify some of the earlier signs and I’ve been able to maybe also give the resources out to people who aren’t identifying as a victim, but who seem to have some of those red flags.” [ID 27]

Other staff also reported learning from the SAs’ accounts of people who experience trafficking.

“One of their stories is going to get stuck in a provider’s head and they’re oh like the provider said this, my advocate told me this story, oh my gosh this person is being trafficked, let me try to investigate. Knowing more of the signs or the unusual things that we wouldn’t even look for because...sometimes we get stuck in the process of being a nurse... asking this medical question that we sometimes miss that [social history] piece.” [ID 07]

This social worker used what she had learned to engage a patient who had been through the hospital system many times before, but continued to present with the same problem: “...we had a woman who came here for five years with STDs and no-one thought to question why. And so I finally questioned her I’m like I notice you come here for a lot of STD related checkups and they are preventable. And so it turned out she had been trafficked and [SA] was able to help us with that.” [ID 07]

Staff gained understanding of why people experiencing harms like human trafficking often do not share that information with healthcare providers, preparing them to better understand and serve their patients.

“We’ve been educated many times that even by the survivor advocates themselves based on their own experience that they’ve come to the [hospital] many, many times and never disclosed. And they explained to us why they wouldn’t disclose what’s been happening to them or be open to services. So, we know it’s part of the process.” [ID 04]

Notably, one social worker reported how an SA made an insightful clinical observation. “And when the advocate noticed, ‘Look at her heart rate as soon as she touches her phone’-- and to me it was just she’s touching her phone, she’s texting something small like that, and it turned out that she was actually getting text messages from the perpetrator.” [ID 08]

## CBO Perspectives

In this section viewpoints of CBO staff are provided related to the SA role and SA value to the CBO.

## Survivor Advocate Role: CBO Perspectives

Staff from the two community-based organizations involved in the project also held solid opinions about the benefits of hiring survivors as advocates, including specifically for work with healthcare agencies.

One supervisor crystallized the value of SAs doing this work:

“Having someone who has had the experience of trafficking, can relate, can understand how the patient might be feeling in crisis I think helps a lot in terms of being able to build trust and rapport with a patient. Because I think that's where we could oftentimes as providers lose people, potentially... I think there's that first step of someone feeling comfortable enough to be able to say yes, I might have had this as my experience and yes, I need help. I think that's where the survivor advocates really have something invaluable to contribute in terms of their experience, in terms of their skills, in terms of the ways that they know how to work with people. And I think that's something that you can't really write down in a resume, but it is something that is super invaluable and it allows for all the work afterwards in terms of connecting people to services, making sure that they get help for their different needs. It makes it possible. That initial linkage makes it possible to do that work.” [ID 19]

The ability of SAs to develop quick rapport with patients in the hospital, which was appreciated by hospital staff, was understood by their CBO supervisors. “It just really goes to speak to that again, that rapport, which I think is key as you're trying to help support a client. It allows you to also discuss the safety concerns or the risk if they potentially choose to go back, for whatever reason, that lifestyle, that home, that individual.” [ID 20] Supervisors noted the value of the connections SAs could create with other survivors due to some commonality of lived experience:

“It is one hundred percent valuable...I've been with this agency 20 years as I said and I've responded to a lot of situations and I've been with people with lived experience and responding with them and I see the difference, it doesn't matter how good I am it's just that immediate connection to the client that is so invaluable. It's night and day.” [ID 13]

“I definitely think it's different insight, different experience, sometimes even a different level of advocacy. I think due to lived experience you truly understand that it could be a cycle where it just takes longer than your typical person... it's really having that insight and knowing it could just take clients a few more steps to exit it.” [ID 20]

Interestingly, while hospital personnel specifically, highly valued the lived experience that SAs brought to their role with patients, CBO leadership at one agency described how, in order to provide better coverage to respond to healthcare agencies, and integrate work among different staff, the role of being an advocate in the healthcare space had become more interchangeable among those with and without lived experience.

“...recently in the past year the integration has been the strongest with the Survivor Advocate and the rest of the team in that they can take shifts from each other. Their jobs aren't as distinct. If someone is out then someone else can step in the hospital really easy, but she has also covered for other advocates. So, they have a stronger working relationship because they're seen as advocates in not necessarily separate programs, just with separate expertise with hers being healthcare and everyone else being like law enforcement and other things.” [ID 18]

However, hospital staff did not necessarily perceive the response by the CBO when the SA was not on call as equivalent to when an SA was available. Only two interviewees described “calling [CBO]” for assistance with patients, while the others all mentioned calling SAs, using their names or saying that they reached out to “the survivor advocate.”

“It's different when you get, when we call the community programs when we have an HT [patient] usually when someone is not on call, the [SA] is not on call and we just get a regular community response person from any of the nonprofits, the personal attention they get from that [SA] is significantly different than what they would get from someone who is coming from the community who has a caseload of 20-30.” [ID 03]

### Survivor Advocate Value to CBO

CBO staff shared examples how the SAs made substantial contributions to the efficacy of their service provision. Whether it was making conscientious changes to protocols, screening tools, or shifting perspectives (e.g., increasing staff awareness of the impact of trauma), CBO staff clearly indicate the SA made a significant impact on the CBO's approach in working to assist people in human trafficking situations.

Two CBO lead shared a procedural benefit to their organizational operations being informed by SA as a result of the SA's initiative to create a new protocol and an improved intake form:

“Yeah, she came up with a whole protocol as to how to respond and she came up with her own intake form. Obviously, we have an intake form but she had adjusted it to what she was doing and the information that she needed... she came up with how she was going to respond, what she was going to bring, what she needed, it was like very detailed...I think that she took the ball and ran with it... of course we have protocols as an agency, but this is a brand-new program and she was experiencing it herself, and she did a really great job of coming up with her own protocols. She of course would run them by me, and she was bringing it, that's a real gift...” [ID 13]

“There is [sic] a lot of things that have been streamlined in the past number of months since our survivor advocate has been in place. Like I said, some process improvements that we brought to the full collaborative and being able to do even more meaningful data collection which we are providing lots of details now being able to do that in that way.” [ID 01]

Below, leadership from two different CBO organizations presented other examples of their positive engagement with SAs:

“She has a number of skillsets that designated are really great for the role and were able to dive into that. And collaborating with her has been honestly one of the easiest things I have to do in my current role and job and position. She is somebody who is a self-starter, she knows the role and she has her own ideas and innovation for things.” [ID 01]

“I’ve just looked back on some of the services that she’s provided, and you know it’s a lot, she’s done a really great job with the patients that she’s had. She’s done substantial work with them, just considering the mental health problems, the substance abuse problems, she’s done a great job in moving these clients forward. I was looking at some of the outcomes and it’s really some great stuff.” [ID 13]

“I love working with [name] She is amazing. She is such a great advocate for her clients...She's been a great leader with our clients but also with outreach to other providers. She's trying to expand the knowledge of human trafficking and always trying to connect us with other agencies just to see how we could collaborate.” [ID 20]

One agency leader further described the SA’s contributions to the organization’s group dynamics:

“It’s always sort of an open forum when we do case conference, you know, who has any issues they want to discuss, who has any ideas they want to put out there... I think it helps everybody to have that survivor voice in there. And you know she’s not the only one but you know there’s always some great insight that she does have.” [ID 13]

The CBO supervisor mentioned above also described the SA “has helped to change systems even at our side as well, some processes. Again, her skillsets that she brought to help us with our data collection and things like that. We have implemented from the Survivor Advocate, so she has been a great entry and fully integrated with us.” [ID 01]

Indeed, both agencies shared they made concrete efforts to fully integrate the SAs into their agency team, “I wanted her to be fully integrated and having a full team of support not only on the clinical side but also on our side.” [ID 01] Given the COVID-19 pandemic resulted in many CBO staff working from home, the CBO supervisor continued sharing it sometimes required additional effort to ensure the SAs could engage with other personnel and develop connections, “She was integrated in the CBO team as well... we usually schedule everything on one day so staff meetings and professional development and making sure she can be a part of that as well.” [ID 01]

Program leadership at the other CBO described,

“... in terms of how I been collaborating with [name], when she notices challenges or gaps in terms of our services, whether it's how can we provide better handoffs to more service providers, has been really great about flagging that with her supervisor...And we’ll actually come together as a team to bring in other team members to kind of talk through these issues and work out next steps and things like that.” [ID 19]

Discussing the former SA who worked on the pilot project, other CBO leadership shared information about the limits of team integration at that time, which the CBO attempted to address during this OVC-funded phase of the program (as described above):

“And then that person [the first SA] attended most team meetings in terms of the case manager meetings, emergency response meetings. They were integrated into the team in that capacity, but their role was always separate, because none of our advocates are able to enter the hospitals like the survivor advocate is. So, any healthcare calls, we have like a tree. I did a flowchart tree for hotline calls and everything healthcare goes straight to survivor advocate as



opposed to other members of the team. So, that hotline call, the tree, flowchart was what was most outward facing to the rest of the team on the differentiation of roles.” [ID 18]

### Survivor Advocates’ Perspectives

For this section, the primary focus is to explore the first-hand SA experiences and assessments related to their role as a survivor advocate. When discussing their roles, SAs focused on the importance of supporting people experiencing trafficking and offering them choices. “I want to be able to be there and support them and just give them those options. I always present them with those options that they will have to make that decision for themselves. And just being able to point them which way to go.” [ID 17] “I enjoy getting to help people on their path to a better life that is really key. So, I enjoy connecting with those different people at different points in their path.” [ID 02]

Both advocates noted that a key part of their role was their ability to quickly establish rapport with many other survivors:

“Well I am very honest and very actually with other survivors you always have the idea that you are a survivor and if you tell people that that creates that automatic connection just like you would if you were dealing with somebody that had attempted suicide and you had attempted suicide, you have that natural connection when somebody says I have that experience then the other person goes oh they know what they are talking about you know. So, we have that natural connection.” [ID 02]

They explained their role in educating hospital staff, noting that they enjoy it. “I enjoy doing training, I enjoy connecting to people like doing outreach for [CBO] or the program and just kind of telling them about the journey of survivors and dispelling myths.” [ID 02] One SA shared how she uses her own experience to educate others.

“I use my story a lot to teach people about trafficking that is a way they are going to remember it more or use other stories without identifying factors to explain how they can recognize it or just even the complexities of dealing with trafficking survivors and not to be discouraged if they don't seek help the first time because you know it took me four times before I would tell anybody my story you know. And so, it takes a number of times and being in a safe place before you can really often tell somebody your story so things like that where you just explain it in a different way that people can understand.” [ID 02]

The other SA especially appreciated the opportunity to work with health care providers:

“I love working with healthcare because they bring on a whole different aspect than what I'm used to, like working with case managers and stuff. They're coming in as physicians. And you could just tie-in that the trauma that we live, tie it in with your body and everything. You learn and I'm just so amazed working alongside physicians. I learned from them as much as they learn from me. That part of the grant I love. I think it's amazing. [They] are eager just to not only treat your body component but the emotional part that comes with it.” [ID 17]

Many other examples were shared indicating various positive impacts and substantive contributions related to the SA program. Next, we turn to exploring interviewee experiences related to the integration of SA into the healthcare setting and working collaboratively with hospital personnel.

## Hospital and SA Integration

As mentioned prior, leadership and Human Trafficking Task Force members introduced SAs around the hospital departments and provided opportunities for them to engage with health care providers in various disciplines. They also included them in meetings. Hospital leadership and staff discussed how the SAs were integrated into their daily work.

“...When situations arise, we immediately think about the survivor advocate because we know they’re the experts, not only because of their personal experience but because of the training and connection that they have with their organization... We have this amazing layer of support from the survivor advocate who we know, we trust, they’re part of our team, and they’re readily accessible, and they’re just amazing to work with.” [ID 14]

Hospital leadership shared the ways that a relationship with the SAs benefitted nurses: “...having emergency department nurses feeling more confident not only about the identification, but also, once they have that relationship with the survivor advocate, is feeling the ease of reaching out to them when they need help.” [ID 24] A social work supervisor also noted the ease of the process. “We call them. We give them a brief of what’s going on. They know, you know, they’ve already been like oriented to our hospital, to our teams. So, they know where to come, where to find us, what are our processes, what information we can give them. So, it’s been a very smooth connection actually.” [ID 04] Leadership in another hospital also shared their process:

“So, if somebody determines that they see an individual that might be a suspected person that...could be traffic[ked], that is being trafficked, we try to get that person aside away from their individual and educate them about the survivor advocate program. If the individual agrees, then we give them the survivor advocate program phone number. We call the Advocate. The Advocate can either come here to the hospital in person and talk with the individual or talk with the individual over the phone with the aim of getting them away from their trafficker and into a safe haven and a safe place.” [ID 28]

Social workers provided more details:

“Social work staff is not 24 hours a day, so if there's something urgent or emergent, they call who's on call, and we do our normal process. We contact CAST and then we keep the patient safe until the morning when we can get an advocate out or CAST to follow up and let us know what the plan will be for the patient.” [ID 15]

“Yeah, we have like a flow chart so we knew when to call [the SA] ...once would identify someone who we thought was a potential risk then we would definitely bring her in, so it flowed just fine, it wasn’t complicated, the whole hospital knows the drill... Because of Covid things have changed and so our safe room isn’t available anymore, but we still follow the same

protocol which is to let our staff know, our nursing chief officer and then we go from there, security and whoever else.” [ID 10]

A nursing leader commented on her surprise at how readily staff would access the SAs. “So, that was really surprising to me because, sometime when it's an outside agency, people are reluctant to reach out. But by knowing that this was truly to help them out and help out the victims, we saw a great adaptation.” [ID 24] This openness to work with SAs likely reflected that staff appreciated how well the SAs collaborated with them when serving patients. “...[SA Name] actually helped out a lot because I explained what I needed to explain and then there was parts I didn't even need to explain because she already understood it, so that made it a lot easier, because she understood the severity of the issue, and she understood what she needed to do....” [ID 08]

Another social worker shared how the collaborative effort with SAs improved the provision of trauma informed care:

“So they just jump in right with us. We introduce them and they just take it over from there. So they don't have to start from zero again. There's no assessment criteria for them. So they don't have to sit there and, you know, go over things with them for another hour. Like who are you? Where are you from? Who abused you? None of that. It [doesn't] needs to be done anymore. So it's definitely a collaboration because if we start the work and then they carry it through. And then we just collaborate together in terms of a safe discharge plan and follow up care for the patient. [ID 04]

Finally, one hospital leader summarized the symbiotic relationship between health care providers and SAs in helping patients who are experiencing trafficking:

“...we're their first entry point and we need to make them feel safe. And the Survivor Advocate program then comes in behind us and really takes that person and takes them through the system and takes them away and takes them to a safe place. That's something that as a hospital we can't do. You know, we don't have those resources. We don't have those tools. So, somebody needs to be trained to be able to be their survivor advocate and to be able to interact with that individual in the way they need to be interacted with at that particular time. So, it's an extremely important program.” [ID 28]

In this prior major section, we covered the various perspectives of the survivor advocate role in the healthcare setting, CBO setting, and shared the perspectives of the SA role by the SAs themselves. In this next major section, we turn to the organizational impact focusing primarily on exploring benefits to hospital staff, benefits to patients, and contrasting healthcare staff experiences when an SA is not available.

## Theme 2: Organizational Impact

The second major theme explored below illustrates advantageous aspects of the SA program, with a focus on the benefits the SA program conferred to hospital staff and patients. Additionally, interviewee

excerpts are provided contrasting experiences of having an SA provided compared to not having an SA available.

## Benefits to Hospital Staff

Hospital staff experiences related to three main areas are explored in this section: SA education of hospital staff, reducing the work burden of hospital staff, and aiding hospital staff in coping with patient ambivalence.

### Education

As noted previously, hospital staff greatly benefitted from education the SAs provided. Some social workers shared how they gained knowledge and/or confidence from engaging with the SAs. “I felt kind of confident that I grew from the beginning when I was calling her out with maybe somebody that didn’t want help yet and I think I grew in understanding who is trafficked, how to ask the questions to assess and who wants help.” [ID 05] They shared what they had learned about how to engage with patients they thought were at risk for trafficking. “Besides what happened to them... I try to get some more sense of who they are. Ask about their lives; were they ever pressured, do they have family... just having them feel like they’re somebody. This person came in who was hurt... but ask what do they like? Do they like music? Or it could be, use my phone.” [ID 22] They appreciated how approachable the SAs were and learned that more patients were eligible for supportive services for human trafficking survivors than they previously had realized.

“...she’s just a great advocate to be available to say ‘Sure I can speak with them and access them to see if they are candidates,’ even times when I thought they may not qualify [to meet the legal definition of human trafficking] There were definitely things that helped them qualify that I had no idea so it was great working with her...” [ID 06]

“I think just by interacting with advocates and just open up my eyes and just like literally it can be anyone and there isn’t a type and even men as well. Just to pay attention to everything: words, body language, if they’re appropriate, how they’re behaving, if they feel withdrawn, like tattoos, just reading the environment, body language, just reading everything.” [ID 11]

Leadership appreciated how the continued presence of the SAs led to professional growth among staff, supplementing standard didactic training methods:

“When it’s done on a consistent basis, it definitely improves because, again, it’s the little huddles that occur between the advocate and the staff, the one-on-ones, teachable moments, and the staff can say, “Well, what made me suspicious is this,” and then the advocate can validate that she was right – she or he was right about being suspicious about the – whatever. And I think that’s more powerful training wise kind of – it sort of reinforces behaviors and So, I think it’s well more effective being able to ask your one-on-one questions.” [ID 25]

### Knowledge of Resources

In working with SAs to support patients, one of the benefits shared by many hospital staff was having someone familiar with up-to-date community resources who knew how to direct patients to these resources and suggest others as appropriate. “I reached out and the advocate definitely helped out... the advocate definitely provided her resources and told her you know we can get you to shelter.” [ID 08].

“They can draw out more of the questions to get the patient qualified for the black and white system that we have with certain agencies, either you aren’t or you are trafficked. Or they may have a magical word to qualify them, or the magical knowledge that I don’t, because I don’t work within human trafficking alone and interact with all these agencies that they have conversations with and say hey you know, actually, by the way if you ask your patient this, and this, and this then you can get in.” [ID 07]

### Reducing Work Burden

Hospital staff perceived the SAs as team members who could help decrease their workload while improving patient care. As two social workers from different hospitals and different departments explained: “Like I want you to see five patients at the same time I’m handling this very intense case, so to have someone sitting there that can advocate for them, and just see a real human being who has been through it maybe they would be more focused.” [ID 07]

“...we don't always have the time to devote to the patients that they may need. So, for me to be able to have someone there who was like a team with me, who could pick up where I wasn't able to with not only their experience but their expertise in a field that I'm not always necessarily very clear on, I found it very helpful to have that educational piece, not only for the patient but for myself.” [ID 15]

A social work supervisor at a different hospital concurred:

“...each social worker has a minimum of two units so their load is very heavy. And when you have a human trafficking [patient], you know, it does require a lot of time to sit with them. Do an assessment with them. Reassure them. Their story is very sensitive so you want to give them the attention that needs. It will take hours sometimes working with someone like that. So, to have additional support step in and help with the safe discharge really helps our social workers because they have so many other patients to see in one day in addition to that HT patient that they may have in the emergency room. So, it’s been a great supplement to our program and to our social work team.” [ID 04]

### Coping with Patient Ambivalence

Hospital personnel also discussed how working with SAs allowed them to better understand why patients experiencing coercion and trafficking may not want or accept offers of assistance, and also to cope with the negative feelings that can arise when patients make decisions that healthcare providers do not think is best for them. As one leader described, “Anybody in the helping profession is always disappointed when somebody doesn't accept the help that they so desperately need.” [ID 25]

“I think it’s difficult anytime you see, to help somebody and they are just not ready to take it...And one of the things that staff struggled [with] before was they want to help somebody, but the victim didn't want help. Right. They're not in that space yet where they accepted their issue and they're ready to seek for that help, and they felt very frustrated that they couldn't do anything about [it].” [ID 24]

The SAs’ success in communicating with healthcare workers about why patients decline assistance and reframing their understanding of success with these patients made a significant impact. Numerous staff noted how the presence of SAs could benefit even patients who were not ready or willing to accept assistance for their situation by providing support and information even to patients who were not ready, establishing the hospital and/or community partners as safe places for them to seek refuge in the future. A social worker explained, “I think even if in the moment if they are not ready to accept services, or want it, I think at least speaking to somebody who has lived it and can help them see it from the other side, even just helping to plant a seed.” [ID 06]

“...I think just having a human being there is immensely powerful and it is very comforting for me as a clinician to have them there, because as I said we have a lot of our own feelings related to this that we didn’t do enough, or we couldn’t get them to get safety. And it’s good to have someone who can listen to us and debrief immediately after the case and that’s really nice when they’re here... sometimes as a social worker and the staff we want safety more than the patient wants it, and you can start feeling very like disheartened if you have someone who can’t guide you and have the ins that you don’t have.” [ID 07]

The presence of an SA to meet with patients provided staff reassurance that they had done their job to the best of their ability, by connecting patients at risk with valuable support. As one social worker explained, “...we do our due diligence, we do everything we think we can do, but that’s the ultimate... I knew I did everything I could do because there’s, you cannot do any more than bring in somebody who has experienced trafficking and put them face to face, this person saying I can help you and then if they make that choice not to get that help, that’s their, that is their choice, so I knew I did everything.” [ID 05]

## Benefits to Patients

As shared by many interviewees, SAs provided a variety of benefits to patients. Providing support to hospital staff enabled multiple enhancements to patient safety, support, and resources. Similarly, SAs contributed to meeting the needs of patients, including support for patients experiencing challenges related to substance use and mental health. Changes were also evident in interviewee responses pertaining to perceptions and attitudes of hospital staff related to serving and understanding experiences of patients in human trafficking situations.

## Enhancing Safety, Support, and Resource Availability

By supporting hospital staff in their care of patients, the SA program contributed to helping and protecting patients. A nursing leader explained:

“I think the program is designed to support these individuals, helping them have resources when they leave this protective environment. Because our [hospital] environment is a very safe and protected environment for them<sup>2</sup> because we can really shield them from a lot while they’re here, with their permission, of course. So, I think it’s a lifeline, a layer of support, and resource guide for them.” [ID 21]

Another nursing leader at a different hospital expressed the value of SAs to patients:

“These advocates really step in. They come here in person. They bring resources. They interact with the patients. They support them mentally, physically, and in any way that they can, which is really critical. Even if the patients aren't quite ready to move into any shelters or things like, you can at least provide them secretly with resources and material so that they can reach out when they are ready, or if they become ready. [ID 16]

A variety of hospital leadership and staff reported that the compassionate peer support SAs provided benefited patients in a unique way. A social worker shared she believed patients were reassured and increased help seeking when she told them there was a lived experience advocate available to meet with the patient, stating, “I noticed once I mentioned she can help you and then when they spoke, she kind of felt a little bit more reassured, like this person knows what I’m going through and that made her more inclined to get more information and seek out the help.” [ID 08] Another social worker explained, “Folks who are coming from a sensitive and a vulnerable situation, knowing that they have somebody that can be compassionate and understanding and help is certainly beneficial to patients.” [ID 23] A nurse and a hospital lead, respectively, noted:

“I think it’s the healing process and having the survivor advocate let them know that it’s okay to speak, and what’s going to happen if they tell somebody and what to expect is helpful. That’s helpful in having the survivor come forward, but also just part of their healing. I don’t expect that just because we call a survivor advocate that we’re going to get the whole story right then and there. I think it’s a start.” [ID 27]

“I think the advantage is that it's peer-to-peer discussion and many of these victims are too traumatized and have been especially – ones that have been in the role for a while or been in the life for a while, they're so traumatized that they don't know – they're reluctant to accept help. And I think it it's helpful to get the survivor advocate in to talk to them and because they've been there, they can fully empathize, and they're more likely to be able to convince the victim to accept services than perhaps anybody else.” [ID 25]

Another social worker believed that the SAs’ lived experience enabled them to help patients in a way that she could not:

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<sup>2</sup> Note: patients, and specifically survivors of violence, may not necessarily perceive the hospital environment as “very safe and protected;” rather they may find it intimidating, frightening, uncomfortable, or anxiety-provoking. One patient served during the pilot project had intense fear of medical settings and was served in an administrative office to avoid entering the emergency department.

[Palmer PK, Wehrmeyer K, Florian MP, Raison C, Idler E, Mascaro JS. (2021) *The prevalence, grouping, and distribution of stressors and their association with anxiety among hospitalized patients*. PLoS ONE 16(12): e0260921. <https://doi.org/10.1371/journal.pone.0260921>; Vande Streek M. (2016) *Characteristics of patients who experience fear during hospitalization*. Honors Thesis, Lee Honors College, Western Michigan University. [https://scholarworks.wmich.edu/cqi/viewcontent.cqi?article=3740&context=honors\\_theses](https://scholarworks.wmich.edu/cqi/viewcontent.cqi?article=3740&context=honors_theses).]

“If I was working independently with this individual, I would say it’s somewhat out of my scope. I’m not educated enough to understand what they’re going through. I could say I think I know, but I, the truth is I don’t know, and I think that they are so bothered in that their minds are, you know, they’re so traumatized and they don’t think clearly, but to know that there’s somebody there who has experienced exactly what they are currently experiencing makes all the difference in the world.” [ID 05]

A social worker shared how SAs strived to meet patient needs, even when patients were not yet ready to accept/receive the assistance, “...I think the only barrier with this specific patient was she just wasn’t ready yet. So, she kind of was, then she would get scared because [the] advocate did offer shelter and then offered to, I think it was, provide transportation, she just needed to be at a specific place or she needed to meet her at a specific place and the patient just wasn’t ready.” [ID 08]

The overall message from hospital interviews was that the presence of SAs enhanced patient care and safety through their knowledge, access to resources, and dedication. As summarized by one social worker,

“[The SA] has that expertise of knowing what the traffic [sic] victim needs. And our staff have learned a lot too in that regard, however again that level of expertise and the connections that they have in the community is priceless and valuable for our patients...One of the main aspects I think of quality of care is that human to human interaction and some of that can’t be measured by particular health outcomes or standard metrics that we use in the hospital. But the truth is that the survivor advocate had the time and motivation and experience to sit with the clients throughout this whole process... I definitely think that increases patient care, that is what patient care is, is having that one on one attention for as long as we can give it, even over the course of multiple days if you need it, and that’s something that the survivor advocate provides and it’s a huge benefit to patient care. It doesn’t necessarily show up on any metrics but it’s certainly there.” [ID 12]

The collaboration between the hospital system and SAs based in community-based organizations facilitated positive outcomes, helping patients to overcome their reluctance or ambivalence, and seek assistance.

### Meeting Patient Needs

Many interviewees discussed how SAs enabled the hospital team to better meet patients’ needs, expounding upon themes described above regarding their role. For example, the SA’s presence on site enabled patients to become more comfortable in the challenging hospital environment, “They do need that attention initially especially coming to the hospital. It’s such an anxiety provoking process to begin with for any person, let alone if you’re escaping a dangerous situation.” [ID 04]

As noted above, the rapport SAs developed with patients enabled patients to more readily ask for help or accept services. Two interviewees from two different hospitals shared their perspective on a patient story. The patient originally declined assistance from the SA, but not long afterward reached out for help, illustrating the powerful impact that a conversation with an SA can have, even beyond the initial



encounter. Describing the nurse who had contacted the SA and was upset when the patient declined help,

“And she [the nurse] suspected that individual, and she talked to her [the SA], and you know nothing happened... She accepted his basic patient choice. But then, when we told her a week later that that individual showed up in another facility and in the emergency room she handed the card to somebody and said, please call this person for me. So, we told her that, and it's like, it worked.” [ID 28]

The second interviewee added, “I feel like after speaking with her, he became more open and willing to accept resources and he even left against medical advice, went to a Sister hospital, And then when he was there, he asked for her.” [ID 06]

Interviews also revealed SAs benefited patients by providing improved access to basic needs, including housing/shelter and transportation, as well as other services. As one of the SAs pointed out below, it is important to be flexible and adaptable given the various needs for each context and every survivor, which can vary from basic needs (e.g., housing) to more specific assistance (e.g., counseling, legal help):

“So, yeah you need to be able to adapt to the different context and also that goes with survivors too. You need to be able to look at this survivor and talk to them and find out what they need and every survivor is going to be different. There are going to be things that are the same. Most of them are going to need housing and basic needs, but then some need counseling, some need legal help, some need help with court cases so yeah you need to just really find out the needs of each survivor. Some need T visas or that kind of thing.” [ID 02]

The SAs' integration into discharge planning provided support and sensitivity for patients in need of housing, often a fundamental requirement for them to leave a trafficking situation: “If the survivor advocate's involved, it's usually more successful and the connections are made. But if we don't have a survivor advocate there, we have run into some situations where it's difficult to find shelter.” [ID 27] The SAs also demonstrated to hospital personnel that survivors needed appropriate housing placements and they would try to ensure that safe housing was identified, even if not immediately upon discharge. “But she does a good job there too, she'll keep in contact with somebody, she's not going to put them in a hotel, not going to put them into emergency shelter, because they won't make it.” [ID 13]

Simple services the SAs provided could have an important impact on patient outcomes. One social worker explained, “A lot of our patients are homeless including our trafficking victims. And so, resources for clothing and monetary resources have been really helpful for them.” [ID 09] Another recounted an episode where a patient was unable to find shelter, but the SA was able to procure transportation for the patient:

“I came in on the weekend, so I was kind of handed off what had already been started with [a] patient. And unfortunately, there was just no option. She needed a place to stay. And through the efforts of [SA name], and my own knowledge of places to call and contact, there was no availability for her, for a place to go. But [SA name] did provide her an Uber to a location where the patient wanted to go.” [ID 23]

Community-based organization staff recognized the flexibility and engagement of SAs to meet these patient needs. CBO staff also shared the organizations' attempt to meet patient needs while also

acknowledging challenges in their efforts to do so, "...I do think that between CAST and Journey Out and some of the other providers that we're working with that the immediate crisis support as far as food, transportation to a safe location, some of the cases on relocation, things like that, I do think that our agencies are able to meet those needs but I think the challenge will continue to be housing." [ID 19]  
*Note: We focus on the challenges of housing later in this report.*

An interviewee at a CBO shared how the SA was an integral part of connecting the patient to basic needs and legal resources:

"[The SA] has really stepped up and utilized that more of having that as being able to improve patient care. Letting people know you are following up on them, you are getting discharged today or you are leaving the hospital today and she's been really good at saying let me give you some additional support which is connecting them with housing, connecting them with transportation assistance, food assistance, legal assistance and helping them like I said do their restraining order." [ID 01]

Interviewees across all roles recognize the importance and challenges in meeting the basic needs of patients of human trafficking. SAs uniquely contributed to this process in ensuring patients' immediate needs were met, creating the stability that is fundamental to any attempt to leave a human trafficking situation.

### Supporting Patients with Substance Use Disorder and Mental Health Problems

Interviewees described it can be a struggle to work with patients with substance use disorder and to find placement for them, but that SAs provided key support in these situations. A social worker provided insight how SAs can be supportive in helping patients find programs and services to aid with their recovery: "So, some of them are under the influence. They're still using drugs. So, we need to make sure they get the proper services in terms of substance abuse programs. So, the HT survivors are very good at finding a program that can help them with that along with a secure, safe place to stay... [ID 04].

She elaborated:

"So, it can be exhausting being interviewed several times and they can get declined many times either because of drug use or what they're doing. But to have the survivor there helping them and saying, I secured a place for you already. You just have to interview. It makes the navigation through the system much easier for them. I think especially the ones with substance abuse history because it's very hard to get into a program and the interview is very crucial so that's been helpful." [ID 04]

A social worker at a different hospital reported a success story:

"...one of the cases that I had with [SA name] we had a young lady who was a suspected trafficking, but also substance [user] unfortunately. When she left here they were able to get her into a program that did like a dual diagnosis program. I don't exactly remember where it was, but it wasn't within L.A., and we just kept her here in our emergency room overnight. Then [SA name] coordinated transportation to get her to the shelter." [ID 15]

Hospital staff with experience related to substance use treatment also shared their insights related to Adverse Childhood Experiences (ACEs) and their professional approach to how using this information better informs and aids the benefit of patients with substance use issues:

“...a lot of them have – or some of them, actually, have been trafficked but certainly they've all survived ACEs in childhood and things like that. So, I think you – the in-person sitting down with them and saying, ‘Look, this is a brain disease. This is not your fault. This is result of the abuse you got while you were a child and this is the way you cope with it because you didn’t know any other way to cope with it. And when you stop using drugs, the nightmares come back...” So, just being able to sit down with them and talk about it in person makes a big difference.” [ID 25]

Substance use contributed to staff challenges related to expressions of patient mental health issues. Below is an example provided by a social worker where an SA provided them beneficial guidance related to a patient with a history of mental health concerns who needed help with her substance use:

“...a patient who came here from another country, and family is like looking for her everywhere, and she did have a mental health history and substance issues, and she was kind of manic at the point. But, I felt like she was using drugs to numb her pain. And if you really take the time to connect with her, she was a very vulnerable soul and that’s gone through a lot of trauma. And when I was consulting with [SA name] it was kind of like...refer her to county clinics as she was not appropriate to be following up on her own.” [ID 11]

The SA mentioned in the situation above shared their perspective and understanding about the beneficial value of resources related to both substance use and mental health, stating, “...clients need a variety of resources, there is just a lot of things to learn and things that you only learn by experience like this client needs a sober living house or this client needs you know has more mental issues that need to be dealt with first or those kind of things that you only find out like how do we help this kind of person by experience.” [ID 02]

Again, we see here having access to an SA increased opportunities to appropriately address patients’ substance use and mental health problems. Gaining access to such supportive programming is essential to regaining autonomy and exiting a trafficking situation.

### Changing Hospital Staff Perceptions and Attitudes

Hospital staff recounted how working alongside SAs softened their perceptions and attitudes. They became less judgmental toward patients engaged in the sex trade, who in this project were the ones most likely to be considered at risk for trafficking. In the context of these interviews, it was sometimes difficult to ascertain if staff understood the difference between sex trafficking and consensual work in commercial sex that was not compelled by force, fraud, or coercion, but their more enlightened perceptions benefitted patients regardless. Again, they observed that patients felt more comfortable when the SAs were involved in their care:

“I think the staff in general...because you learn about how people get into those situations, and sometimes they were just trying to get a life, get going, get money, or take care of family, or what not...You become definitely more compassionate and understanding, and the staff I think

have less judgment for patients having learned the background and more about it, and being able to apply it to actually help our patients as well.” [ID 16]

“I think growing up I thought it was a choice and I never, I was I don’t know ignorant I suppose, I just yeah I never—it never crossed my mind that someone can actually be kept against their will. And I think when that—and I learned a little bit about it, I mean they talked about it in grad school...But it wasn’t until actually I met someone in real life with a real story that I was just blown away, I couldn’t believe it. So, absolutely it changed my view completely and just a need to be more compassionate and more understanding and know that it’s not a choice, you know, like who wants to live that way.” [ID 10]

“...I definitely think it was beneficial, they felt understood, they felt like—they didn’t feel judged, if anything, like you know, whenever I would bring it up and say ‘hey you know we have someone here that can help, she’s been in a similar situation,’ and immediately was like, ‘yeah, I want to.’ Hardly ever did I get a no, I don’t think I ever got a no, so absolutely I think it was beneficial. I think our patients needed that.” [ID 10]

“I was working with a young lady that was identified as a victim. I was doing her exam; she had a difficult time talking to me and talking to law enforcement because we didn’t know what she was going through. And she had asked me that, she asked me if I’d ever experienced what she was experiencing, and I couldn’t tell her yes. So, I think that it’s so beneficial to say, ‘Although I haven’t, I have somebody that can understand what you’ve been through more than I can.’ And bring them in.” [ID 27]

The aforementioned social worker admitted that working with the SA increased her compassion. “Yeah, definitely I think from working with her I think it really again made me see this whole situation in a different light. And I think it was just I’m a lot more compassionate to someone who potentially is going through or potentially is exposed...” [ID 10]

### When Survivor Advocates Are Not Available

As evidenced above, SAs were heralded by hospital staff as absolutely crucial in providing patients with trauma-informed care and essential resources. Often, interviewees contrasted their experiences serving patients with the SAs and their experiences without SAs. A nurse manager’s candid statements below exemplified their frustration, which captured this contrast succinctly:

“So, yeah, like since we haven’t had her,<sup>3</sup> it’s like trying to deal with the social worker. The social worker doesn’t know what to do. Not that she doesn’t know what to do, but trafficked victims require a special type of care especially the pediatric ones. Right. So, it was just – it didn’t go – none of those cases went as well as the previous cases [working with the SA]. So, I don’t like that the fact that we don’t have a person now.<sup>3</sup> And it makes no sense especially in this demographic. We work – we’re in Downtown LA, like come on.” [ID 26]

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<sup>3</sup> This interviewee was not aware that after the original Survivor Advocate left, two new ones were eventually hired. This interview occurred many months after the second advocate was added to the hospital response.

“Now, I don't know what we're doing. I'm just call the social worker. Like I don't have time to be calling some crazy hotline. We need a dedicated person. This is crazy.” [ID 26]

Social workers shared similar contrasts that recognized how they depended on the SA services. Without SAs, connecting with patients diminished, as did the quality of attention and care provided: “So, if we take away the advocate, you know, I think it would be a loss because we are going to feel the void because now we are so used to it and it has been so helpful.” [ID 03]

“But when you don't have that [SA] and it's lacking, it's more chaotic for the patient. They have to trust what the nurse is saying. And the nurse has other patients that they're also working with. The doctors are in and out. Emergency rooms are very busy. A lot of times you don't have much privacy. You don't have your own private room. It's just a curtain that's dividing you from the person next to you. A lot of these people are being watched. They're being, you know, traced. So, there's that level of vigilance for them so when you have someone there physically, I think it really does benefit. And unfortunately, for this patient, we didn't have. And she ended up leaving with a lot of negative feelings and not getting the help she needed... But we saw the difference. You know, when the survivor is not there to hold them and help them and carry them through to a safe environment. So, there was definitely a noticeable difference between someone who has someone there versus someone who doesn't.” [ID 04]

A nursing lead described a situation when SAs were not available.

“We have specifically had patients that are in the ED that are being trafficked, and also they are here with injuries from being assaulted in their sex trafficking relationship, I guess, and we didn't know what to do. We didn't know what to do with the patient. We didn't have a safe place for them to go. We waited actually until the next day.” [ID 16]

From the description of this case, it seems that an advocate was able to assist the next day. Nonetheless, without weekend coverage, and during the months that no SAs were available to respond because of COVID-19 and then personnel transitions, healthcare providers often lacked options to offer patients, even when the day shift arrived.

CBO staff also recognized this contrast in having an SA present versus not having an SA present:

“And, even though a survivor advocate isn't going to fully understand everyone's experience, because human trafficking is an issue that there's so many different experiences that could happen, we have seen more positive responses from clients of just talking to a person who understands as opposed to talking to an MSW student with a clipboard. The vibe is different and is better, generally, for a lot of our clients, for somebody to be able to make that connection via lived experience. It also gave us the ability to talk to clients who weren't fully ready to leave.” [ID 18]

Above are only a few poignant samples of various interviewees sharing their observations of the contrast between the involvement of the SA versus no SA involvement. The organizational incorporation of SAs provided considerable positive impact and benefit to patients, and to healthcare providers.

### Theme 3: Challenges and Growth Opportunities

Despite the clear benefits of the Survivor Advocates in Healthcare program, some challenges emerged during the project period, providing opportunity for improvement and growth. In this third major theme we broadly examine challenges and growth opportunities in hospital, community, and CBO contexts as shared by interviewees. An extensive examination focuses on the CBO context related to the SA role. Then a wide range of recommendations are presented that were shared by interviewees applicable to both CBO and hospital contexts, followed by evidence indicating the SA program achieved the expected programmatic goals. Lastly, suggestions are provided to inform implementing future iterations of the SA program.

#### Hospital

In addition to two interviewee responses highlighting opportunities for hospital staff to be more focused on trauma-informed care, two primary challenges related to the hospital context were observed: concerns regarding SA program implementation in hospitals, and limited understanding and identification of patients experiencing labor trafficking.

There were some interviewee responses that suggested that despite the CommonSpirit system's effort to educate health care staff in the provision of trauma informed care, the delivery of trauma informed care was not consistent. One particular response illustrated an instance where a social worker noticed hospital staff lacked sensitivity around a patient's self-presentation:

"Yes, like she was a very pretty girl, and she was very flashy also and being in that industry of being provocative a lot of the staff were kind of looking at her inappropriately it was kind of visible also. And I kind of noticed that and they would make remarks or kind of like you would see security walking by and kind of like laughing, you know, so just be more considerate of our patients, you know, and their vulnerabilities and more sensitive." [ID 11]

Similarly, an interviewee at a CBO shared their dismay related to some health care providers' lack of understanding of the long-term impact of trauma on mental health:

"I think a lot of people don't understand what trauma really looks like, severe trauma, you know, I mean they just think oh it's mental illness, okay in a way it is but it really is trauma it's not like you know, schizophrenia, it's not bipolar, they're traumatized individuals and I think people can't spot that, they just want to put some label to it. So, that's beyond their scope, you know sometimes it's so bad and seriously I have worked in this field for 20 years, if someone doesn't get therapy, if someone doesn't deal with the trauma that they have suffered, it might turn into you're hearing voices, it turns into that seriously." [ID 13]

#### Hospital Implementation Concerns & Logistical Issues

Interviewees shared gaining access into hospitals and staff turnover were two primary issues related to implementation and logistics. Not being a formal hospital employee provided challenges resulting in delays for SAs to gain access to hospitals. Additionally, staff turnover presented its own unique contribution to impeding the planned SA program implementation.

### Delays in Getting SAs into Hospitals

One unique feature of the Survivor Advocates in Healthcare program is the access that SAs, as external CBO staff, gain to hospital patients. The process of credentialing the SAs to work on-site in the hospitals, however, was a long process. One of the SAs shared their frustration with the process, “The hospitals are really slow in the onboarding process. It took me like three months to get my first badge and then I think it was like almost six months before I got the last badge so just a long process. A lot of hoops to jump through and there are four different hospitals that we service.” [ID 02] CBO leadership believed this process could be streamlined, “...a lot of these onboardings are the same across the hospitals, they may have a different requirement that might be one or two differences, but can we take all the documentation from the one hospital that you are confirmed and send it to the second one instead of having the survivor advocate start over from Point B and Point C again and again. It can really become a delay that took a couple of months.” [ID 01]

In Spring 2022, as the SA was still completing the process to be on-site at all four CommonSpirit hospitals, the CBO supervisor noted:

“I cannot wait till we can be fully more having her on site a bit more. I think that would help but right now having her virtually there and still getting the number of referrals she’s getting... we are still trying to streamline that referral process and sometimes I am getting called or text messages from the hospitals so I know she is getting these calls and referrals so it’s definitely a benefit. The fact that there are people looking for that advocate and reaching out for the clients they have identified or patients.” [ID 01]

At the time, the SA expressed acceptance about the situation but was eager to learn more about the work she was specifically hired to do:

“...I’ve felt like there was a context that I just didn’t quite get that is part of my job that I will I guess now kind of figure it out together. That is why [hospital staff name] is going to take me and [other SA name] together to the hospitals to kind of show us around so we kind of have an idea of what we are trying to do when we just walk around and talk to the staff.” [ID 02]

### Staff Turnover

Hospital personnel also noted that it could be challenging to optimize the benefits of the SA program given the level of staff turnover, especially in light of the crises of the COVID years, which led many people in nursing and other healthcare professions to leave their jobs. Two hospital leaders, based at the hospital where the first SA had spent most of her time, described how turnover necessitated ongoing staff education about the program and the issue of human trafficking among patients. When

asked how to improve the program, they both encouraged more ongoing interaction between the SAs and hospital personnel:

“...unfortunately, during this period of time there's been a lot of staff turnover as you you've heard about. All the hospitals have had terrible turnover. So, you may have a person who has gone through the [CommonSpirit HT training] modules but really hasn't had any personal experience dealing with a victim and doesn't know the resources available, doesn't know really all the things that CAST has to offer in terms of the attorney, the educational programs, the referrals for social – various social and psychosocial, mental health support as well as housing. So, that's one of the downsides of the turnover is that they're not well-schooled in what what's out there whereas before, when [first SA name] was there, everybody knew because everybody heard about it every day but – or almost every day. So, it was top of mind... And I think we should go back to that because I think that's very powerful and helpful and, because we have such staff turnover, it can't help but make some new people more aware.” [ID 25]

“I would ask them to use as much as they can and continue to create awareness within their departments because one thing that we do experience in hospitals...is rapid turnover. I mean, it's up to 45% turnover in staff. So, you may have all these newcomers that are coming in all the time and it takes time for them to learn those things. And so, I would say the leadership in the hospital should truly concentrate on including some of this education, training, socialization of the role at the front end, just so that everybody's who's onboarding is learning about those roles. Then they're going to be using it. But if you're not comfortable, and if you haven't met the survivor advocate, you're in orientation, you may not be asking for help... share that information in staff meetings maybe, you know, on monthly staff meetings saying, “Hey, we had a case this month. You know, here's a survivor as a kid.” She would give you a quick review of what happened, how it was identified. Maybe that's a teaching moment. So, partnering with them to come to the staff meetings, I think that would be a great idea.” [ID 24]

Turnover of the SAs also created challenges, as one interview revealed that not everyone who utilized the original SA to assist their patients knew that new SAs had been hired. Upon learning that a new SA had been available for most of the past year, this nurse responded:

“Yeah, like I don't know who this person is. I thought we had no one? Like, you know, I was like, oh, she's gone. We have nobody. Like that's how I started off this conversation like since she's been gone, it's been sad. Because if I – if we had a person that I knew about, I wouldn't be – for those other three cases, I wouldn't have been calling social work. I would've been calling the actual trafficking [advocate].” [ID 26]

A hospital lead also recognized the need for better promotion of the SA program.

“I think one thing I've noticed is we need to really make sure that the program is always out there, and we constantly have to remind people you know that is there. Because it's kind of a small program that does a big, a lot of work and it takes it takes a lot to you know make sure that they're constantly out there that we're constantly reminding people that they're there. So, that's kind of where I see always at a constant push that we need to do, but once I know once the nurses understand, and it's engrained they use it like that nurse in L&D. She got it. She understood it. She heard it. She knew what to do. So, it's just like a constant reminder.” [ID 28]



It is not clear that all relevant hospital personnel were updated or informed about the Survivor Advocates in Healthcare program, potentially leading to underutilization of SAs during this grant period.

### Labor Trafficking

Hospital personnel shared minimal information about labor trafficking, though each interviewee was asked about it. Some in leadership believed they were ready to address labor trafficking in the patient population, as this person explained:

“...When the education was happening for the staff, we were not just focusing on one kind of trafficking, it was about all kind of trafficking and labor trafficking is included as part of their education. There is even the resource manual that was created with the help of [first Survivor Advocate] and our Human Trafficking Task Force, where you have agencies that are listed, where you can reach out for different kind of trafficking help.” [ID 24]

No other participants expressed any understanding of labor trafficking nor described interactions with patients who may be experiencing it, except for one social worker, who astutely encapsulated the challenges of identifying labor trafficking in the hospital setting:

“When it seems like we might have a patient who could be a victim of labor trafficking, it’s a little more nuanced because at least in the times that I have suspected it, it’s been males. They don’t speak the language, and they don’t give you much information. They don’t say where they live; they tell you they’re staying with a cousin. That everything’s okay and it’s fine...usually when I’m here, it’s in the emergency department. So, when these folks are coming in, they don’t give you much – they just want to go, and they’ll tell you the cross streets that they want to get to, kind of thing.” [ID 28]

In some instances, it could be that some hospital staff do not understand how common labor exploitation and labor trafficking can be in a major metropolitan area (like Los Angeles County, California) as where there are many low wage workers, immigrants, and other potentially vulnerable people, there is often higher risk for both sex trafficking and labor trafficking in the population:

“I don't know from the numbers perspective how many more victims were identified just for the sex trafficking. That’s something you could probably look in the data, but it is overall awareness no matter what kind of trafficking it is. And being in downtown LA, I think we see more cases of sex trafficking than any other kind of trafficking just because of our location. So, it definitely contributed to knowing those indicators or those symptoms and being aware and be ready to get help.” [ID 24]

Despite the low levels of hospital staff identifying people who may be experiencing trafficking in industries other than commercial sex, the SAs seemed ready to respond to this population. One of the CBOs involved in the project typically serves survivors of sex trafficking and sexual exploitation, but not labor trafficking. Nonetheless, the SA employed by this agency, whose lived experience was in sex trafficking, educated herself and felt comfortable supporting survivors of labor trafficking.

“I have worked with labor trafficking, actually two now, two of the clients have been labor trafficking survivors and I did do a lot of training on that and research on that. Like I said I love

research so whenever I find a gap in my experience or understanding then I start researching stuff.” [ID 02]

### Systemic/Pervasive Issues: Substance Use, Mental Health, and Housing

Staff at hospitals, community-based organizations, and SAs also contended with various intersectional challenges. Substance use disorder, mental health struggles, and housing were three pervasive and consistent challenges shared by interviewees who aimed to assist people escaping human trafficking situations.

In some instances, substance use may be the one primary presenting issue, as a social worker shared a conversation with the SA:

“...I know from over the phone I could just tell her ‘hey the patient’s really aggressive. I’m not sure if it’s meth,’ and she’ll say ‘yeah we see it.’ I think for providers too because they see it just hear ‘hey it’s trauma’ it might not be entirely the meth, it can also change, I guess how they feel or interact with the patients because I think most providers are kind of up to their ears with meth use and the results of meth on our patients that we see here.” [ID 07]

A lead social worker shared example of how substance use disorder can create barriers to patients accepting help for a trafficking situation:

“Well, I mean, a lot of them are addicted to drugs too and I see so much of that in the homeless population, that nothing matters. They come in, they want help, but the drugs speak louder, so what I’ve seen is some of, it’s hand in hand. For the limited knowledge that I have on trafficking, I do think a lot of them are provided with drugs and it plays a role or they just get scared of someone actually helping them, even though they want it, you know.” [ID 05]

CBO leadership also described intersections between trafficking and substance use disorder, noting how these patients can be perceived only as people struggling with addiction: “Oftentimes these vulnerable patients they learn to cope to survive in unhealthy ways whether it’s through alcohol or they were put into that category, and then they become addicted and many times they’re just seen as just like drug users and it gets dismissed or people don’t really see the vulnerable parts.” [ID 13]

A social worker at the hospital also described this dynamic:

“A explained I think I’ve done this long enough that I’m mindful of educating our staff as things occur as well, if I notice like interactions with our nursing staff and our patient. Because a lot of times our nurses are jaded, unfortunately, because they have a substance patient and they’re treating this patient as just a typical substance patient. Whereas, if there’s other triggers that are identified, or risk factors that are identified, then we have to handle it a little bit differently.” [ID 15]

In some instances, as shared by social workers, mental health conditions precluded the possibility of addressing the trafficking situation, because patients were not stable: “...if [patient] mental health is so pervasive, or they’re suicidal, homicidal, that takes priority over getting them into a shelter or the advocate to be able to help.” [ID 15] Another social worker described:

“We had one patient who was completely manic, and just was not alert enough to participate. I’m not sure what trauma, experience happened, but she wasn’t able to – but it was to the point where she couldn’t function, not changing clothes... just not there to be able to communicate with us. And to actually give consent to anything, really, because we weren’t sure she was understanding what was being presented to her.” [ID 22]

As shared by nursing leadership, these concerns resulted in extensive barriers, depleted resources, and frustrated staff who want to help, but functionally cannot:

“...the one challenge with mental health is that the resources are fairly limited because it’s sort of a hands-off approach to someone who is admitting with psychosis or has a diagnosis of schizophrenia. That seems to be a barrier for some people. Sometimes we’ll have a willing participant, but because they’re taking medication and they have a psych diagnosis and if they were hospitalized for whatever reason, sometimes the resources available are not – they’re leery, or they just flat out deny assistance.” [ID 21]

Another hospital leader noted the intersections between mental health problems, substance use, and the need to treat underlying issues in order for patients to leave their situations:

“...getting them high quality mental health is key if we're really going to really help them in the long run because most of them – most of the substance abuse is coping or it's – they're started on it by their pimp to make them be dependent on him. So, yeah, that's a problem but I think if we do a good - if they get high-quality mental health services, then they can sort of resolve both issues.” [ID 25]

Even when patients want help for substance use disorder, resources may not available for them.

Another social worker explained,

So they [SUD treatment programs] do have criteria based on the type of drugs that they have been using. When was the last time they used? Have they been clean for like 10 days or whatnot? So they do have criteria to accept someone. And a lot of these individuals have not been clean. You know, they’ve been using recently before they came to the hospital. So where do you send them for a few days to meet the criteria of these substance abuse programs? Sometimes, they say they need to be clean for like three days or four days or five days. You know, that’s not feasible. It's not possible especially if they're out on the streets. So that’s been our challenge; the criteria are not practical to what’s really happening to our patients. [ID 04]

The social worker continued, “So that’s where the HT advocate has really been helpful. Sometimes, they can help with hotels and a safe place for the patient to stay until they meet the criteria to go to a substance abuse program.” [ID 04]

“Unfortunately, not all patients presenting with substance use concerns, mental health issues, or in need of housing were able to be helped. One nursing lead noted, “We do see some that are able to get resources, but then some that due to just their presentation, their illness, there’s not anything we can do for them.” [ID 21]

An experienced hospital leader provided an account of an unfortunate event with a such a patient:

“...we had a victim who was on a psych [hold] and unfortunately – and so she was sent to a psychiatric bed but they – even though we told them what her issue/situation was, they discharged her back to where she came from which was not what they had originally agreed to do. They were supposed to notify us when she was ready for discharge and then [CBO] was going to step in at that point. So, that's another problem in getting to – making sure that when they are put on a hold, psych hold, that when they're ready for discharge either the survivor advocate is called or somebody from [CBO] called but somebody who's going to look after – make sure the patient has the appropriate triage at that point. So, this was a sort of a disaster, the patient ended up – and she had been willing to accept services. That was the other sad part of it was, even though she was pretty out of it and suicidal and all, she was – I think she sort of reached the end of the rope and she was willing to accept services but she was discharged back to her situation.” [ID 25]

Housing is one of the systemic issues shared by many interviewees as a major barrier to supporting patients impacted by trafficking, even in the absence of substance use or mental health problems. A few interviewees described how shelters would need to interview patients before accepting them for placement, resulting in a lack of trauma informed care as survivors had to repeat their stories over and over again to different agencies to find an emergency bed: “The biggest issue is shelters and the process of it, it's also they have to speak to the patient; they have to get the information and them having to speak to multiple people.” [ID 06] Others described basic lack of availability:

“That would be the biggest challenge, the biggest barrier is you know finding shelters, and not even necessarily like sometimes they would even... get to the point where the shelter was [not] able to like interview or assess or screen our patient over the phone because there weren't any shelter beds available.” [ID 09]

“There are not a lot of shelters that are for just women and children. And they're small. You know, they fill very, very quickly. So, that is a need. And I have heard that is a need in the community.” [ID 28]

“I came in on the weekend, so I was kind of handed off what had already been started with that particular patient. And unfortunately, there was just no option. She needed a place to stay. And through the efforts of [SA], and my own knowledge of places to call and contact, there was no availability for her, for a place to go.” [ID 23]

Patients trying to leave human trafficking situations who had mental health needs faced additional barriers to placement.

“I mean I guess I had hopes that they would be able to help our patients with like housing and shelter and things like that. That has been difficult, that has been a challenge because of our population and that there seems to not be a lot of experience or knowledge base in the shelters for people who have severe and persistent mental illness. Their needs may be too great for the shelters that are available to them.” [ID 09]

Leadership at the CBOs also described challenges faced in securing appropriate placement for patients leaving hospitals with mental health or substance use issues. “We continue to see a challenge around, in particular, supporting clients with severe mental health needs in terms of trying to find adequate

housing options for them. That's something I think many providers are really struggling with. So, I think in particular for patients with severe mental health needs or for patients who have children, I think the housing piece is something that really is a gap." [ID 19] The interviewee also noted,

Another CBO lead described efforts to address this, describing challenges faced by the SA she supervised:

"Some of the challenges I think that she's run across is that there's a lot of mental health issues with clients and substance abuse, and the severe the mental health the more likely you're [not] going to be successful working with the client. You know if it's not seen to first, then how do you address everything else, the same thing with substance abuse. And so I think that's a big challenge that she's run across. I think they're dealing with it now coming up with the way of connecting to agencies that do deal with the mental health issues... these clients have as well as you know connecting with substance abuse treatment centers and detox. So she's been doing that recently." [ID 13]

CBO leadership expressed the desire to serve more survivors with housing support, "So, I would say in an ideal world we would have a nice safe house that accepts everybody. But that's not something that we have. We have a shelter but it only accepts certain types of clients." [ID 18] Another CBO leader explained the complications of contending with serious mental health issues of clients seeking support at a shelter. "Someone who can't traverse their life because of mental health issues is not going to make it in the shelter, and that's just really unfortunate." [ID 13]

However, one of the SAs provided their insight regarding how some CBO staff perspectives may also be advertently preventing placement or maintenance of patients in shelters. She described how survivors who wanted help but faced substance use or mental health challenges were not treated with enough patience or understanding by other CBO staff. In this instance, a survivor who had surrendered her child to the Department of Children and Family Services and stopped using drugs so she could be placed at the CBO shelter was found pacing in the yard after hours and was subsequently discharged from the program:

"...the stories [I hear] – they just don't add up to especially when a client has voluntarily given their child up to DCFS, that tells me a whole lot about my client, right. My client is really accepting, does want the services, was willing to give the child up to DCFS in order to get the services. And then, once they get to the shelter, I hear a whole different story. That, to me, just doesn't really add up. I know that things are going to come up with the client. I totally understand... and I, myself, having that lived experience and knowing how hard of a situation it is to give up your child, right. Being trafficked and giving up her child and asking me – saying, "Hey, I need the assistance." And just going to a place and then they're just like – maybe because you have that addiction part of you and you're not that content at being in your room and you want to go to the yard. And that, to them, it's like, oh, that's mental – just a mental [health problem]– going on and, 'We can't support that,' instead of them saying, '...why don't we give her those resources to getting mental health or on medication to calm her anxiety down.' They just come up with all kinds of weird stuff and discharge the client. That, to me, is really – not being trauma informed and sensitive to the client." [ID 17]

She added,

“I really feel that there needs to be more sensibility to some of our survivors instead of [CBO staff] just trying to overanalyze them for not being able to qualify because of [CBO] protocol, how [CBO staff] assess them to go into the shelter, there is no perfect client that's going to come in off the street. There is no perfect client that's going to be able to be in four walls when being out there in the street their last eighteen years. And so – once they start finding that this client is too much for them, they just find whatever reason it is not to continue assisting them and I don't think it's fair for the client...” [ID 17]

This SA believed the CBO’s criteria for allowing patients served in the hospital into the shelter were too strict, and that she had to advocate for her clients with her colleagues, often to no avail. “I feel I'm just advocating to my staff within my organization, just trying to get them to be more sensitive to my patients' needs. Just trying to get them to understand that not everybody that comes off the street is perfect and just because they're taking medication they're not capable of staying in a shelter.” [ID 17]

One CBO lead provided comprehensive commentary incorporating all three aforementioned challenges, particularly for patients with medical needs related to behavioral health:

“I would say the gaps are substance use. We are not a detox program and that can be a real barrier. And there are no human trafficking organizations that have a combination of detox program and human trafficking. They're always separate programs, which is a huge barrier because a lot of human trafficking survivors have issues with substance use. And so that can be a barrier. Also, just really high mental health needs is a barrier. So, a lot of times human trafficking survivors will be in the behavioral health unit, and they will have very high mental health needs that require a high level of support that a nonprofit does not provide. So, someone can't come into our housing if they need constant supervision or if they cannot feed, clothe, and bathe themselves. So, there is a high population of clients in which we are not the service provider for them and sometimes it can be difficult to find a type of assisted living that is trauma informed and that does understand what human trafficking is.” [ID 18]

In another instance, another social worker remembered attempting to procure housing for a patient which could have been less traumatizing to the patient if shelters were more forthcoming at the outset in their lack of availability, “I understand why we have to do this intake, but they’re telling their horrific story over and over to several shelters only to be told I don’t have a bed, why don’t you just say it in the beginning, so they don’t have to tell this terrible story.” [ID 07]

## Improvements and Changes from Pilot

Following the pilot project, which ended in early 2020, CommonSpirit and CBO staff adjusted the protocol for the Survivor Advocates in Healthcare program. Interviewees discussed their experiences with the current iteration of the SA program compared to the SA pilot program. A hospital leadership interviewee indicated the most notable change: increasing the number of SAs from one to two, “It's nice now that we have two [SAs], because it covers a little bit more of the hours. So, having that and then having the on-call services that have been added in, I think, over the last year, year and a half, they've actually grown the coverage and support that we have, so that's been sufficient.” [ID 16] While on-call services through the CAST hotline were available during the pilot project as well, findings from that

evaluation indicated that many hospital personnel utilized the SA's cell phone number and did not know that a 24/7 hotline was also available.

For healthcare staff familiar with the pilot SA program, there was much appreciation expressed for the provision of an additional SA and extending the amount of coverage in the hospitals from days to also include evenings. Additionally, many healthcare staff shared in their interviews how they would like to see the program expand coverage further because the program helped with both educating staff, identifying patients who may be in a trafficking situation, and also providing connections to community resources for their patients via the SAs. Two social workers' perspectives are shared below:

"I would just in terms of us, I think we're progressing in a good speed. I think the program started well with our first advocate and we saw that it was successful. And we saw that it's doing great for our patients. So, now that she left, we got another one and on top of that we're getting an a.m. and p.m. shift coverage which is great. Because a lot of them do come after hours. So, I think we're onto the right path of growing it. You know, it's been several years, but it's been great to see it blossom. And it's been great to see how it's been helping our patients. I think we should continue on developing more that it becomes standard of care for every hospital. Every source that I think a lot social workers would benefit from it at every hospital." [ID 04]

A social worker and a nurse also appreciated the extended support and availability into the evening shifts compared to the availability during the pilot program:

"...it's nice for those who are working the late shift to have that support so we can continue to do this really important work and to have them as our partner is trust me I think all the social workers, ...we love our advocates, we think that they are such a great gift." [ID 07]

"Before, it was a little bit of an issue because there was no evening/nighttime response. But that's been taken care of, so yes, they're able to pick up the phone, call and text and definitely get somebody that's available." [ID 21]

Other changes to this OVC-funded program cycle related to CBO support and structure for the SAs. One challenge identified and improved upon was that the first SA felt that she lacked sufficient back up from CBO colleagues. For example, if she was struggling to find placement for a patient on a Friday evening and her shift was ending, she often felt she had no one to turn to, and perceived that her choices were to continue working – typically without compensation – or to abandon a patient to routine hospital processes, which would typically leave the patient without any good options. The CBO took concrete action to remedy this situation in the continued SA in Healthcare Project.

"So, our 24 hour emergency response team knows how to cover the survivor advocate role. So, the survivor advocate says it's 2 PM on a Thursday and am done, like I need out, there is somebody to jump in. That can be really hard for most CBOs to do. We are huge. We are massive. We have a lot of staff. And it still even a struggle for us to make sure there's coverage everywhere, but that was critical so that they did not feel like the weight of the entire program rested solely on their shoulders, that they had backup." [ID 18]

The CBO also acted to strengthen boundaries and work-life balance during this phase of the project, after these issues were identified as problems during the pilot.

“...we're building in the right systems, so the person has boundaries as far as their work time and their time to really commit to their self-care and also their workload. And I would say as an agency, I think in the last year we've made a number of changes to this role to make it easier for the person in the world. So, doing things like communicating out, like writing out protocols and communicating out dedicated work hours in terms of when the person is actually on call; making sure that the survivor advocate has time for admin duties so that they're not responding out five days a week but they have dedicated time to do work from home as far as following up with clients, doing service reporting, things like that; and then also the big change I think especially from the pilot years was really also making sure that as much as we do want the survivor advocate to be present in the hospitals that they're not based out there full time, that they are able to work from home or from the [CBO] office so that it's not them traveling to hospitals five days a week.” [ID 19]

One of the SAs was appreciative of the boundaries her supervisors established:

“What I really appreciate about her is that she is just very clear like there is no, she is just very clear in how she communicates and so and she would always tell me ahead of time if there is something I needed to know and she is very good with you know knowing what the position is about and like maintaining the lines of the position you know. And so telling me the hospital isn't, this is your shift from 3 to 11, if the hospital calls outside of that you don't have to answer you know and so I appreciate that because it's in these kind of positions it can be a very boundaryless position but she is very good at taking care of me in that way just saying this is the position we created and these are the boundaries and you don't have to go outside of that.” [ID 02]

Another notable improvement discussed the creation of an employee group at the CBO comprised of fellow survivors. This group provided the opportunity for CBO employees to share any personally triggering experiences in a safe space:

“Something that's new that we've done that I'm super excited about, and this is just in the past couple months, but we've actually started [CBO]'s own lived experience steering committee, which is all of the staff with lived experience meeting monthly to give feedback to upper leadership. And that's across programs. So, it includes a survivor advocate, but it also includes the legal fellow who has lived experience. It includes our survivor leadership program manager. It includes our training manager who has lived experience. So, we all meet in a closed space once a month to talk about what is it like to work at [CBO] and have lived experience and how can we give feedback to upper leadership on changes that they need to make to make this a space where more survivors want to come work. And that has been, by far, the most successful thing...A lot of survivors are afraid of giving honest feedback and the way that it's received, coming across as unprofessional. Or it's somehow docking them as a professional to talk about 'hey, this is personally triggering for me.' That maybe professionals don't talk like that. Because you don't see examples of professionals in the workplace talking about being triggered. That's not a thing. So, how to frame that, how to get that across. We have a safe space now to do initial processing and as a group, how do we frame this and all this stuff?” [ID 18]

It is important to state one of the most notable changes from the pilot study was the impact of COVID on the SA program, which is evidenced by one of the SAs, “I think that the structure of the program or



the position is really good. But...because of the pandemic and everything that connection with hospital staff has been a little more distant..." [ID 02] and mentioned by hospital leadership:

"...I started right before COVID. So, the survivor advocate we had – whom I heard amazing things about, and what interaction I had with her was amazing – but with COVID she was kind of pulled out of the in-person setting. But she was still available for telehealth and assisting in those ways, which was great, because we were kind of all left with a lot of missing factors with the COVID pandemic." [ID 16]

A CBO leadership interviewee elaborated,

"I don't think you could really talk about the program without talking about the pandemic at how that's really changed the program, especially over the last year and change. Many hospitals had to redirect their priorities, they had to close down units to visitors, and it became a lot more difficult to respond in person and also build those relationships for training and outreach opportunities. I will say that with COVID numbers going down and healthcare centers becoming a bit more open, I think that's been less of a challenge this year. But I will say that it was a challenge especially earlier in the pandemic." [ID 19]

Another CBO lead explained how the agency adapted the program to the times:

"One of the biggest things that we changed is that the way the role was written is that every time a client from the hospital calls the survivor advocate runs out to meet them. We actually changed that during COVID, obviously, because hospitals were like, 'We have a lot to do. We cannot have you in here.' And so, we ended up doing remote responses, which is like video chats and calls. And the initial advocate, [name], mentioned hey, this is better for my capacity." [ID 18]

The CBO lead continues further about SA remote engagement:

"The remote response is faster for the nurses and ultimately that does make them happier. Because we can be like, 'actually this person was not trafficked.' We know that after a 10-minute phone call. 'You did identify some red flags, but they're actually red flags for a different crime. And here is the agency you can call now.' Or we'll be like, 'This person does not want help. They do not consent to this. I understand that you want them to get help but you have to discharge them for that is what they want. There's no mandated reporter things we can do here. We have to discharge them.' So, it does speed the process up. Other than like we waited two hours for the advocate to get there, because it's in Long Beach, and that person is like 'Yeah, I don't want to talk to you. Okay. Goodbye.' This bed could have been available two hours ago. So, as a whole, it's pretty good." [ID 18]

There were some additional improvements ranging from additional clarity to the SA position to decreased response time by phone (countered by fewer in person interactions). For instance, the same CBO leader mentioned above, who worked with the SA in the pilot, shared their perspective of the program relative to the current SA program:

"...I worked alongside our first survivor advocate and her role at that time wasn't super clear, but that was in 2019, early 2019. So, during the first year, between 2018 to 2019, there was a

little bit of unsure-ness about how that role would be fully integrated. But by the time I [joined CBO leadership] we had actually come up with a written working plan for how that person would integrate into other teams and what would be different and what would be the same compared to the rest of the emergency response team.” [ID 18]

## Challenges: CBO Dynamics, SA Role, and SA Impact

Much like in any workplace, organizational dynamics can shape the collective experience and also differentially impact individual employees. The dynamics of striving to achieve the goals of the Survivor Advocate Program are presented in this section, with interviewee perspectives exploring organizational dynamics at the CBO, sharing experiences, insights, and concerns of SAs and CBO supervisors and leadership. An in-depth focus on one SA’s challenging experiences is provided. We also discuss staff-suggested growth opportunities for CBOs.

### SAs Working with other CBO staff

Supervisors at both agencies discussed the importance of providing support to SAs in their role, “I mean if you have a whole team behind you and the resources that you need, that’s an important point too, you have to have that and you have to be set up for that.” [ID 13] One of the SAs also shared how great the program experience was because of the variety of exposure working on the team provided, “It’s been a great experience. There’s like about 10 other team members and they just [have] a wide variety of experience so I am always trying to find the expert on anything I need help with and there is a lot of expertise, so I really appreciate that about that team... I feel like it’s a very cooperative team that just seeks to support each other. And is always available to answer questions or give insights.” [ID 02]

According to the other SA, working in the survivor advocate role provided opportunities to work closely with other CBO staff, but also contributed to challenging experiences. Particular concerns were shared related to how the SA felt she was treated by CBO staff, how the hospital patients who became clients were treated by CBO staff, and complications related to shelter screening processes and placements.

Overall, the SA shared she felt supported by leadership at the CBO, but not necessarily by the people she worked more closely with. When asked about what it was like to join the CBO as staff, the SA shared, “...upper management is great. Upper management, I feel like I have their support. With lower staff, I don’t feel supported. Sometimes, at times, instead of them assisting me, for me it’s like criticism helps me grow. I don’t feel their support at times.” She added, “I think they need to be more trauma informed and sensitive when it comes down to me as a survivor myself and when I speak for some of my clients. I feel that my coworkers, some lower management staff, I feel that they’re not trauma informed or sensitive to some of the clients, some of the survivors requesting services...I feel like they’re very biased to a certain degree, especially with the shelter staff. There is no perfect client coming from the streets. It actually takes a client about seven times to actually get it. It took me seven times to actually get it.” [ID 17]

Expanding further, the SA shared her seemingly frustrated feelings in wanting to be a voice of, and serve, patients/clients in need, but finding a lack of engagement and support from some of her CBO colleagues:

“So, it’s just like any job and I feel that sometimes there isn't that support...there is some of those in the room that actually not all. I could just count on my fingers and stuff. There is some that listen to the advice that is given and vice versa. I listen to their advice that they’re giving me. But I feel that there is a lot of work to be done [...] I'm here to make a difference in another survivor’s life. I'm not here for no one to really like me. I would be great to make new friends, new colleagues, and learn from them, but I'm actually here to be that voice for other survivors coming through our doors, right. It would be nice, but I mean the way that it is now, I don't feel that I have that support at times [...] I feel like I'm not there to challenge them and I feel in some type of way they feel like what I’ve got to bring to the table is it's not the way their policies are written down [...] and then when I kind of challenge them, they throw a lot of like educational stuff...” [ID 17]

The comments provided by the SA above contrast with the position shared by CBO leadership, who expressed that the organization had modified practices to better incorporate SA feedback, including eliminating the requirement to meet with an attorney before getting services:

“So, we changed a lot of things for this role. The survivor advocate said that they felt that our legal intake was too much for the clients. That they were witnessing, because we have our attorneys ensure that clients meet the federal definition of human trafficking to get into services. And the survivor advocate was like I hate this. [...] We trust your judgment. Here's the intake screening questions that the attorneys use. You can modify them. And so, creating a loop in which the survivor advocate feedback could be solicited and then implemented was the biggest thing. So, they had to see transparency into action. And that was the biggest thing that helps us build sustainability and trust with the survivor advocate.” [ID 18]

Given this contrast, it is evident there may be opportunity for the CBO to better explore the relationship between the approach of CBO staff and their impact on the SA. Aware of challenges CBO staff and an SA had encountered in developing an integrated working relationship during the earlier phase of this program, one CBO leader reported:

“There was this desire to make sure that case management meetings and case review and common spaces with advocates with that lived experience, that they felt like they understood how to talk about cases. Like do you talk to an advocate with the lived experience differently than you talk to other advocates that you know don't have lived experience of trafficking? So, there was I want to say organizational and interpersonal adjustment periods around, because there are tons of employees with lived experience at [CBO] but not in the direct service field. All of the folks with lived experience were on the advocacy level. And doing organizing, training, policy, but not direct service. So, that was new. But that quickly dissipated once there was the

In the next section, a more careful and thorough exploration is provided related to an SA’s challenging service provision experiences at one of the two CBOs.

## SA Frustration/Friction with CBO in Supporting Patients/Clients

Additional consideration provided by the SA suggests thinking beyond the contribution of an advanced education, and even beyond the experience provided by the length of time in the field, but underscores the importance of emphasizing being trauma-informed and sensitive when assisting people in this population:

“When people are not trauma-informed, not sensitive. You can be in this field and work in this field for quite some time and have your bachelors and your masters degrees, but not be trauma-informed. That's heartbreaking to me. Because in front of people you say you're trauma-informed but when you work alongside a survivor that actually went through it and not be trauma-informed, that's... heartbreaking to me.” [ID 17]

In the context of placing clients in the agency's specialized trafficking survivor shelter, the SA reported, “Sometimes I just have to let them have their say. But as a survivor for myself I feel that we're not doing enough. And sometimes it is heartbreaking just to be able to see that they have their set of thinking and I can clearly see that it is not trauma informed. They're not sensitive to the patient. And sometimes it is hard. I could just communicate but I can't change their way of thinking. I can just choose the way of how I go about servicing my patients. So once I see that their guard is up, I just perceive it. Okay, move on to the next shelter.” [ID 17]

As result of these experiences, in some instances the SA chose to remain silent in meetings and case reviews rather than appear as though they were challenging CBO staff, “...so most of the times when I am with my other coworkers, I just – I don't really say anything. I just stay quiet because it's like I just I don't want them to feel a certain way and I don't want to challenge them in any type of way.” [ID 17]

However, the SA described how in the presence of upper management, some CBO staff presented themselves as supportive of their opinions, but when upper management leaves the room, the CBO staff revert to their previous, dismissive engagement with the SA:

“I feel we definitely need more sensibility to some of our clients, sensibility in the way that you have your opinion and I have my opinion and just find a common ground for it. And I think that in the public eye where my supervisor sits and they come in and they join the group, I think that they do that in front of the supervisor. They do – they communicate perfectly, they – but once they're out of the meeting, it's like they just go back to their old behaviors, right, like the way they thinking. It's more like... I don't want to say it but it's like when like someone tries to bully you just because I have this education and I just want it to be done this way and you're just a survivor and that's just who you are.” [ID 17]

Even though CBO leadership may have the intention, expectation, and execution to provide a supportive and engaging environment within their organization, the follow-through may not materialize in practice. Evidence of this is shared by an interviewee in a leadership role at the CBO, who described exactly what the SA reported:

“It has to do with creating pathways for feedback that pull feedback as opposed to just waiting for it. And then also making sure that that feedback gets to leadership and doesn't just stay with that person's one supervisor. Because I would say that's a common thing I see as well. A survivor

will come into an org, they'll give a ton of feedback, but it will get kind of shut down or it will stop right at that level and it will never really go up the chain or go up anywhere." [ID 18]

Despite steps the CBO had taken to better structure the position, including the creation of the lived experience committee, the SA also shared, "I feel I have more support out in my community other than having internal support within [CBO Name]." [ID 17]

The SA further perceived that a lack of trauma-informed service delivery impacted the clients she served, "I think they need to be more trauma-informed and sensitive when it comes down to me as a survivor myself and when I speak for some of my clients. I feel that my coworkers, some lower management staff, I feel that they're not trauma-informed or sensitive to some of the clients, some of the survivors requesting services." [ID 17]

The SA also stated, regarding her clients, "I feel that I would have a better outcome if I had more of a survivor supervising me, because they're more trauma-informed, and I feel that I would have way more support." [ID 17] She explained that she had previously benefited from the support of a supervisor who was a trafficking survivor: "I've had two supervisors. I think that in the beginning it was amazing and the reason why it was great is because I do to a certain degree have a learning disability and my supervisor was actually a survivor himself. So that was really helpful because they would meet me right where I'm at. And for me the comprehension was, sometimes my disabilities would hinder me. But the explanation they would give me kind of assisted me." [ID 17]

Specific to SA's continued engagement and assisting with patients, the two CBOs had different protocols. At one CBO, the SA engaged with patients and continued to provide peer support that was both open-ended and ongoing. Her supervisor explained,

"...Letting people know you are following up on them, you are getting discharged today or you are leaving the hospital today and she's been really good at saying let me give you some additional support which is connecting them with housing, connecting them with transportation assistance, food assistance, legal assistance and helping them like I said do their restraining order. So they are the same things the other survivor advocate was initially not really involved in. They considered that case management. We consider it, the way we structured it as continued service or continued assistance for that person who is you know leaving a hospital setting and integrating them back into you know other services." [ID 01]

However, the other SA's engagement was mostly as part of the CBO's emergency response team. The CBO's policy of taking the SA off a patient's case once they became a CBO client, were accepted to the shelter (even if not physically housed there yet), and were assigned another case manager, prevented the SA from providing ongoing peer support, even in situations where the SA could have provided specific practical, trauma-informed courses of action. She explained, "...once they are in the [CBO name] program, it gets handed off to someone else in case management whether it's the shelter continuous case management support. I am just an emergency. Once I place them, I have no contact with [them]" [ID 17]. Ironically, the SA at this agency was able to have more contact with patients she connected with if her own CBO did not provide ongoing services to them: "So, if the client is placed outside of the [CBO] shelter, I might be able to still be able to have some sort of like maybe two months, three months 'cause I've had those clients when they're placed outside of the [CBO] shelter. But if the client is placed in the

[CBO] shelter, no, I cannot continue contact. That would be another case manager that handles that case.” [ID 17]

The SA shared their perspective of an unsettling week-long situation. In this recount, a patient with substance use disorder whom the SA had served in the hospital was not able to move into the CBO shelter for an extended time. Though the SA has experience providing support to people with substance use problems at other agencies and her own history of recovery, she was unable to help the client because of the CBO’s policy of transitioning the client away from the SA to a new case manager. This resulted in a situation that could be described as neglect:

“...my client, just came out the hospital and being placed in motel, right, it feels that usually it takes about three days for them to get moved but for one of my clients to be left in a motel for about a week without you transporting my client to your shelter, it's like – and I have the client texting me, letting me know that she relapsed and she needs help, no one is responding...I've done it for some of my clients who I – they start – when the mental health issue come up, what I do I usually call an evaluation for them to go to the motel instead of me just leaving them there where they could just mess up all on their own, right. You don't do that. I don't do that. In the profession that I work and I've work in this field for seven years, a little bit more, you don't do that, right. That's a client that's asking you for help. And I had that scenario where I couldn't respond to my client because, once they're in the shelter, they belong to shelter. And when I did address this situation, it was – that I couldn't respond back because someone – a new case manager took over and we don't overstep.” [ID 17]

The SA expressed other frustration with other CBO policies, such as this one that caused what she perceived as unnecessary delays in moving clients into the CBO shelter. In this example, the client needed a COVID test before entering the shelter, even though she had just come from the hospital, where she had already had a negative COVID test.

“...one of clients being at the motel... so once they get accepted [into the shelter], I no longer have communication with the client, right. I had a client come out where the client was placed in a motel because ...once they're accepted to the shelter, what would happen is that they will transfer them to a motel until they could get COVID clearance, right. But for me, it's like it's really dumb because if I'm communicating to you that they're in the hospital, they just took a COVID test, why not take them in, right? But that's their protocol which I don't agree to.” [ID 17]

This SA recognized growth related to language challenges, but also recognized their own overall improvements in working with patients, “I think for me, English is a second language and sometimes it's hard. Other than that, I feel like I, myself, have made a lot of improvements but overall, in the way I encounter the patients, I'm doing great with them.” [ID 17] When asked to consider their experiences in the early stages of their involvement at the beginning of the Survivor Advocate Program, the SA shared an interest to have more influence in the organization to better assist patients:

“I would give my position more power than it has. Like I said before, I would give myself more power within my own organization where if I feel that a survivor is fit for my shelter and that's what I want and that's what you should respect. Who would know more of what the survivor than another survivor, right? Implementing more life skills into our shelter and more trauma-informed with my shelter staff and having more survivors get hired to this position. So, yeah, I

would do a lot of changes. If I could just have a little more power for the benefit of my patients. Because I remember being vulnerable and not having someone to speak for me. They didn't have these programs. Just being able to be more open.” [ID 17]

At the same time, the SA expressed positive hopes for the program. “I just hope that the survivor advocate program grows. I want to see it grow. I want to be able to continue this. I think this is a great program and I think it could grow to bigger things. I just would like to see more survivors being hired.” [ID 17]

## CBO Growth Opportunities

Though the aforementioned patient situation raises concerns, it is important to also highlight that CBO staff interviewees shared they are cognizant of potential growth opportunities. A lead at the same CBO as the survivor cited above explained how the movement as a whole is evolving:

“Within the antitrafficking movement at large, I think that there is a lot more conversation being had in terms of what authentic survivor engagement looks like. Whereas maybe in other movements such as the DV movement, for example, it's kind of assumed that a lot of the folks who work within the movement, work that these agencies have lived experience. And so there is culturally a difference in that way and I think the antitrafficking movement has a ways to go to being comfortable with having more people with lived experience in direct service roles and in management roles as well.” [ID 19]

She also shared the organization’s interest in investing in their staff through resource provision, workload management, and being more trauma-informed:

“There's certainly more that we could be doing, but I think the big pieces for me has really been making sure that staff feel supported with their supervisors, making sure we make mental health resources available, and I think the next big area is really making sure that the workload is manageable. So, one of the things that we're looking at is also revising our ER [Emergency Response] calendar so that staff get more time for rest, less days lives consecutively being on ER. That's one of the things we're looking at in terms of making sure our space is more trauma-informed.” [ID 19]

The same CBO lead continued further about the organization’s focus on emphasizing mindful and supportive strategies pertaining to staff with lived experience, and recognizing there is opportunity for growth moving forward, “...internally we could always be doing more work to check in with the staff who have lived experience to make sure that folks feel supported and feel a sense of belonging with their teams, feel like they fit within the remit of the organization they're based in. I think that we've made a lot of ground in the last year but I know that there's more work to do.” [ID 19]

## Professional Development and Growth of SAs

Exploring SAs’ perspective on their experiences in the Survivor Advocate Program, one shared their perspective related to participation in the program and how it provided learning opportunities

facilitating both individual growth and professional development. When asked about any personal challenges related to the position, the SA shared, "...it was just a learning curve as far as learning about what I hadn't experienced myself. But yeah, learning how to take care of people, how to resource people best I think that has been the learning curve for this year and I learned about that through my coworkers both at the hospital and at [CBO]." [ID 02]

She expounded upon learning new topics and how to manage boundaries, particularly when it came to survivors with substance use issues:

"I am a researcher so I just started watching everything that I could, especially about substance abuse because it is a different way of interacting with people too as far as like people that are engaged in substance abuse... they are used to kind of manipulating their environment and so you have to set different boundaries with them than you would with somebody who has always been on their own, very independent, just a different context." [ID 02]

The other SA noted how she would like to move into a case management role and be able to follow her clients for longer time periods, believing this would lead to better outcomes. "That's what I would like to see, continue as a case manager for longer term period of time, maybe six months, and I believe that ... if I am able to continue giving them case management service, I could guarantee you that that support, that emotional support as me being the case manager, we will have most of our clients staying a little bit more longer period of time than there is without my emotional support being there, right. 'Cause they usually open up – a survivor will open up to another survivor more than a case manager. That's just my opinion." [ID 17]

Interviewees in leadership roles at CBOs shared their investment in aiding and encouraging the professional development and growth of SAs. One example provided by CBO leadership shared how they facilitated connections between the SA and others they could learn from in the field, "We also have connected the survivor advocate to HEAL Trafficking, which is a network of medical providers and allied professionals who focus specifically on healthcare and human trafficking. So, they are connected to that advocacy network and that advocacy network sends out research for healthcare providers." [ID 18]

Similarly, the same CBO leader also discussed an instance where the CBO provided the SA an opportunity to convene with high-profile human trafficking policy makers where the SA was the only person with direct experience in providing services to a human trafficking population:

"... [SA name] has been doing a lot of extra training on things that she finds personally or calling her work. And there was a global leader convening in San Francisco last year and [SA name] did attend that, and she was one of the only people with direct services in the room. And it ended up being immensely helpful to have somebody with current direct service experience and not like I did direct service 20 years ago and now I'm a fancy funder. But current experience in that room. And it was a stretch for her skill set. Like she had never been in a room that big, at a meeting that high-profile, speaking on behalf of an org, but it was awesome. She was like 'I love doing this. Maybe I want to do policy.' So, we're also trying to figure out what's the balance of keeping the role while also feeding the advocate." [ID 18]

As result of this experience, the SA shared with CBO leadership an increased interest in professionally growing and expanding their career experience to also include shaping human trafficking policy.



Beyond service provision as someone with lived experience, and specific to increasing SA engagement and expanding the role of the SA at the CBO moving forward, a different CBO lead shared what they would like to see for the SA related to their development:

“I think there's certainly a ways to go, if I'm speaking quite honestly, because we all have things we're working on, but I'll say that especially in the last six months at [CBO name] at least we've been relieving a lot more deliberately in terms of, for folks in this role, how can we better integrate it so it's not someone with lived experience doing this program and not feeling like they're part of a team. So, some of the things we've looked at was really making sure that for [SA name] that she not only supports the survivor advocate program, but she's really part of the broader ER [emergency response] program. So, also supporting ERs, having a caseload of her own, really being incorporated as a case manager. And we felt that was very important not just in allowing the survivor advocate to feel like they're part of a team but also for professional development as well. So, it's not just about responding out in person and using lived experience, but also supporting our team in terms of any professional development they would like as far as providing direct services and the like.” [ID 19]

The same CBO lead continued further sharing their observations and discussions with CBO staff about the SA's obvious investment in working with survivors, the SA's growth as a professional, and the SA's role in expanding the SA program where the SA could take on more of a leadership role:

“Obviously, she's interested in hospital response and is really invested in working with survivors, but how can we think about this role that really allows for her to grow in her professional development and in her interests. So, we've been having more of those conversations and really thinking through also projects that could fit under the survivor advocate program as far as expanding the reach of the program but allows for [SA name] to feel like she could lead a project. So, we've been having those discussions more recently.” [ID 19]

The SA's supervisor added, “[I see] opportunity for ongoing professional development. I see a lot of, for example, [SA name], I work with her a lot, and I see a lot of leadership, managerial skills. So, I think that's great.” [ID 20]

Lastly, one of the SAs shared their interest in wanting to continue their education, “I think my education is missing a little bit. Maybe support on my education on how to get my bachelors or something like that. I think that would be great.” [ID 17] which would help not only their personal development, but also their development as an advocate for survivors, and provide more opportunities to advance in the field as well.

## Recommendations

Interviewees across the hospitals and CBOs, including SAs themselves, provided suggestions for improving the Survivor Advocates of Healthcare Program, both in the context of improving the existing program and in how they would advise systems and agencies elsewhere who were interested in developing such a program for their own locality. Qualitative interviews revealed several recurring recommendations highlighted below, and some additional recommendations that surfaced worth noting. Recommendations are shared below grouped by CBO and hospital interviewees.

Please Note: Following the Discussion, we provide a distilled series of recommendations based on our observations and these analyses.

### CBO Staff Recommendations

The main recurring recommendations shared across many of the CBO interviewees focused on increasing the presence of SAs and bolstering development of SAs. Specifically, the most recurring recommendation by CBO interviewees was to increase the number of SAs available in the program, followed by providing increased opportunity for training, education, and professional development for SAs. The next two recurring recommendations were to further develop and expand the SA program, while also providing clearer expectations of the SA role, such as providing a training manual with clear trauma-informed protocols, guidance, and resources for SAs.

#### Increasing SA Presence

Increasing the number of available SAs and their hours of coverage was the most recurring recommendation across all CBO staff.

“I would add an additional survivor advocate to the program. So, not just one with [CBO1] and [CBO2], but an additional one. So, three survivor advocates. Or more would be great. Part of it being that I can imagine it being very challenging between the two survivor advocates we have right now to have the mandate of responding out to any potential patient response in any healthcare facility in LA County. It's a very big geography. It's a lot of facilities. But to do the response in the outreach I think is quite challenging. So, to be able to add an additional staff member, an additional survivor advocate with the lived experience who could both do the response and also do outreach, I think will help expand the program.” [ID 19]

She added, “I would love for us at [CBO name] to continue to hire survivors, folks with the lived experience in these direct service roles, because I think it really does help the work improve.” [ID 19] The SA's direct supervisor shared their recognition of the need to increase the number of SAs to better serve the expanse of Los Angeles County, which would also require increasing the number of support staff at the CBO as well, “...I would love to have more staff, because I think expanding that would be great. Especially because we service LA County, and we really only have two survivor advocates. I just feel like it's meeting it right now at a level, but I'm sure as an agency we could expand that, but that would potentially mean we would need more staff to be able to support that need.” [ID 20]

These summative statements underscore the need to invest in hiring additional SAs, expanding the SA program, and providing more development for both SAs and the SA program. Next, more specificity is shared by CBO staff for each of these recommendations.

## Providing SA Training, Education, and Professional Development

Moving beyond increasing the number of SAs (and also increasing CBO support staff), the next most common recommendation was bolstering SA development. Suggestions offered were providing SAs with additional training, advanced education opportunities, and professional development experiences. Specifically, the SA's supervisor shared the importance of training regarding trauma, burnout, boundaries, and how these are essential to understand for an SA's longevity in the field, "I think ongoing trainings for survivor advocates as well in regard to trauma informed work, in regards to vicarious trauma, in regards to burnout and setting boundaries. I think those are key components for longevity in this field." [ID 20]

One of the SAs described other training needs: "I think that might be a good add if there was an add to the training program would be to having learning on substance abuse, homelessness and mental health housing or residential treatments. Those are three areas that come into the picture in dealing with different survivors but again that is something that you are going to learn on the job one way or another so. But a base of initial information might be good on that." [ID 02]

The previous CBO interviewee shared further it would be beneficial to also hire more survivors in the CBO in general, not only as advocates, but as support staff and in other roles in the organization, "Continuing education and outreach work, more grants in order to hire more staff. And not just in the survivor component, like the healthcare setting, but even just within the agency. I think that would be great as well. In different sectors." [ID 20] After noting the SA's professional development potential, she added, I feel like I'm sure there's a lot more survivors that are in that place and I would love to see them have an opportunity. So, hiring more survivor advocates to be in this role, continuing our education and outreach work in healthcare centers at a more consistent level." [ID 20]

## SA Program Development and Expansion

The next set of recommendations by CBO interviewees were related to further developing and expanding the SA program. Whether it was providing more control of the program by SAs, expanding beyond human trafficking, expanding the service area, or developing additional support services for survivors, these types of recommendations were central to growing the SA program. One of the CBO leads interviewed shared their perspective on increasing SA ownership and management of the SA program:

"I would love to have [SA name] or someone like [SA name] have more of a hybrid management role to do more program design. I love that it's housed in our emergency response program, but I think that in order for there to be a lot of buy-in as well from these survivors that we're hiring, they need more control over their program. And I think also that brings in not just, because sometimes with survivor leadership in organizations that are like I want to hire survivors, it always stops at where there is power. Like no, just as case managers. Not as managers. We want to start here. But I genuinely think this could be its own larger program." [ID 18]

A different CBO lead shared their evolving ideas and perspective on bringing in other community-based providers not only expanding the reach of the program geographically, but also expanding into other areas serving domestic violence and sexual assault survivors:

“...when I think about ways to move forward, things we could consider, I do think that part of it maybe is bringing in other community-based providers who might be interested in starting a program like this and maybe they focus on a specific geographic area. Or it might be that we potentially, if we're willing to do this, expand out the remit of the survivor advocate to not just focus on human trafficking but maybe focus on also including domestic violence or sexual assault, like maybe including more victim categories might be a way to go about that. But I'm just kind of speaking off-the-cuff. I know that would be a huge change to the program. These are some things that are on my mind.” [ID 19]

The above CBO lead continues discussing expansion further focusing on building relationships in the community, and correctly assessing the resources and structures needed to achieve the goal of program expansion:

“To really build those relationships and really think through what would an expanded survivor advocate program for LA County look like and how do we make sure we get the right resources and structures in place in order to really support this. I think there's a huge potential if we were able to expand and have this additional infrastructure [...] And I just think that there's the potential, if we were to think about having an infrastructure similar to that in terms of scope, scale, investment, but having that based and community providers and healthcare providers and social service providers, I really do think that there is a huge potential in terms of the impact of really identifying more people and offering more services to survivors.” [ID 19]

It may be promising for the future of SA program development to learn of CBO leadership interest in developing and expanding the SA program into other communities and geographic regions. Understandably, working with communities to start and grow the SA program's reach and scope would likely require more activity and investment by organizations to provide more clarity to the SA role and guide what is expected of SAs. Recommendations related to SA role expectations are discussed next.

### Additional CBO Staff Recommendations

In addition to the above, some CBO staff also shared other pressing recommendations worth highlighting. One of these focused on the macro level of creating community-based responses for trafficking survivors at the level we now see criminal justice focused approaches:

“Right now is there's a lot of federal funding, for example, through the Office of Victims of Crime in terms of antitrafficking response being something that is based through taskforces that largely sit with law enforcement agencies right now. And I just think that there's the potential, if we were to think about having an infrastructure similar to that in terms of scope, scale, investment, but having that based and community providers and healthcare providers and social service providers, I really do think that there is a huge potential in terms of the impact of really identifying more people and offering more services to survivors.” [ID 19]

Another CBO lead noted the need for improved community resources for survivors:

“...number one would be improving what are considerations for housing and emergency shelter and also improving considerations for actual transportation cost.” [ID 01]

Both CBO staff and hospital staff suggested incorporating screening questions for healthcare staff use during intake to help aid identification of a trafficking situation:

“I do think that building in and investing in that training for healthcare providers so that when they do have the one or two minutes before they get into the healthcare visit to ask the person how they're doing, to build in questions in terms of asking the question how their work life is going. Asking all these questions that we oftentimes advise providers to ask as far as whether the person still has their identification, whether they're still working while they're sick. Just asking these questions that could potentially help us identify a survivor. The more people that we have involved in really supporting survivors and identifying the trafficking I think the better in terms of our movement at large.” [ID 19]

Other recommendations to share were improving the process and protocols related to the hotline as many staff mentioned SAs were contacted directly because the hotline was not as effective, especially during the evenings and weekends. Another recommendation provided by CBO staff was related to having clearer understanding on the order of who to report to or who to seek assistance from if someone is not available (e.g., on sick leave, etc.). It would be helpful to better articulate who the back-up or failsafe might be if there is a disruption to the standard operating process.

Mentioned by CBO staff was also the consideration to be mindful of the private lives and work-life balance of SAs. In some instances there may be inquiries made to the SA about very personal issues or expectations that the SA is always available. In the future, it would be helpful to keep in mind SAs would benefit from exercising their ability to disconnect from the workplace which may, occasionally, remind them of previous traumatic experiences.

Lastly, CBO staff also shared the benefits of feedback. Given the availability of survivors and advocates working with the CBOs, it was suggested to find time to solicit, and be welcoming of, feedback from SA, fellow survivors, and advocates related to protocols, processes, and policies. Related to the feedback recommendation and also being respectful of private lives, it was suggested for CBOs to consider engagement in “reflective supervision” where supervisors are mindful of the potential of an SA (or survivors in general) to relive their trauma because they are hearing trauma stories from the victims all the time.

While recommendations from CBO staff highlighted increasing the presence of SAs and bolstering development of SAs, recommendations provided by hospital staff were more focused on SA service provision.

### Hospital Staff Recommendations

The primary recommendations provided across many of the hospital interviewees focused on increasing the presence of SAs and incorporating SAs into more routine processes in the hospital. By far, the most consistently recurring recommendation by hospital interviewees was to increase the availability of SAs in the hospital, followed by increasing SA inpatient integration, then SAs bolstering hospital staff education and training related to human trafficking, and making SAs part of the standard of care in the hospital. Additional recommendations included SAs updating hospital charts or intake processes to aid identification of human trafficking patients, aiding hospital staff in maintaining currency on human

trafficking related education and community resources related to human trafficking, increasing coverage by integrating more SAs into additional healthcare facilities, and SAs providing more resources to patients.

### Increasing SA Availability

Similar to CBO staff in the previous section recommending bringing more SAs on board, multiple hospital staff provided recommendations during their interviews to increase the availability of SAs. “I wish we had one that was here 24/7 with us, because it can happen any time and they create that safe holding environment for the patient, but also for the staff, and they also free us up to do other things, not to like use them just for our human trafficking patients, but those survivors they’re always intense.” [ID 07] Another social worker shared their ideal situation, “In an ideal world - They would be available 24/7, just because, you get called at different times. Sometimes that opportunity is between midnight and some other time, so I think, they are just so good that I wish they were available all the time.” [ID 06] This was also shared by many others:

“...Night shift is always the concern of not having someone who can come in at two or three in the morning. A lot of these incidents, or patients, come in late at night.” [ID 16].

“We make it work, but it would be great to have them 24 hours a day.” [ID 27]

“...if there could be anything I would say 24/7 an advocate, probably good luck with that, but I do think the advocate really, really helps [...] 24/7 advocate. Bottom line.” [ID 05]

“...the only area where there probably would be a concern is that the Survivor Advocate right now is not 24/7. There’s those gaps. And it would be nice if somehow those gaps could be filled because sometimes you know you can lose people in that those gap periods.” [ID 28]

As in last excerpt above, interviewees who shared wanting an SA available 24 hours a day, seven days a week, indicated this would provide opportunity for healthcare providers to have someone to turn to in hopes to not lose a patient who may be in a trafficking situation and may otherwise return to it.

The next set of recommendations cover the services healthcare providers recommended for SAs while on site supporting hospital staff.

### Increasing SA Integration

Some interviewees shared they wanted SAs to be more involved and integrated into the inpatient process, working side-by-side with healthcare providers while seeing patients. One hospital lead shared how they believe the utilization of SAs at their hospital, currently in two departments, should be expanded:

“I would want to bring it more into the inpatient part of the hospital, because we see more in the ED [Emergency Department]. Well, the whole hospital kind of gets the education and the training. Our focus was I think ED initially and then OB [Obstetrics], just with the patients coming in, but I think bringing it more in the inpatient side, because sometimes things don’t present

themselves or come out, or things may come later, or maybe a visitor comes into med surg, and then they see that dynamic and kind of wonder, 'hey, we know what type of relationship is that really...' So, I think bringing more to those areas would be beneficial for the program." [ID 16]

A nursing lead succinctly shared recommendations informed by their first-hand experience:

"I would say if they are really trying to maximize utilization, just invite them in; incorporate them into your treatment planning, introduce them to your staff. Let them do – we've even had them come be in-services, talking to the staff, like I mentioned before. Really integrate them into what you're doing on your units as far as everything that we have to do from a psycho-social standpoint. And the support we provide our patients. I would really just involve them in that process as much as possible." [ID 21]

A social worker lead echoes and expands on the previous recommendation further, but provides suggestion that nursing staff and other providers should be more familiar with the program and talk with patients about it, rather than the social workers being the first to notify patients about the option.

"I think they need to utilize and when I think of a survivor advocate as almost a complement to your social service, too...you're making the process whatever that looks like at your hospital, so that's easy and streamlined and kind of an extension of social services. And that everybody kind of knows this is our process, this is a service that's available, that's offered, that should be offered, and that nurses can even begin that discussion. So, I know a lot of nurses are having conversations with the clients before we get them, and they're the first people that are getting that information or asking those questions about the red flags. And for nurses even or whoever is making that initial contact to feel comfortable bringing up the fact that we do have this resource, I think planting that seed as early as possible might make it easier, because then when social services gets on the scene they're already thinking okay well there's another person I can talk to too." [ID 12]

A social worker at a different hospital mentioned how beneficial it would be to have SAs as actual hospital employees. "If I could, and funding was no issue, make them an actual [hospital] employee that is working in tandem with [CBO name] or something and have them here on site. I know they're not going to get a lot of patients, but when they are needed, it's intense and I rule out human trafficking almost daily." [ID 07] She noted limitations to the interaction with them as CBO staff: "there's problems with them being in our area because they're not Dignity Health employees, it's like a HIPAA violation, so if I can't have my advocate sit with me because doctors come and talk to me about other patients, but I still need them here so I can get updates and consult with them." [ID 07] A nursing lead also enthusiastically shared their support of SAs being integrated as part of the hospital team, "I would have them here every day! With a badge, here in the hospital clocking in at least eight hours a day. Just as much as possible." [ID 21]

### Other Recommendations from Hospital Personnel

Two healthcare staff (a social worker, followed by a hospital lead below) suggested continued SA engagement might provide opportunity to changes to hospital processes to increase the likelihood of

trafficking survivor identification, or aid in decreasing early discharge of a patient in a suspected or confirmed trafficking situation:

“...so maybe just adding a little component of when initially a nurse meets with a patient for a screening and they oftentimes will ask are you suicidal, or have you had thoughts. Maybe a human trafficking question just like if they’ve ever been abused or assaulted and for a social worker to get a consult to explore more. There’s been numerous times where they do have a history, but it was not dig deeper unless I did a full assessment and explored that.” [ID 11]

“...something written in bold type that's on the top of her chart that really tells them when the patient is ready for discharge call this number. Do not, do not release her back to where she came from.” [ID 25]

A social worker expressed their desire for an improved feedback loop between the CBOs and the hospital. Even though many clients are lost to follow up, the CBO could routinely report back what they know to the healthcare providers who referred them to the CBO in the first place. “I think it would be also helpful if it was a full circle just for us to get feedback if they do come to the hospital and what the outcome is within six months or a year, you know, and get their feedback as well to us kind of like what was helpful, what worked, what didn’t, you know, for it to be a learning experience both ways.” [ID 11]

This same social worker commented on a patient need that was not covered by the SA program or other programs that hospital staff could access:

“I feel many of them also don’t have phones so I don’t know if maybe there could be a program also to offer them a phone or to stay connected if they leave, there’s just I don’t know while we have them or if they leave on the weekend the communication or sign off doesn’t stay consistent. And now if we can’t get ahold of them or they don’t answer if some way there could be an advocate to transition them from the hospital into the community like whether it’s going to a hotel temporarily or just like someone that’s kind of like their advocate to journey out through the system.” [ID 11]

### Increasing Hospital Staff Education

Similar to CBO staff recommendations, hospital staff also offered suggestions related to SAs increasing the availability of staff education and training opportunities. The impact of the pilot SA program was seemingly so substantial that one hospital lead reflected on their experience working with the SA from the pilot study prior and offered suggestions for future program SAs to incorporate some of these additional means of educating hospital staff:

“I think having them do little informal huddles, training huddles, on the units like [pilot SA] did is very helpful. [...] I think having those trainings more often I think would be helpful or make – or put it on a Pathways module and so people can look at it.” [ID 25]

“[Pilot SA] put some materials on the on the floors in all the units in a binder so they could look at examples of some of the tattoos and things like that. So, it’d be handy to look at. Having things like that I think is reinforcing. And knowing – having that survivor advocate rotate to the



different floors, point out the binder and what's in it so that they know they can look at it and say – if they have a question about something, they can know where the resource is.” [ID 25]

A hospital lead from a different hospital shared their suggestion to also invest in education (and re-education) despite challenges because it serves as a helpful reminder for staff especially for departments most likely to identify survivors, “I would say to best utilize the program again it goes back to education and it goes back to reminding the staff and re-educating. You know the departments that are going to really have an impact emergency, labor and delivery, case management, the different programs like that, it's all about education and continuing to keep that reminder out there. And it's sometimes hard to do, but that's how we get it done.” [ID 28]

Similarly, a social worker from the same hospital as the hospital lead above shared their recommendation that it is important to continually educate staff, as well as serve as a reminder, referral, and resource to sustain the importance and salience of human trafficking situations:

“I think first would be staff educations, to definitely have them come for smaller staff like our social workers and case managers to do staff meetings, whether that's via Zoom or in person, so that way you get the frontline staff educated first. Then secondary would be to have the advocates actually on site and go around to the units and just remind them of who they are and that their services are available and how to access them, and how to know which patients are appropriate for referrals to them. So, just kind of keeping in the forefront of hospitals' minds of what trafficking is and who they are, and that they're available to help and what their services look like, or their hours are to be able to assist our patients. I think it's just because it gets so lost in all the other things that come up within health care that we don't always treat it as the priority it needs to be.” [ID 15]

Throughout the entirety of the recommendations provided, there was one overarching, common message: to accomplish this, there is a clear need for additional funding for SA programs. Whether the recommendation is to increase the number of SAs, increase SA availability, continue to expand and develop SA programs, increase the number of healthcare facilities involved, increase availability of staff education and training, or increase resources for patients, these all require increasing financial investment into the sustainability of SA programs.

One final recommendation provided by a CBO lead sums up the defeated tone of the situation related to procuring funding and serving this simultaneous at-risk and hard to identify population:

“...the advocate is frustrated, the hospital is frustrated, and the client is frustrated, when there's really nowhere for [patients] to go. So, sometimes you just have to do hotels for a while until a space opens up with a bed. So, that is something that [CBO] also is doing. We're working on a state level, that's what I do in policy, to try to increase the governor's budget this year for human trafficking services. So, that more people get funding to get more beds. Because that I think is one of the bigger issues in the program. Like I said, the systemic barriers are hard to face. So, people burn out because they're tired of witnessing the failure of a system to protect people despite all of these people trying really hard.” [ID 18]

The next section explores how the SA program achieved many of the program aims while also contending with limited funding.

## Achieving Program Goals

Despite the challenges and recommendations for improvement, overall, the Survivor Advocates in Health Care program achieved many of its aims. A social worker succinctly summarized the overarching goal of the program, “I feel like having a patient survivor advocate really helps people to focus their efforts towards supporting patients who are experiencing human trafficking.” [ID 07] Additionally, a hospital leadership interviewee also shared the impact of achieving the goals of this program:

### Improving Identification of Trafficking Survivors and Referrals

The SA program provided opportunity to improve the identification of trafficking survivors and their acceptance of referrals to community-based services. A social worker shared how the SA program raised awareness of human trafficking across the entire hospital and is viewed as one of the hospital’s mainstream resources:

“Just the program in terms of, you know, not just the social work team now knowing about HT survivor advocates. It’s also the hospital as a whole. Leadership knows about it. The nurses know about it. It’s becoming like a common resource to have at the hospital when we say we’re triggering the HT protocol. We have someone in house. Security knows what to do. Everybody pretty much knows what to do just like any other service in the hospital that commonly would get that type of attention. This is becoming another resource that’s become more mainstream as more people are seeing it.” [ID 04]

Further, a hospital leadership interviewee discussed how they believe identification of human trafficking patients has increased substantially as a function of the implementation of the SA program:

“You know, if you look at the data of how many more cases were identified in California hospital alone or that time frame, it increased a lot. We didn’t have that many people identified initially. Even for the whole year, I think they were like six or seven victims. And then we when we rolled out this program, because of the awareness, I – don’t quote me on the numbers but I think it was like somewhere around ninety or more than one-hundred victims that they identified within a year and reached out to get some help for them.” [ID 24]

Leadership at a CBO also shared the benefits of incorporating SAs in the hospitals. Through this embedding and integration, hospital staff maintain their awareness of the SA program, which also resulted in assisting the SA with patients, who are then able to provide services to patients, to which the SA takes the lead in working with the patient:

“...how we structure things with [SA name] being embedded and integrated with the staff they are all fully aware of the survivor advocate program. [SA name] has been able to [reach out] to our staff about the survivor advocate program and they also assist with [SA name]’s patients that come in too. They have other resources that they assist and connect those clients to and

are able to support [SA name] when she is in the office looking for resources and looking for things, so our staff is also assisting with these clients indirectly at times with [SA name] taking the lead.” [ID 01]

One of the SAs shared their response to working with hospital staff in helping to identify and support patients:

“I feel their support. I feel their warmth. Not only for myself but for my clients. Because one thing is me, but for me, my biggest thing is how do they treat my clients, how do they treat my patients. When I go see my patients are they really asking the questions they're supposed to? Are they being trauma-informed and sensitive to my patient? And I believe they're 100 percent being trauma-informed in how they treat and how they go about explaining and getting to the point where they contact me where my clients are wanting to receive these services.” [ID 17]

### Satisfaction and Assessment of CommonSpirit and CBO Personnel with SA Program

Next, CBOs also afforded the opportunity to gauge assessment of the satisfaction among community-based service personnel and hospitals staff. Overall, both CBO and hospital staff shared exorbitantly positive evaluations and assessments in their engagement with SAs. From raising awareness in the healthcare setting, providing information and access to community resources, or working to assist patients beyond the hospital system’s capabilities, SA engagement was crucial in providing support to patients with immediate needs:

“You know, our social workers can do a lot for these patients, but when you have someone that their specialty is HT and they have that personal touch to speak with a patient. I think it really took it to another level. Not just for us but also for the patients.” [ID 04]

“[SAs] can organize these grand plans where [in] social work we can't. We have to do it within the system of the hospital. We can't be like 'Hey we're going to meet you outside at the corner of Roscoe and Reseda on Saturday and we're going to help you.' And I'm not on duty on weekends so again we don't have that ability to do the follow up and the advocates are really great too, they actually tell me so and so followed up with me, I followed up with them, and I think for survivors it means something because somebody's finally saying what they're going to do what they mean to do.” [ID 07]

“I've just been impressed more so than surprised. I guess surprised, but just impressed on bringing that into a hospital is key. Because, as much as you can say that we're out here, we have these resources, come to us when you need us, people don't always come. So, it takes having that available where they are already going and recognizing and offering those support services. So, I guess it surprised me that it was in a hospital setting, but impressed because it makes sense, and it's what works, I think.” [ID 16]

Similarly, staff interviewed at both CBOs shared they received feedback from hospital staff indicating SAs are making a substantial impact:

“I know they see a benefit to this because they are out there doing these referrals. They are out there trying to find help and assistance and talking to them for the patients that they identified

and the people they are worried about. They know the patients that are there are not just there for medical services, and they want to make sure they can do their parts to connect them to the social services piece so in that way the hospital staff they are the ones making the calls, they are the ones reaching out to us and that means there is a benefit to them.” [ID 01]

“I think in terms of the goals that [CBO 1] had hoped for, we were really invested in terms of thinking about a different model for response that really prioritized connecting survivors with patients, and for that to be the linkage for people to get services. [...] I think we were also interested in thinking through how can we support a different antitrafficking movement that really prioritizes partnership with different actors in our civil society and our ecosystem. And I think investing in partnership with healthcare providers is something that has been really valuable. So, I think on those goals, reflecting on the last couple years and the fact that it's grown to also include [CBO 2] and the fact that we are talking more about how we can expand this to other service providers, I think we have accomplished those goals...” [ID 19]

One of the SAs provided their perspective and motivation related to working with a survivor population:

“I planted that seed. So, now I know they have a little bit of that voice. That's what I enjoy. I enjoy working alongside other survivors until they get themselves and being able to just present those options for them. That's what I love the most out of this position. That vulnerability when they go to a hospital and understanding that I went through that. And if someone like me can go through those doors and just hug you and meet you right there where you're at, that's enough.” [ID 17]

A variety of interviewees across healthcare providers, hospital leadership, social workers, CBO staff, and SAs shared positive evaluations that the SA program achieved many of the proposed aims. Additionally, many interviewees shared glowing reviews of SA engagement with not only patients, but also when collaborating with healthcare staff and CBO staff.

One of the greatest indicators of success of the Survivor Advocates in Healthcare Program was how many hospital staff who worked with SAs thought it “should become standard care at every hospital.” [ID 04] A hospital lead shared their perspective on scaling up the SA program to include more healthcare facilities as a solution to the issue of human trafficking broadly:

“...It would be important for more hospitals to be able to have access to a survivor advocate, to be able to better work with this particular patient population and get them into the services that they would benefit from. I think if more hospitals did it, then we could make a dent in this problem.” [ID 25]

## Planning for Future Survivor Advocate Programs: Hiring Survivor Advocates

Hiring the right staff is perhaps one of the most important aspects in ensuring that an organization accomplishes its mission. When hiring a Survivor Advocate in particular, it is vital to select individuals who not only demonstrate the needed professional competencies and skills, but who have a strong desire to take on direct service work with other survivors. Advocates, with lived experience or without, should maintain awareness of their emotional responses to potentially triggering situations, which they will likely be presented with through the course of their work. Ensuring that a survivor has the capacity

take on the difficult task of helping others out of trafficking is not an exact science, but the interview process can provide useful insights, as one CBO lead explained:

“I would say the hiring process and picking the right person is everything. You can’t have someone who still has a whole lot of trauma, and has things to work through, and of course you know they all do.<sup>4</sup> But it’s just the being established in the trafficking community and having worked with clients, I mean it’s so important that they have the experience... it’s not everybody that can do the work.” [ID 13]

Another CBO lead also commented on the importance of an SA having some distance from their own traumatic experiences:

“Something that we always consider is how long that person has been out of a life and away from that. Again, that can help reduce the trauma that person is experiencing, the amount of triggers they experience and also their job performance. Some people who have been out of a life may not, this is a rigorous role, it’s a role that does require a level of professionalism and you don’t want someone who has been out of the life for six months or even a year. You want them to be able to have some other type of work experience before they come in and they are dealing with a role like this that is rigorous and has a lot more demands and has a lot of other type of skillsets that are required of them. Not every survivor coming out of that trafficking experience is that proficient in things like Excel and Word and these other databases that a survivor advocate has to use, so just to keep that consideration when looking to interview or hire a survivor advocate, they have to have some time out of a life and have some time to gain these skillsets to make sure that they are going to be a success or even be able to handle the rigor of the position.” [ID 01]

Given the diverse contexts that an SA might find themselves in, having experience in different work settings and communities was mentioned as an asset for the right candidates. In discussing one of the current SAs, a CBO lead noted: “They had a lot more experience doing direct service. They had done direct service with human trafficking survivors. They worked in a community health clinic as well. So, they had a lot of relevant experience.” [ID 18]

In addition to selecting a Survivor Advocate that has proven experience in working with clients and the community, the CBO stressed the importance of an SA that had some knowledge of how the clinical setting works, including specific norms and legal regulations that govern communication and information sharing:

“But the good thing is that both of our survivor advocates had a little bit of experience working in healthcare settings, so they actually knew a bit about like how do I talk to a nurse, who gets to make these decisions, and what decisions aren’t ours to make. What are state regulations? What are things that you can lose a lot of money over, things like HIPAA? Things that can’t change.” [ID 18]

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<sup>4</sup> As a different CBO lead shared, and as is often discussed among anti-trafficking practitioners, many service providers have histories of trauma that motivate their work, but they are generally not expected to publicly disclose these experiences or share them in the way that human trafficking survivors are.

Aside from the internal structure of a hospital or clinical setting, the CBO noted the need to assess the full range of experience for a Survivor Advocate candidate, and their ability to step into a clinical role that can often be overwhelming and complicated: “A desire to do direct services might not mean a capacity to do direct services... Meaning that the housing crisis, going into the hospitals where everything is loud and fast-paced, it's not the most trauma-informed environment, the ER is not the most calming place to be.” [ID: 18]

Another vital aspect mentioned as a consideration in hiring a Survivor Advocate was the personal motivations of the SA, and what they felt they can bring to an organization. One CBO interviewee mentioned the importance of having an SA not just enjoy the work, but also bring a unique perspective that would have a strong impact in the specific setting: “I would say that our first survivor advocate did enjoy the work initially and did enjoy being a part of [CBO] because they brought a unique perspective and they felt like that perspective was unique. So, they felt like they were making really meaningful change because no one else was saying the things they were saying.” [ID 18]

Incorporating other CBO staff members into the interview process, especially those that the SA might collaborate with, was also an important part of selecting the right SA. Making sure that the values and work style of the SA meshed well with the rest of the team and the organization as a whole was vital, with one interviewee noting that they didn't always get it right but kept working to improve their hiring process by involving other team members: “[With] our first survivor advocate there was a values misalignment... With our second person we did values alignment. They met with the whole team before they got here. That was part of the interview, was meeting members of the team.” [ID 18]

Aside from individual experiences of the Survivor Advocates and their general readiness to work in the field, CBOs also noted the importance of having SAs who can relate to the communities they'd be serving, which can be difficult in a place like Los Angeles that is home to a diverse cultural, linguistic, and demographic population. “It's impossible to have a survivor advocate that everybody is going to relate to. Because that's just not possible. But I would say that it's very important to look at not only your organization and who it serves but your local community. Who is in your community?” [ID 18] The same interviewee noted discrepancies between those often in a position of hiring within the CBO, compared to the communities that will be receiving these services, stating “...often nonprofits do not reflect the community that they serve. They're often whiter and more cisgender and more heterosexual than the actual communities that they are serving. And that creates a disconnect with clients.” [ID 18] This is an important consideration, as ignoring it can lead to skews in the people that receive care and support.

“Also picking people that reflect our community, like the actual identity of the survivor advocate in which communities are going to see them as relatable and which communities are not. Like our current survivor advocate also speaks Spanish. That is a huge skill set that we did not have in our first survivor advocate and has opened up an entire other demographic of client who now feels like okay, wait, I see myself in this person. I see my community and this person and I want to talk to them.” [ID 18]

One final consideration mentioned was the importance of having an SA who is able to let go of expectations of what clients ought to do. The ability to recognize that clients will often make decisions that are contrary to what the SA recommends is paramount but can be difficult for some Survivor Advocates, as it is for many service providers. An interviewee noted:

“You have to have some grey area and you have to be okay with the grey, you know, you have to go with the flow, you have to understand that clients are not going to meet your exact expectations. It’s their life, it’s their choice, they get to choose what they want and not everybody can do that, right, not everybody has that in them, so I think that’s the most important point right there is trying to pick the right person.” [ID 13]

In order to plan for dissemination of the Survivor Advocates in Health Care Program, to enable other health care systems and CBOs around the U.S. to design and implement their own version of this collaboration, we also explored perspectives on the characteristics and skills of people who served as effective Survivor Advocates.

## Survivor Advocate Traits

### Hospital Perspective

Social workers described numerous characteristics that they valued in SAs. “Just being approachable, open-minded, and be willing to be like a team player, like brainstorm together, you know, based on like what the presenting issues are and help us also giving us actual solutions or how to keep them safe or connected.” [ID 11] They also noted “the patience, the communication skills, the empathy, that’s more for the client, but again just more like the patients and the knowledge to able to tell us and kind of teach us what we don’t really know too much about.” [ID 08] They commented on “knowledge of resources, compassion – that skill. And the ability to communicate and collaborate” [ID 23] and “composure and her professionalism.” This social worker also appreciated that SAs were conscientious and thoughtful, following up with staff “...if she thought about resources she hadn’t thought about before she would send us all an email or text.” [ID 10]

One social work supervisor described the ability to overcome challenges connecting with patients, saying “And the third one is very fresh. So we just started working with her last week, but even last week she had to work with someone who was disabled who was hard of hearing, and she was phenomenal. She jumped right in even though there was [sic] some limitations communicating with her.” [ID 04] Another social work lead stated, “I would say obviously empathy, but self-disclosure and not to be afraid of self-disclosure. I think that would be very, very important...” given that the SAs often shared their personal stories with patients to connect with them and with hospital personnel in order to bring the issue to life in a concrete way. [ID 05]

### CBO Perspective

CBO supervisors remarked upon both SAs ability to take initiative. For example, “If she connects with other agencies, you know, she doesn’t just say hey [name] what should I do, she’ll reach out sometimes, but she’s not going to sit there and wait, she’s going to go out and she’s going to find something, find the right resource available.” [ID 13] This CBO leader added, “She’s so logical and really a mix of that and with the great boundaries, with you know highly intelligent as well, problem solver, I think all of those things are so important.” [ID 13] She expounded,

“Well, see I think that’s what’s so great is about [name] is that she can communicate with people, she can connect with folks, and I think that’s really needed in order to be able to move forward in a good way. I know that some survivors that have worked with us they just don’t have that ability...You have to do the substantial work that’s necessary for the individual that you’re serving in order to gain that trust. And so, I think it’s about trust, it’s about making people aware that this it could be anybody, it could be like some really horrific story or it could be someone just coming in because they got a cut on them and you never know, given the signs of what trafficking looks like is a really good start, and continued education.” [ID 13]

CBO leadership discussed the challenges of finding candidates who could fulfill this difficult role, noting that certain personality types were better suited to the job but that it was difficult to predict who would enjoy the job and achieve success in it.

### SA Traits from SA perspective

Survivor advocates listed many traits that they thought were important for a person being employed to perform hospital response work, including being friendly, honest, and analytical. One described, “I think yeah you need to be able to interact with a variety of different kinds of people. For instance, the survivors are going to be very different from hospital staff, very different from the [CBO] staff and then also in doing trainings then that is another group of people that you need to interact with. So yeah, you need to be able to adapt to the different context.” [02] This SA considered herself a natural teacher. Her responses to interview questions revealed that she enjoyed learning new things, and was intellectually curious.

“I am a researcher so I just started watching everything that I could, especially about substance abuse because it is a different way of interacting with people too as far as like people that are engaged in substance abuse... So yeah I researched and I watched and read everything I could and talked to other people like the new survivor advocate that has different experiences. I really love to soak up other people’s expertise you know what I mean. Everybody is an expert on something so find out what they are an expert on and learn from them.” [ID 02]

She also noted, “I think being very organized is another benefit because of like all the reports that we do for Susie [evaluation PI] and the hospital and putting everything in the database so you really have to keep track of your time and you know for each client and put that in the appropriate place so.” [ID 02]

Finally, this SA commented that learning to ask for help was an important trait she was learning. “I was always on my own, doing things on my own so I am very slow to ask people for things” [ID 02]

### Summary of Qualitative Results

Qualitative analyses conducted across interviewees from hospitals and community-based organizations, including survivor advocates, showcased three primary themes:



1. Survivor advocates quickly became a celebrated, valued, and integral resource for hospital and CBO staff
2. The Survivor Advocate Program made a sizeable organizational impact in its contribution to benefitting both hospital staff and patients; and
3. Challenges arose over the course of the program across all contexts providing opportunities for continued growth and improvement which can inform future iterations of program implementation.

Overall, survivor advocates in hospitals appeared were well-received by hospital staff, strongly benefitting the healthcare personnel and patients they served, and their value to community-based anti-trafficking work was also valued by CBO colleagues.

### Theme 1: Survivor Advocate Role

It was a boon to hospitals for CBOs to provide survivor advocates in the healthcare setting to support patient care and aid connecting with patients, while also providing education and training for hospital staff. The valuable first-hand, lived experience of survivor advocates was also recognized by CBO staff as crucial to aid patient support, and provided additional insights on community outreach, management, data collection, and other aspects central to work conducted by CBOs (e.g., topical meetings, revisions to protocol and screening tools, etc.). In sharing their first-hand experiences, survivor advocates specified their primarily focus is supporting people experiencing trafficking, and also as both a resource and providing resource guidance to patients. Hospital staff reacted positively with extensive appreciation of the integration of survivor advocates in the hospital, consistently expressing interest in increasing their availability and presence.

### Theme 2: Organizational Impact

Organizational benefits were observed at every participating hospital as a function of integrating survivor advocates. Interviewee responses pertaining to the integration of the Survivor Advocate Program into the healthcare setting proved consistently advantageous to hospital staff and in supporting care provision for patients. Survivor advocates provided staff with opportunities for additional education and training, reduction of work burden, aided staff coping with patient ambivalence, and facilitated change in staff perceptions and attitudes toward patients. As for benefits to patients, survivor advocates assisted with patient support, and served as a connection to community resources to help meet patient needs (e.g., emergency housing). The extensive appreciation of survivor advocate integration by hospital staff is most apparent in the examples provided when survivor advocates are unavailable. In these examples, it is abundantly clear there has been a considerable organizational impact on hospital staff as a function of their engagement and experiences related to the Survivor Advocate Program.

### Theme 3: Challenges and Growth Opportunities

As to be expected with most programs, opportunities for growth are often presented, as are challenges. The focus of this section was to best structure and convey the challenges and opportunities expressed by interviewees.

Hospitals struggled with issues related to logistics and the initial implementation of the Survivor Advocate Program and with identifying or recognizing instances of labor trafficking with patients. Interviewees shared examples how systemic complications in the community related to pervasive intersectional challenges (across substance abuse, mental health, and housing) complicated and sometimes precluded their ability to supporting patients.

Several perspectives and opportunities associated with CBO challenges and growth were shared by interviewees. Improvements since launching the pilot program indicated the attention and investment in further developing the program to better support patients/clients as well as SAs. CBO leadership conveyed multiple examples of their encouragement and investment in the professional development of the SAs. Exploration of staff perceptions of the organizational dynamics illustrated some contrasts between SA experiences and CBO leadership, which can provide additional opportunities for the growth of the organization.

Across hospitals and CBOs, staff recommendations reflected their careful insights, thoughtful considerations, and clear investment into the continued evolution of the Survivor Advocate Program to improve support for future patients. Additionally, evidence is provided related to the program achievements to support patients through increased identification and in provision of referrals, coupled with gauging community-based providers' satisfaction and assessment. Suggestions for traits considered advantageous for someone considering working as an SA, and organizational planning insights for hiring SAs, are also provided to guide future program implementations.

These qualitative analyses aimed to cohesively amplify the voices of interviewees from hospitals and community-based organizations. Through this amplification, our goal was to instigate a purposeful conversation to convey the key considerations improving support for patients experiencing trafficking by incorporating survivor advocates into healthcare settings. In the forthcoming Discussion, we expand on both our quantitative and qualitative results in more detail while sharing connections to evidence-based research, implications, applications, and conclude our evaluation of the Survivor Advocate program.

## Discussion

Thus far, we have detailed the implementation, outcomes, and impact of this program on health care providers, personnel at community based organization, and survivors working as advocates. In this section, we provide an in-depth analysis of our findings, and explore the broader significance. Specifically, we discuss the program's successes and challenges, highlight areas for improvement, and offer recommendations for future iterations. In doing so, we hope to contribute to ongoing efforts to support survivors of human trafficking in clinical settings, in partnership with essential community based service providers, with the goal of transitioning patients experiencing human trafficking to safety. We also hope as well to promote a more comprehensive understanding of the role that healthcare providers and Survivor Advocates can play in combating human trafficking.

During the three-year project time frame, Survivor Advocates saw 169 patients across more than 30 hospitals. Compared to the pilot project, in which 148 patients were served over 18 months by one SA, the program's success was limited, largely due to the onset of the COVID-19 pandemic in March 2020. Los Angeles County was particularly impacted by the pandemic, both by expansive Stay-At-Home orders and by the sheer number of cases that plagued local hospitals, keeping clinicians as well as the evaluators at Los Angeles County Department of Public Health focused on managing their increased workload for much of the grant period. Nonetheless, despite the delayed implementation and optimization of the SAs in Healthcare Program, evaluation results speak to the importance and value of integrating Survivor Advocates into a hospital setting.

## Discussion of Quantitative Findings and Text Fields

### Patient Characteristics: Gender

As noted in Table 1 above, most of the patients referred to the Survivor Advocate identified as (cisgender) female. Men only accounted for 4% of referred patients, and an even smaller percentage were gender minorities. Male identifying individuals face the common misconception that they are only perpetrators and never victims, or that trafficking among them is far less common than it is in women but in reality, men and boys are targeted for both sex and labor trafficking. Common indicators of trafficked individuals, such as displaying emotions or expressing pain can often be viewed as traditionally non-masculine traits, further stigmatizing male victims and minimizing their experiences.

Male victims may feel even more ashamed of what they have experienced than female survivors and worry about being stigmatized or judged by the clinicians taking care of them, as well the SAs there to assist them. Society often portrays (and expects) men to be strong, self-sufficient, and invulnerable (Kaye, 2018) to the same kinds of issues that befall women, which can make male victims feel immense shame for disclosing to have been victimized in ways that are generally reserved for women and children, whose experiences most fit the traditional narrative of human trafficking.

Many men may not even realize that they are experiencing a crime, let alone recognize that they are being trafficked. Common perception is that men are generally perpetrators of violence, rather than victims of it – as such, it is not a stretch that to assume that the very men being exploited may not see themselves as part of this conversation and may struggle to see themselves reflected in the Survivor Advocates that present a way out of their circumstances.

On a similar vein, gender minorities are often left out of the conversation altogether, despite being disproportionately impacted by trafficking and affected by common precursors to trafficking, such as abuse, violence, homelessness and survival sex (Dank, et al., 2015; Fehrenbacher, et al., 2020; Tomasiewicz, 2018). Gender minorities face similar assumptions to men, that they are often offenders rather than victims themselves (Fehrenbacher, et al., 2020), which can result in bias when they present to a healthcare provider. Adding to this complexity is the fact that exploitation of gender minorities is intertwined with other social identities, such as race and immigration status. The common discourse that trafficking primarily affects cisgender women is deeply flawed, and can leave males, transgender, and gender nonconforming people vulnerable to further victimization. Training SAs and healthcare staff

to be keenly aware of gender minorities and men can greatly improve cultural competency all around and capture these victims who have historically been excluded from the trafficking conversation.

### Patient Characteristics: Origin and Language

Most patients seen by the Survivor Advocate noted the U.S. as their country of origin, which follows population dynamics in Los Angeles County (LAC), where about 33% of residents are foreign-born. However, over 55% of LAC residents speak a language other than English at home, while SAs reported only 11% of referred patients spoke a language other than English in the hospital (primary language was unknown for the remaining 15%). The under-representation of foreign language speakers may reflect that many immigrants in LAC are bilingual, but also suggests the existence of other barriers to recognition of immigrant survivors, given that immigrants and people who do not speak English face elevated risk for trafficking (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011; Office for Victims of Crime, 2023; Zhang, Spiller, Finch, & Qin, 2014). The profound fear, mistrust, and shame that trafficking survivors experience as barriers to disclosure are especially difficult to overcome in the context of a foreign country and culture, where victims sometimes do not even recognize that their abusive working and living conditions are illegal.

Furthermore, when dealing with a sensitive and potentially complex topic like human trafficking, it can be difficult to tease out nuances in how patients experiencing trafficking respond to questions or talk about their personal experiences, hence limiting referrals for non-English speakers and speakers with Limited English Proficiency. Adding to the complexity is the sensitive nature of human trafficking itself (and subsequent conversations about forced sex work, debt bondage, abuse and threats, sexual assault etc.), which may further limit the ability of clinicians to identify a patient who may be unable to express themselves in their preferred language. This could lead to an unintended selection bias, where English speakers are more likely to receive a referral compared to patients who need additional language support. That non-English speakers were underrepresented during the project period indicates that both clinicians and SAs should be hypersensitive to language needs, and request assistance to avoid miscommunication.

### Patient Characteristics: Labor vs. Sex Trafficking

Compared to labor trafficking, sex trafficking was far more commonly identified in the project period. Responses to questions about working with survivors of labor trafficking yielded minimal information in research interviews. Labor trafficking has lately received increased attention in the U.S. media following the uncovering of widespread labor trafficking among migrant children throughout the nation, and the U.S. Department of Labor and some state and local jurisdictions are more aggressively pursuing wage theft cases, which exist on the spectrum of labor exploitation and trafficking (The Advocates for Human Rights, 2016; Harkins, 2020; Kuang & Kalish, 2022; Mangundayao, McNicholas, Poydock, & Sait, 2021) However, since the passage of the Trafficking Victims Protection Act in 2020, which bifurcated sex and labor trafficking under U.S. law, sex trafficking has received disproportionately more attention in the criminal justice system, faith community (Gira Grant, 2012), social service sector, media coverage (Albright & D'Amano, 2017; Austin & Farrell, 2017; Herbert, 2016; Logden, 2021), and funding. Many

human trafficking trainings for law enforcement, the transportation and hospitality sector, as well as for health care and social providers, focus exclusively on sex trafficking, sometimes with a further specialization on commercial sexual exploitation of children. This has created widespread misperception that human trafficking equates to sex trafficking, when in reality, the incidence of labor trafficking exceeds that of sex trafficking across the globe and very likely in the U.S. as well (International Labour Organization, 2023; U.S. Department of State, 2022). The “red flag” trainings that aid in identification of human trafficking victims contribute to this misperception, as many widely taught signs of trafficking also reflect the appearance of people working in the sex trade consensually or in the absence of force, fraud, and coercion (National Survivor Network, 2023).

In a medical setting, labor trafficking also tends to be more difficult to identify, since there may not be any physical signs or overt emotional ones either. On the other hand, sex trafficking may present with indicators that are readily observed by healthcare providers and can lead to suspicion of trafficking even among patients in the sex trade who do not experience force, fraud, or coercion. Meanwhile, presentations of sexual assault typically lead to deeper assessment by healthcare providers and sometimes law enforcement, to ascertain the conditions in which the assault occurred and provide trauma informed care where possible. It is vital for medical providers to be aware of signs that a patient may be experiencing labor trafficking. Workplace injuries may not be obvious, and generally require additional prompting and information gathering in a systematic way that can tease out coercion, restricted movement, and extortion. The structure of the U.S. health care system, in general, and the operations of emergency departments, in particular, often preclude the assessment of social histories by doctors and nurses that could elicit better understandings of patients’ day to day lives. Survivor Advocates in health care could play an important role in addressing these issues. Even in best-case scenarios where clinicians refer a patient to a Survivor Advocate, there may be biases within organizations that work with trafficking survivors, leading to assessments that miss gender minorities, men, and labor trafficking. When such survivors are identified, there are few resources and programs available to serve them.

### Presenting Medical Complaints

Most patients referred to the SA during the study period presented to the hospital with multiple complaints, most commonly mental health related (55 complaints), physical injury (40 complaints) and substance use (17 complaints; note that the third most common complaint category was ‘unknown/unspecified’). These are common presentations that are not necessarily indicators of trafficking, and thus trafficking can be easily missed if a clinician is not aware of other signs or symptoms to look out for in identifying trafficked patients. The more glaring signs – abuse, sexual assault, violence – that are more commonly associated with trafficking may not be present at all. Notably, the SAs served eight individual presentations of injuries stemming from a motor vehicle accident. All the patients who presented with MVA injuries were able to provide more information on how the accidents occurred (thrown out of a moving vehicle, run over by pimp etc.), but it not unreasonable to assume that MVA-related injuries could be overlooked in the clinical setting as an indicator that a patient is being trafficked.

Recent studies (Chisolm-Straker, et al., 2021; Mumma, et al., 2017; Richie-Zavaleta, et al., 2019; Shandro, et al., 2016) aimed at identifying human trafficking in emergency departments and other

healthcare settings highlighted reproductive/gynecologic concerns, abdominal pain, and trauma as common presentations, but also note that with widespread screening, people may present with a variety of complaints that are not as clearly aligned with trafficking, such as seizures or GI problems (Chisolm-Straker, et al., 2021). This further illustrates that clinicians should be more vigilant in noting underlying indicators that may prompt further intervention, even when the presenting complaint seems relatively mundane. The use of screening tools for trafficking that are validated in healthcare settings can also aid in the identification of patients at risk for trafficking who do not present with signs of violence, abuse, or trauma.

### Discharge Outcomes and Services

About 20% of the patients referred to the Survivor Advocate did not have a discharge outcome noted in the final database. Several of them received referrals to services (legal, social services), though it is unclear whether they had a safe place to go following their hospital visit. Among the 80% for whom a discharge outcome was recorded, 15% left against medical advice. About 2.6% of all discharges in California are against medical advice, and studies note that these patients are 2-7 times more likely to be readmitted within a month. Leaving AMA is not advisable for many reasons and for patients who may be trafficked, it reduces the likelihood of meeting with a Survivor Advocate, undergoing a safety assessment prior to discharge, or receiving resources and referrals from social workers and other health care staff. However, coupled with other indicators, this notation on a medical record can be a tool for identifying returning patients at risk for or experiencing trafficking, and prompting a referral back to the SAs. Information on discharge outcomes during this project was limited, unlike the pilot project, which offered more detail on the kinds of housing patients were discharged to, including substance use treatment facilities and providers outside of LAC. Most current patients (28%) were discharged to a shelter, though the final database lacks clarification on what kind of shelter placement (i.e., CAST's human trafficking shelter, domestic violence shelter, general homeless shelter) each patient received.

### Hospital Staff Survey Results

The survey administered through SurveyMonkey was designed to gather information on the experiences of clinical personnel who worked with the Survivor Advocates, as well as to assess the impact of the SA program on their confidence of in working with potentially trafficked patients. While over 260 interviews were expected, 66 hospital staff consented to the survey, and only 45 completed the survey past the consent stage. Overall, hospital staff noted positive interactions with Survivor Advocates, and increased confidence working with patients who are suspected of sex or labor trafficking. Of note, the survey found that hospital staff perceived patients were more receptive to speaking to someone about their experiences and accepting referrals when an SA was involved in their care. This speaks to the vital role that Survivor Advocates play in a clinical setting. Results from the survey were overwhelmingly positive with regards to SA involvement, even though there were a limited number of respondents. Most respondents had been in their profession for over 5 years, indicating that they were likely more invested in and aware of human trafficking, and the positive impact that SAs can have on an organization. In the question about which year respondents worked with the SA, 17% reported they did

not have interactions with SAs from 2018 – 2022, which does not make sense because the survey screened out people who did not interact with the SA. We are unable to interpret these responses.

### Quantitative Data Limitations

The data collection tool included a number of fields to capture patient needs along with referrals to services and resources that were provided to patients, which was an expanded version of the TIMS data collection sheet used by the Office for Victims of Crime. Additional fields were added to the TIMS form in consultation with the CBOs. However, CAST and Journey Out used the tool in different ways. During the data analysis phase, we discovered that these data were not usable, as they were incomplete and often included contradictory information. As such, the research team decided against including them in this report.

While the SA patient needs and referrals data collection tool was created with extensive input from CAST and Journey Out, the data collection process was not clear, thorough or streamlined enough. OWH should have implemented measures to review the data on a timely manner in order to parse out potential issues with data collection. However, staff capacity at OWH was severely strained due to the COVID-19 pandemic response efforts undertaken by the LAC Department of Public Health (DPH). While the pandemic affected the workload of health departments across the country, LACDPH was severely impacted as 75% of staff were deployed to different units within the emergency response, including 100% of the PI's staff, where no research analysts were available during the three year grant period. This made timely and regular data reviews impossible to implement. Data reviews would also have provided a chance for SAs to gain knowledge in how the data they collect may be beneficial for their organization not just for the purposes of the project at hand, but in future program planning, and in adding to the field of human trafficking research overall.

Most of the patient data analyzed here were collected by the Survivor Advocates, including patient indicators of trafficking and presenting complaints. While many of the patient characteristics are readily observed by the SA, racial and ethnic data may be misclassified. Presenting medical complaints can often be complex, and Survivor Advocates may not always have the capacity to understand medical terms and interrelated presentations. As an example, one presenting complaint was specified by the SA as "stomach pain." While this may be exactly what the patient said to the medical provider and later relayed to the SA, it is possible that "stomach pain" was used as a general term for a more specific pain or injury – such as pelvic pain or even injury of an internal abdominal organ. Review of medical records would be preferable to ascertain many of the presenting complaints, and to capture nuance in the medical evaluation that may not have been communicated to or understood by the Survivor Advocate. The research team, including OWH and Dignity Health/CommonSpirit, may pursue exploration of medical record data for the patients served in the program.

Periodic check ins with the CBOs did not bring to light the misunderstandings about the data collection tools or the use of the CARE measure. For the CARE measure in particular, CBO staff reported that patients were not coming into the office due to the pandemic, so they could not administer the paper survey that had been designed originally. An electronic version was created, but by the time it was approved through the IRB and disseminated to clients by the SA, the grant period was nearing a close and most people served were either lost to follow up or did not respond to emails and texts. Staff

changes within the CBOs may also have contributed to confusion around data collection tools. This is a common but preventable issue that, again, could have been rectified had it been possible to provide data collection training exercises for all members of the team and repeat the training exercises with new staff.

Finally, engagement in the staff survey was quite low, as the number of respondents represented only 17% of the sample size goal. Efforts by CommonSpirit research team members to increase participation helped but overall, this component of the evaluation fell short. Implementation of the survey was delayed two years due to the stressors of the COVID-19 pandemic on hospital operations and staff, and subsequent turnover of clinical personnel, especially nurses, likely resulted in people eligible for the survey no longer being employed at CommonSpirit hospitals. The pandemic also limited the presence of SAs in the hospitals for the first half of the program period, stemming from strict stay at home orders for several months and high case rates in the County during much of this time frame.

## Qualitative Data Results

### Survivor Advocates: Roles and Benefits to Personnel and Patients

Qualitative findings revealed universal praise of the Survivor Advocates in Healthcare program by both hospital and CBO personnel. SAs fulfilled the promise to better engage patients, establish rapport, and increase the acceptance of community aftercare services by patients in the four CommonSpirit hospitals. They educated hospital personnel, increased their levels of compassion for marginalized patients, and reduced the work burden of social workers by providing emotional support to patients and arranging for safe discharges. They were perceived as professional, hard working, effective, and indispensable by the health care providers who most often worked with them. Data demonstrate how the SAs catalyzed the provision of trauma-informed care, operationalizing the principles of safety; trustworthiness; peer support; collaboration (particularly in decision-making about referrals and reporting harm); and empowerment, voice, and choice. The support SAs provided patients directly manifested these principles, while their presence in the hospital and interactions with clinical staff modeled trauma-informed behavior and appropriate survivor engagement. When asked how to improve the program, the overwhelming response by interviewees was to expand it – in number of advocates, hours of operation, and reach to other departments and hospitals.

On the CBO side, SAs provided crucial insights on community outreach and internal processes such as documentation and screening tools.

The third theme to emerge was the challenges that arose over the course of the program across all contexts, providing opportunities for continued growth and improvement which can inform future iterations of program implementation. Perhaps the most prevalent challenge was noted to be providing support to patients with complex challenges – mental health needs, substance use disorder, housing needs – which uncovered systematic problems in resource finding and reflected the need for community resources that center intersectionality. Finally, at one CBO, findings revealed the need to explore how to better empower Survivor Advocates and integrate their input into decision-making.



## Program Challenges

The greatest challenges faced during the program were systemic problems—issues that our society in general, and Los Angeles County, specifically, are struggling to manage despite investments of billions of dollars. As a county, state, and nation, we lack sufficient capacity to take care of all unstably housed people with mental health problems and substance use disorder. In California, high housing costs have created the highest rates of poverty and homelessness in the U.S. (National Low Income Housing Coalition, 2023). As a nation, nearly seven million more affordable housing units are needed for people with extremely low incomes (Walters, 2023) and Los Angeles County alone has an estimated shortage of half a million affordable housing units (County of Los Angeles Homeless Initiative, 2023). Crisis response beds are also in short supply.

While changing these conditions requires protracted effort and reinvestment by society as a whole, including government and private sector partners, ultimately, shorter term solutions are essential for the Survivor Advocates in Healthcare program and similar programs to succeed. As noted in interviews, once a trafficking survivor is ready to accept assistance and services, they often need, first and foremost, a safe place to stay to extricate themselves from their situation. Greater investment in housing solutions by government and private funders could allow social agencies to procure the space and staff needed to provide additional emergency and transitional housing, as well as more crisis beds in hotels and motels with accompanying case management support.

As noted in interviews, even with CBOs that do have the capacity to shelter survivors of trafficking, placements are lacking for survivors who face any complicating issues. While many patients who experienced trafficking were turned away from housing for serious mental health or substance use disorder issues, some clients faced barriers that may have been grounded in provider bias, stigma, and fear. Ongoing assessment, re-evaluation, and exploration of shelter placement criteria should be conducted to remove barriers to this essential service, even if additional investment in staff time and training are needed. Again, investments in housing stability for the most vulnerable are desperately needed, and ideally would include innovative tiered systems from crisis housing to longer term transitional and permanent housing, all with programmatic support.

## Four Hospitals, Four Programs in Different Stages of Implementation

One issue that emerged for the evaluation team was the different levels of implementation of the SA program at the four different hospitals in the Dignity Health/CommonSpirit system in LAC. Though these concerns emerged rarely in interview data, quantitative data described above reflect the varying level of engagement of SAs at the different medical centers, through the numbers of referrals to the SAs and the number of staff who participated in the evaluation survey. Participation in research interviews also varied greatly by hospital, with a range of only two interviewees from one hospital to a maximum of ten (comprising 50% of all healthcare participants) from another. During meetings with hospital leads during the course of the project, the evaluation team also observed a lack of consistent participation, and sometimes a complete lack of participation, by certain hospitals, whereas other leaders were fully engaged. Furthermore, the team was surprised to learn that one hospital staff member referred to us for an interview did not even realize that the SA program had re-started since the original advocate left employment, even though the interview occurred over a year after another SA had been hired. While

healthcare staff actively engaging with SAs believed the program was well-known and well-integrated into their work, gaps clearly existed in communication about and implementation of the program during this grant period.

### Models for Survivor Advocates in Healthcare: CBO or Hospital-Based?

One important consideration the research team has discussed during this project is whether it is more advantageous for Survivor Advocates to be based within community-based organizations and respond out to bedside calls for assistance from hospitals and other health care agencies, as is common in sexual assault response advocacy programs, or for hospitals and health care systems to employ Survivor Advocates directly.

In the Dignity Health and CAST pilot which preceded this Office for Victims of Crime-funded project, circumstances resulted in the Survivor Advocate spending much of her time in one particular hospital that was near her home. This created a different dynamic for the program, with the development of strong relationships and deep trust between the SA employed by a CBO and the hospital staff she engaged with several days a week. She became a regular presence in the emergency department and other hospital floors there and gained access that an outside person would not normally have in a health care setting, although she could not access to patient charts or be privy to conversations involving personal health information. Indeed, the CBO employee was so enmeshed in the hospital that people observed her identifying herself as a Dignity Health employee. Advantages of the SA spending so much time on site were described by personnel at the hospital she frequented most, with interviewees noting that human trafficking stayed “top of mind” when the advocate was physically present and that she was thoroughly integrated into their response to patients at risk.

On the other hand, hospital employees who care for patients typically are not able not focus on developing deep partnerships with all the diverse community and government agencies collectively serving survivors of human trafficking and other forms of violence, which is a key asset of community-based SAs that hospital personnel value. Furthermore, by being based in the hospital setting during the pilot period, close connections between the SA and her CBO teammates were not fostered, and relations became strained, which created a different set of problems. An exploration of the implications of the pilot project model versus the current project is beyond the scope of this grant and this report, but warrants further analysis and discourse.

Meanwhile, interviews for this evaluation revealed a new model for the CBO response to hospitals, that began out of necessity during the coronavirus pandemic, in which the SAs connected with patients on the phone to ascertain if they wanted assistance *before* the SA physically traveled to the hospital. This approach has clear benefits, as interviewees described, in allowing the CBO to more quickly connect with patients referred to the SA, thereby enabling hospital staff to more quickly discharge patients who decline assistance. This frees up needed emergency department or inpatient beds and prevents SAs from driving to hospitals to see patients who then decline assistance—which in a geographically large place like Los Angeles with congested traffic, can cost hours of valuable time and effort. On the other hand, many interviewees from both the hospitals and CBOs valued the conversations SAs had with patients who were not ready or able to disclose a trafficking situation or to accept assistance.

This illustrates an important trade-off of the phone triage model, whereby having in-person SAs can provide more intimate encounters and opportunities to educate patients not ready or able to leave their trafficking situations. These moments of connection provide rare, brief windows to “plant seeds” of kindness, respect, autonomy, choice, and hope in the psyches of survivors who may be unfamiliar with all these concepts and lack any sense of having options in life. While these SA encounters do not result in patients immediately exiting trafficking, they create opportunities for secondary and tertiary prevention through future engagement, as personal connections are made, contact information shared, and resources provided. Furthermore, having in-person SAs also allows them to model for other clinicians how they interact with patients unwilling or unable to accept help, including through subtle modifications of language or demeanor. Many hospital interviewees described how working with SAs allowed them to better understand and accept patients’ decisions to decline help. Given the value of highly accessible SAs, in smaller communities it makes sense to have SAs respond on-site whenever a healthcare provider has concerns that a patient may be trafficked. In LA County, given the opportunity costs of in-person responses, phone triage seems like a necessary modification, unless the program could be greatly expanded to provide locally based advocates for each site to reduce travel time and cover the geographic expanse of the county.

### Role and Voice of Survivor Advocates in CBO Structure

The employment of human trafficking survivors in anti-trafficking work is widely discussed and debated in government and non-profit circles; at local, regional and national conferences; and online. Trafficking survivors did not initiate the movement to create responses to the crimes described in the United Nations Palermo Protocol and the U.S. Trafficking Victims Protection Act of 2000 – these steps were largely taken by government entities, wealthy donors, and non-profit organizations that were not survivor led. This stands in contrast to other modern social movements, like the disability rights movement (“nothing about us without us”), AIDS activism (e.g., the AIDS Coalition to Unleash Power, ACT UP), and the domestic violence (“battered women’s justice”) movement, which all arose from the collective power of people directly impacted by the conditions they advocated to address.

For many years, survivors of trafficking have lamented their tokenization in efforts to combat trafficking, reporting that anti-trafficking organizations have them repeatedly tell their stories of exploitation (sometimes known as “trauma porn”) for fund-raising, media, and educational purposes, often without compensation or sufficient respect for them as human beings whose lives encompass more than their experience of harm. Throughout the nation and the world, survivors are organizing themselves, starting projects and agencies, writing about their experiences in the movement, and working to gain access to diverse anti-trafficking jobs in programmatic, policy/advocacy, administrative, and leadership roles. At both Los Angeles County-based CBOs involved in this project, survivors of trafficking have been integrated into a variety of roles and their presence welcomed as part of organizational culture. Nonetheless, findings in this evaluation indicate that the dynamics of collaboration and power-sharing remain fraught, despite the organization’s best intentions.

One distinction revealed during interviews was the difference in how each organization structured the SA’s roles and also work with survivors. For one organization, the SA provided emergency response to patients in the hospital and continued to serve them as her agency’s clients, comprising what essentially is a case management role. Clients at this agency seem to be able to come and go from programming with no definite end date, so as survivors navigate the road to recovery, healing, autonomy,

independence, and financial stability, they may step away from and then reconnect with this SA or other advocates as needed. At the other organization, the SA worked as part of the emergency response team and not formally as a case manager, and she reportedly lost access to clients she worked with in the hospital as soon as they were accepted into one of the CBO's programs, where they were assigned a permanent case manager. Clients here receive a full range of services as needed but eventually graduate or otherwise transition out of the programs, though they have the opportunity to join a survivor caucus for continued peer mentoring and advocacy if this interests them.

Each model reflects the complexity of CBOs' staffing levels, available talent, services offered, funding, and histories, and it is beyond the scope of this evaluation to explore how staff who identify as survivors of trafficking are integrated (or not) into all aspects of the work. However, one SA's descriptions about how she was unable to support her clients in times of need due to the constraints of her role does raise concern and is worth highlighting here. These cases seemed to involve patients the SA engaged through hospitals, who were then temporarily housed in hotels or motels prior to entering the CBO HT-specific shelter. At this time, they were technically "transferred" to the shelter program at the organization, but in reality were on their own, and left to fend for themselves pending physically moving into the shelter. In one of the accounts the SA shared, a client placed at a motel was struggling with addiction issues, having just gotten clean in order to receive trafficking aftercare services. Given that the SA is in recovery from substance use disorder and has professional experience as a case manager and resource navigator, she was well positioned to provide peer support to this survivor in crisis, but was not able to because of CBO policies or rules. A negative outcome ensued.

In general, the quick disconnection of the SA from the patients who become agency clients may be short-sighted, because peer support and peer mentoring are documented to be important to human trafficking survivor recovery and healing (Rajaram & Tidball, *Survivors' Voices - Complex Needs of Sex Trafficking Survivors in the Midwest*, 2018; National Human Trafficking Training and Technical Assistance Center, 2019). An online report highlighting findings of a study of adult sex trafficking survivors in Nebraska highlights one survivor saying, "It just seems like if I were able to talk to more survivors, there could be more that could happen...for healing....I'd like to see a certification program for survivors...for peer support nationally...so that you know...all these people can employ peer support along with social workers...A lot of people have, gone back afterwards, and I think that peers could gain trust faster and, and, stop some of the recidivism." <sup>5</sup> (Rajaram & Tidball, *Nebraska Sex Trafficking Survivors Speak - A Qualitative Research Study*, 2019)

Peer support is also well-evidenced to be essential to recovery from substance use disorder (National Human Trafficking Training and Technical Assistance Center, 2021). As noted in OVC's recent request for proposals, "Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse (Office of Victims of Crime, 2023). While one interviewee discussed

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<sup>5</sup> With use of the term "recidivism," this survivor talks about sex trafficking victimization as if were the committing of a crime, which may reflect that many services provided to trafficking survivors in the US are accessed largely through engagement with the criminal justice system.

the value of advocates at the agency with and without lived experience playing the same roles, and being able to cover for one another to prevent overworking and burnout, the CBO has the opportunity to creatively structure the SA role. They could explore utilizing the current SA's unique skill set to improve the response to trafficking survivors fresh out of exploitative situations, especially those whose trauma is compounded by addiction.

The other CBO challenge identified in evaluation interviews regarding the SA role reflected a theme that unfortunately also emerged during the pilot program. While this SA enjoyed many aspects of the work and hoped to grow the program and her position, she did not feel respected or valued by her co-workers, and believed her clients' needs were not being met because of inflexible CBO policies and lack of trauma informed care. She believed that some colleagues used her lack of formal education against her— she used the term “bullying” to describe this— and highlighted their own education as a reason to not listen to her recommendations about how to best meet her clients' needs. Two stories she shared in the interview about how the CBO failed to adequately manage or support clients newly dealing with sobriety, leading to client suffering, warrant exploration and reflection by this experienced anti-trafficking agency.

Mistakes are inevitable, and hospital personnel also shared accounts of patients discharged back into the trafficking situation they could have otherwise escaped with better assistance. In one instance, according to a hospital lead, a patient on a psychiatric hold was unfortunately released back to the trafficking situation that she came from, which was not the plan. Even though the patient was psychologically unwell, and indicated she was willing to accept services, hospital staff discharged her back into her trafficking situation. This result could have likely been circumvented if appropriate hospital staff, an SA, or other CBO staff were notified by the discharging team, highlighting a need identified in some interviews for better coordination of the program at the hospitals.

Given the conscious awareness CBO interviewees shared of the importance of survivor voices and input, it is well-advised for leadership to consider earnestly cultivating fuller engagement of staff with lived experience. The CBO where the SA expressed concern has taken important, concrete steps to elevate survivor voices in the agency's operations, and this effort should continue. Through this meaningful engagement they can ensure people impacted by trafficking are also involved in the development, implementation, and evaluation of solutions. (Ash & Otiende, 2023).

### Qualitative Data Limitations

As with all study methodologies, there are limitations to consider. First and foremost, qualitative research studies often do not have large sample sizes, which can contribute to the limitations of the qualitative component of the evaluation. However, the limited number of interviews conducted (28, with one person interviewed twice) provided opportunity to explore more depth of experience, rather than breadth.

Similarly, the selection of interviewees was not systematic and the participation of interviewees may be biased to those willing, able, and interested in participating in the evaluation process. The demographic characteristics of interviewees were not explicitly of interest, but we did aim for greater variety of staff roles among interviewees than we were able to achieve. More interviewees were sourced from one

hospital compared to all other hospitals, most interviewees were social workers, and not as many interviews were provided by clinical staff including nurses, advanced practice clinicians, or physicians as desired. Along the same lines, there were slightly more interviewees from one CAST than there were at Journey Out, and more diversity in roles at the CBO could have been represented.

Another potential limitation could be the number of interviewers and interview engagement with interviewees. In some instances, there was more a conversational back-and-forth between the interviewer and the interviewee than in other interviews. This is not of particular concern, though, because some interviewees may have needed more explication than others to aid in the depth of processing of the question to aid constructing their response.

Due to staff experiences related to only the pilot program, and not the current SA program, some interviewees were unfamiliar with the SAs for the current project and instead referred to the pilot SA in their interviews. Though this is a limitation related to the current study, the experiences with the pilot SA were deemed valuable and interesting because the nature of the successful relationships between the SA and hospital staff were still relevant in supporting patients and exploring the Survivor Advocates model. However, it is important to note that CBO staff interviews largely did not discuss the original SA, so the positives of the work done in the hospitals 2018-2020 were explored while CBO dynamics during that time period were only touched upon.

The timing of the interviews could be understood as a limitation as some interviews occurred in earlier phases of the program relative to others which occurred in later phases. More insights may have been available if all interviews occurred at the later phases of the study, but given the limited time available to conduct the interviews, staffing complications related to the ongoing coronavirus pandemic, and necessity to complete work during the grant period, timing was of the essence.

## Recommendations

### General Recommendations

#### 1. Improving access to Survivor Advocates

- More advocates and more hours of coverage, including nights and weekends or 24/7 coverage.
- Build out the program and hire more survivors.

#### 2. Expansion of program

- Better integration of SA project into all four local hospitals and into in-patient and other Departments within hospitals
- More on-site visits to hospital units for program promotion
- Model should be “standard of care”

- Extend cooperation with additional community referral partners to meet patient needs, including patients experiencing domestic violence and sexual assault or cross-train SAs
- Hiring of diverse advocates

### 3. Improved Coordination of Program

- More streamlined, timely onboarding of SAs to hospitals, rather than individual, prolonged processes for each hospital in the system
- Clear point person at each hospital for SAs to connect with
- Additional staff to support the program
- More clarity around processes when the SA is not available
- Development and dissemination of a training manual for the program (a deliverable of this grant-funded project)
- Regular dissemination of updates about the program due to changes in resource availability, staff turnover, and organizational change within the hospital, CBOs, and other partners

### Hospital Recommendations

- More streamlined and efficient process at the hospitals for onboarding SAs
- Ongoing education for staff, including on labor trafficking and more subtle presentations of human trafficking, including with patients with limited English proficiency, immigrant populations, and non-English speakers
- Adding human trafficking questions validated for use in health care settings to intake forms to identify patients not presenting with clear signs of injury, violence
- Point person at each hospital/department for SAs
- Charting mechanism to highlight key discharge instructions while maintaining patient privacy
- More awareness related to risks of sending survivors to some types of shelters

### CBO Recommendations

- Hotline response improvements
- Better integration of coverage across SAs and organizations
- Ongoing trainings for SAs – coping with vicarious trauma, burnout, and setting boundaries [to improve longevity in this field]; also challenging, commonly faced patient/client issues including substance use disorder, mental health problems, homelessness, and housing or residential treatment programs
- SA support until and beyond hospital discharge

- Prolonged engagement of SAs with survivors newly out of HT situation, providing peer support, vs. limited to emergency response role; survivor mentorship by SAs
- Implementation of life skills training for survivors
- Increased provision of immediate and long-term support
- Provide phones for survivors/clients/patients for follow-up
- Transportation availability for survivors/clients/patients
- Survivor-informed CBO guidelines/policy/processes; more power provided to SA in decision-making for clients
- More survivor leadership; increased utilization/engagement of Lived Experience Steering Committee
- Avoidance of sending survivors to shelters that may be uncomfortable or unsafe
- Encouragement of feedback/feedback loop between SA, supervisors, leadership
- Creation of feedback loop with healthcare providers who refer patients to SA program
- More time off and better pay for SAs

#### Recommendations for Policy Makers and Funders

- Greater proportion of funding to comprehensive survivor services and primary/secondary/tertiary prevention vs. criminal justice responses
- Prevention funding to support survivors of violence and exploitation who do not meet legal definitions of trafficking but remain vulnerable to severe forms of trafficking in persons
- Funding for health care systems and providers to improve responses to patients impacted by human trafficking
- Funding for health care systems and providers to understand and implement trauma informed service delivery and harm reduction approaches
- Funding for reserved hospital beds to allow people to stay overnight for safety and security purposes, who are otherwise medically cleared for discharge; not discharging before safe arrangements and follow up appointments are made
- Innovative investment in housing, including focus on housing for survivors experiencing acute and chronic problems with mental health, substance use disorder, injury, and disability; vouchers for Section 8 housing
- Survivor-led shelters and more trauma-informed shelters
- Funding for smart phones for survivors/clients/patients for follow-up



- Transportation availability for survivors/clients/patients
- Funding for both immediate and long-term supportive services for survivors
- Investment in IT funding for database advancements and funds to cover staff time for data training and entry
- Investment in survivor leadership

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## Appendices

Four interview documents:

- A. Clinical Personnel
- B. Administrative Leads
- C. CBO Staff
- D. Survivor Advocates

Additional Data from Patient Characteristics

- E. Hospital Names
- F. Presenting Complaints
- G. Referral Reasons
- H. Patient Indicators
- I. Survivor Observations

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## **APPENDIX A: Semi- structured interview script, clinical hospital staff**



## **Dignity Health Survivor Advocates in Healthcare Program Evaluation – Los Angeles County Department of Public Health**

### **Semi-Structured Interview Questions for Clinical Hospital Personnel**

*Note to interviewers: Whenever possible, ask interviewee for specific examples to support their responses.*

- Please explain your job in the hospital—what you do, in what setting.
- How long have you been in this professional role here? How many years have you been in your profession?
- Have you worked with one or both of the Human Trafficking Survivor Advocates?
  - Which one, or both?
  - What were your expectations for working with Survivor Advocates?
  - How has working with Survivor Advocates compared to what you initially expected?
  - Has anything surprised you about working with the Advocate(s)?
- How were you able to work collaboratively with the Survivor Advocate(s)?

*[Note to interviewer: if needed, working collaboratively means that you and the Survivor Advocate were in a professional relationship that was: well defined, mutually beneficial, respectful to each other's skills and roles, and allowed you to achieve a desired and shared outcome.]*

- Are there any skills, traits, or knowledge that you think are important for a Survivor Advocate to have for working with hospital staff? (If yes, please give examples.)
- Were there any challenges to working collaboratively with the Survivor Advocate? (Please describe.)
- Do you think having a Survivor Advocate available to respond to potential victims of trafficking was **beneficial for you or your team**?
  - How so? (If not, why not?)
- Has working with Survivor Advocate(s) impacted your ability to recognize risk factors, signs and symptoms of *sex trafficking* in your patients? (If yes, how so? If not, why not)
- How has working with Survivor Advocate(s) impacted your ability to recognize risk factors, signs and symptoms of *labor trafficking* in your patients? (If yes, how so? If not, why not)
- Do you think having a Survivor Advocate available to respond to potential victims of human trafficking was **beneficial for the patients** at this Hospital?
  - How so? (If not, why not?)

**Dignity Health Survivor Advocates in Healthcare  
Program Evaluation – Los Angeles County Department of Public Health**

- (If not already addressed) Do you think/how do you think having a Survivor Advocate available has impacted patients' openness to speaking with someone about their concerns, particularly about violence they've experienced?
- (If not already addressed) Do you think/how do you think having a Survivor Advocate available has impacted patients' willingness to accept social service referrals and other referrals for care outside the hospital?
- Can you describe if/how working with Survivor Advocates has influenced **how you think about and respond** to patients who disclose that they are victims of human trafficking, or who you suspect are experiencing this?
  - How about patients who have experienced other forms of violence, like intimate partner violence or sexual assault?
- Thinking about experiences when you interacted with patients who had risk factors or signs or symptoms of human trafficking or other forms of violence or abuse –
  - How would you describe your comfort level with patients who not disclose that anything was wrong or who declined to accept help?
  - Do you think working with Survivor Advocates has helped you feel more comfortable or able to respect these patients' attitudes or decisions? (if so, how? If not, why not?)
- Was the Survivor Advocate response efficient?
  - Were you able to integrate it into the routine provision of care? How so, or why not?
  - Did you run into issues regarding the timeliness of the response?
- What challenges did you face when trying to assist patients in partnership with the Survivor Advocate? For example,
  - Regarding finding services or shelter/housing for
    - Adults or children?
    - Women vs men vs trans/gender non-conforming people?
    - People who did not speak English?
    - Patients with mental health problems?
    - Patients with substance abuse problems?
    - Patients with criminal backgrounds?
  - Other challenges based on hospital systems or resources in the community?
- What would you do to improve the Survivor Advocates in Healthcare program?

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## **APPENDIX B: Semi- structured interview script, hospital leads/administrators**

## **Dignity Health Survivor Advocates in Healthcare Program Evaluation – Los Angeles County Department of Public Health**

### **Semi-Structured Interview Questions for Hospital/Task Force Leads/Administrators**

*Note to interviewers: Whenever possible, ask interviewee for specific examples to support their responses.*

- Please explain your job in the hospital—what you do, in what setting.
- How long have you been in this professional role here? How many years have you been in your profession?
- In your professional role, how do you interact with the Human Trafficking Survivor Advocate program?
- At which hospital do you work (or work most often with the Survivor Advocate)?
  
- What is your general understanding of the Survivor Advocate program and what it aims to accomplish?
- Has anything about the program been different from what you expected, or has it surprised you in any way?
- Do you think having a Survivor Advocate available to respond to potential victims of trafficking is beneficial for you or for staff?
  - How so/why not?
- Do you believe that placing Survivor Advocate(s) in the hospital has impacted staff's ability to recognize risk factors, signs and symptoms of *sex trafficking* in patients?
  - (If yes, how so? If not, why not?)  
*Note to interviewer –ask for specific reasons/examples*
- Do you believe that placing Survivor Advocate(s) in the hospital has impacted staff's ability to recognize risk factors, signs and symptoms of *labor trafficking* in your patients?
  - (If yes, how so? If not, why not?)  
*Note to interviewer –ask for specific reasons/examples*
- Do you believe that having a Survivor Advocate working with hospital staff to support patients exposed to violence has improved quality of care?
  - How so or why not?  
*Note to interviewer: explore reason for answer – specific examples, anecdotes, or data*
- Do you believe that the Survivor Advocate program has improved provision of appropriate referrals for specialized social services, shelter, and other needs at discharge for patients experiencing human trafficking?
  - How so or why not?  
*Note to interviewer: explore reason for answer – specific examples, anecdotes, or data*
  - Do you think having the Survivor Advocate has helped staff learn how to better accept patients' decision to decline help or support, and engage in shared decision making?  
*Note to interviewer: explore reason for answer – specific examples, anecdotes, or data*

## **Dignity Health Survivor Advocates in Healthcare Program Evaluation – Los Angeles County Department of Public Health**

- In your role, have you been able to work collaboratively with the Survivor Advocate?  
*[Note to interviewer: list attributes of collaborative traits if needed: you and the survivor advocate were in a professional relationship that was: well defined, mutually beneficial, respectful to each other's skills and roles, and allowed you to achieve a desired and shared outcome.]*
- Has the Survivor Advocate response been efficient?
  - Have staff been able to integrate it into the routine provision of care? How so, or why not?
  - Have there been any issues regarding the timeliness of the response?
- Are you aware of any challenges with community-based resources that have limited the usefulness of the Survivor Advocate program? For example—
  - Regarding finding services or shelter/housing for
    - Adults or children?
    - Women vs men vs trans/gender non-conforming people?
    - People who did not speak English?
    - Patients with mental health problems?
    - Patients with substance use problems?
    - Patients with criminal backgrounds?
    - Other?
- Has the Survivor Advocate program shifted your thinking about patient-provider interactions, particularly staff interactions with patients who have experienced human trafficking or other forms of violence?
- Are there any other systems, policies or support that should be in place for health care staff to facilitate working with a survivor advocate?
  - What about systems, polices, or support for the Survivor Advocates themselves?
- What changes or improvements would you make to the Survivor Advocate program to make it more effective?
- What would you tell other Task Force Leads/Hospital Leads/Managers about how to best utilize a Survivor Advocate program?

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## **APPENDIX C: Semi- structured interview script community based organization staff**

## Survivor Advocates in Health Care Evaluation by LA County Department of Public Health, Office of Women's Health

### Semi-Structured Interview Questions for CBO Staff

- What is your role at CAST/Journey Out and how have you interacted with the Survivor Advocate?
- Was it clear from the beginning of the Survivor Advocate Program how you or your team would engage the Survivor Advocate?
  - If yes, (if not the person who planned the program), how did you learn about the plan for the program?
  - Did the process of engagement or roles change over time? (If yes, how so?)
  - If not, how did you determine the process for engagement and what works well about it? What could be improved?
- What challenges have you identified in implementing the Survivor Advocate Program and how have you addressed these challenges?
- How are you able to work collaboratively with the Survivor Advocate?
  - **Interviewer note:** *You and the survivor advocate are in a relationship that is well defined, mutually beneficial, respectful of each other's skills and roles, allows you to achieve common goals, a desired and shared outcome.*
- What are your impressions of the Survivor Advocate's experiences with your organization?
  - Do they work well with other staff and leadership?
  - Do they seem to enjoy their position?
  - Does integrating a person with lived experience into the work flow require any modifications to how you operate?
  - How do you ensure that the workplace is trauma informed?
  - What measures are incorporated to provide support to the Survivor Advocate, especially when they may be re-traumatized by a client's case?
- Do you think having a Survivor Advocate available to respond to potential victims of trafficking is **beneficial for your organization?**
- **In your perception, is the Survivor Advocate Program accomplishing the goals [CBO] hoped for?** [*Interviewer note: have participant identify goal(s) they are referring to if not explicitly stated.*]
  - If yes, what factors contribute to its success?
  - If no, what factors prevent it from reaching the level of success you hoped for?
  - Additional goals you would recommend?
- **Do you think having a Survivor Advocate available to respond to potential victims of trafficking is beneficial for your individual work at [CBO]?**
  - **Interviewer note:** *How could the benefit increase?*
- Do you think having a Survivor Advocate available to respond to potential victims in hospital settings is a good strategy/resource to address Human Trafficking?
- Do you have a sense if the Survivor Advocate Program is **beneficial for hospital staff?**
- Do you feel the services and resources currently available through your organization and its partners meet the needs of clients identified by the Survivor Advocate?
  - **Interviewer note:** *this includes CAST/Journey Out and/or other services*
  - *(If no, what else is needed?)*
- What improvements would you make to this Survivor Advocate program to make it more effective or better for the Survivor Advocate?
  - For [CBO] staff and clients?
  - For connecting HT clients to resources in general?
- What would you want hospitals to know about Survivor Advocates before they implement a collaborative program with CAST/JO or another agency?

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## **APPENDIX D: Semi- structured interview script, Survivor Advocates**



Dignity Health Human Trafficking Survivor Advocate Program  
Community Based Organization Interview Scripts - Survivor Advocates  
Evaluation by LA County Department of Public Health, Office of Women's Health

**Questions for Survivor Advocate:**

- What was it like for you to join the staff at CAST/Journey Out?
  - What worked well for you? What could have been improved?
- What other CAST/JO employees have you worked with during this program?
  - How would you describe these work relationships in terms of --
    - Training, guidance?
    - Availability and support offered by other staff?
- What were the most helpful aspects of your work with your supervisor?
  - What elements of this relationship could have been improved?
- What characteristics and skills do you feel you possess that allowed you to engage and work collaboratively with hospital staff?
- Did you feel valued or appreciated in your work by doctors, nurses, and other hospital staff during the time you spent in the hospital?
  - If yes, please explain what helped you feel valued/appreciated.
  - If no, please explain what contributed to you not feeling supported/valued/appreciated.
- What kind of training or other preparation do you think clinicians and other hospital staff should have to effectively engage with a survivor advocate?
- What characteristics and skills do you possess that allowed you to work effectively with patients who hospital staff suspected were victims of trafficking or other forms of violence?
- What additional characteristics or skills do you feel a Survivor Advocate should have to maximize their success in this position?
- What were the greatest personal and professional challenges you faced while working as the Survivor Advocate?
  - How did you handle these challenges?
  - How could they have been prevented?
- Do you think having a Survivor Advocate available to respond to potential victims of trafficking was **beneficial for potential victims of trafficking**?
- How do/did you manage any stressful or triggering aspects of this work?
  - What changes to the program could be implemented to support, reduce or alleviate this?
- What changes would you make to the Survivor Advocate position (i.e. workload, schedule, vacation days/PTO, etc.) to improve it?
- What elements of the current Survivor Advocate position were most important to you and would benefit other survivor advocates in similar programs?
- What improvements would you make to this Survivor Advocate program to make it more effective?
- What aspects of this position did you enjoy?
- What aspects of this position did you not enjoy?
- If you were to start this position from the beginning, what would you do differently?

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## **APPENDIX E: SurveyMonkey Questionnaire**

## Introduction

**You are invited to participate in the evaluation of Dignity Health’s Human Trafficking Survivor Advocates in Healthcare Program. This evaluation is a research study on the process and outcomes of this program, and will include approximately 260 employees across four Dignity Health hospitals. You were invited to participate in this study because you may have engaged with the Dignity Health Human Trafficking Survivor Advocate Program.**

**This survey will take 6-10 minutes to complete and your responses will be anonymous.**

**Question 1 explains what else you can expect as a participant if you choose to volunteer in the study.**

**We know you are busy and we appreciate your time.**

## Informed Consent

### \* 1. Purpose:

The purpose of the Survivor Advocate Program is to increase engagement and support of victims of human trafficking who are identified in hospital-based settings. The evaluation will serve to identify successes and areas for improvement in the Program to further support nurses, social workers, doctors, and other healthcare professionals in their work with patients who may be trafficked. We also want to improve the delivery of trauma-informed care to victims of violence who seek care in the hospital.

### Procedures:

If you volunteer to participate in this study, you will complete the following survey.

Results will only be shared in aggregate (results from many people pooled together) and any specific comments from you that we highlight will not include any information that could reveal your identity.

### Potential Risks or Discomforts:

Some of the questions could trigger uncomfortable or uneasy feelings, even if you choose not to answer them. If this occurs and you would like to speak with someone for support, please contact the Employee Assistance Program (Anthem Blue Cross) at 1-800-999-7222 or [www.anthemEAP.com](http://www.anthemEAP.com) (enter "Dignity Health" to log in as an employee member).

### Potential Benefits:

You may feel a sense of satisfaction from sharing your personal experience and expertise with the research team. More importantly, your participation will help us better understand how trafficking victims are identified and supported in community hospital settings, and how health care professionals can learn to better respond to patients who may be trafficked.

### Compensation:

You will not be paid for your participation in the study.

### Participation and Withdrawal:

Your participation in the interview and survey are voluntary. Some of the questions in the survey must be answered before you can move to the next question; if you don't want to answer a required question, you can stop taking the survey at that point. By participating in the survey and checking the box below, you are consenting to voluntarily participate in the evaluation.

Your decision is to participate, or not participate, in this research is completely optional and voluntary. Your decision will have no effect on your employment, affiliation, or job performance at Dignity Health. Nor will your decision have any effect on your relationship with CommonSpirit Health, Dignity Health, your supervisor or hospital leadership.

### Questions about the Research:

If you have any questions about this study, please feel free to contact Dr. Susie Baldwin, Principal Investigator:

Office of Women's Health  
Los Angeles County Department of Public Health  
1000 S Fremont Ave, Bldg A-9 East  
5th floor, Unit #105  
Alhambra, CA 91803  
(213) 810-4304 (mobile)  
sbaldwin@ph.lacounty.gov

If you have questions or concerns about your rights as a research participant, you can contact the CommonSpirit Health Research Institute Institutional Review Board (CSHRI-IRB) by phone at 844-626-2299 or by email: [chirb@catholichealth.net](mailto:chirb@catholichealth.net).

I consent to participate in this survey.

## Your interactions with Survivor Advocate(s)

\* 2. In the course of your work, have you interacted with Human Trafficking Survivor Advocate(s)? (Check all that apply).

- Yes, Human Trafficking Survivor Advocate(s) from the Coalition to Abolish Slavery and Trafficking (CAST)
- Yes, Human Trafficking Survivor Advocate(s) from Journey Out
- Yes, one or more Human Trafficking Survivor Advocate, but not sure which organization they were from
- No, have not interacted with a Human Trafficking Survivor Advocate

3. If you can remember, in which year(s) did you work with a Human Trafficking Survivor Advocate? Check all that apply.

- 2018
- 2019
- 2020
- 2021
- 2022
- Don't know

\* 4. Approximately how many patients have you referred to the Human Trafficking Survivor Advocate(s) or consulted the Survivor Advocate(s) about, in total? (This includes in-person and/or over phone/videoconference; short interactions as well as longer ones.)

- 1
- 2-3
- 4-6
- 7-10
- More than 10 times

\* 5. Since March 2020, how helpful have your interactions with Survivor Advocate(s) been

	Very helpful	Somewhat helpful	Not helpful	Not applicable
Over the telephone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Over videoconference?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* 6. Have your interactions with the Survivor Advocate(s) been helpful to you in delivering victim-centered, trauma informed care?

	Very helpful	Somewhat helpful	Not helpful	Not applicable
Survivor Advocate from Coalition to Abolish Slavery and Trafficking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Survivor Advocate from Journey Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't remember who, but in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* 7. In your experience, have patients been more receptive to speaking to someone about their experience of violence or trauma, or their needs, when a Survivor Advocate is involved in their care?

- Yes, very
- Yes, somewhat
- No
- Don't know

\* 8. In your experience, have patients been more likely to accept referrals for services outside the hospital when a Survivor Advocate is involved in their care?

- Yes, very
- Yes, somewhat
- No
- Don't know

\* 9. Have you encountered any of the following challenges in working with a Survivor Advocate to assist a patient?

- Long wait on hotline/phone to reach Survivor Advocate
- Needing Survivor Advocate during a shift when no Survivor Advocate is available
- Difficulty reaching a Survivor Advocate who is scheduled to be working
- Patients you perceive as high risk for human trafficking declining to speak with Survivor Advocate
- Finding safe place to discharge a patient who is/may be trafficked who has special needs including mental or behavioral health issues, physical impairment, etc.
- Finding safe place to discharge a patient who is/may be trafficked because they are male
- Finding a safe place to discharge a patient who is/may be trafficked because they are transgender, non-binary, or gender non-conforming
- Finding a safe place to discharge a patient who is/may be trafficked who is cis-gender female
- Patient leaving AMA
- Other (please specify)
- None of the above

10. Please enter any comments about the helpfulness of the Human Trafficking Survivor Advocate(s) in providing trauma-informed care and/or challenges/barriers to using this service for your patients.



## Staff Confidence in Working with Patients at Risk for Human Trafficking

\* 11. Since you began working with the Survivor Advocate(s), how would you rate your **confidence in your ability to recognize risk factors and signs or symptoms of sex trafficking** in patients?

- Very improved     Somewhat improved     Stayed the same     Somewhat decreased  
 Very decreased

\* 12. Since you began working with the Survivor Advocate(s), how would you rate your **confidence in your ability to recognize risk factors and signs or symptoms of labor trafficking** in patients?

- Very improved     Somewhat improved     Stayed the same     Somewhat decreased  
 Very decreased

\* 13. Since working with the Survivor Advocate(s), how would you rate your level of **confidence in responding to patients who disclose possible sex trafficking and/or request/accept assistance for this?**

- Very improved     Somewhat improved     Stayed the same     Somewhat decreased  
 Very decreased

\* 14. Since working with the Survivor Advocate(s), how would you rate your level of **confidence in responding to patients who disclose possible labor trafficking and/or request/accept assistance for this?**

- Very improved     Somewhat improved     Stayed the same     Somewhat decreased  
 Very decreased

\* 15. Since you began working with the Survivor Advocates, how would you rate your **comfort with respecting patients' decisions** when they choose not to disclose and/or do not accept services, **even if you disagree** with their decisions?

- Very improved     Somewhat improved     The same     Somewhat decreased  
 Very decreased

16. Please provide comments here about your confidence and comfort in providing care to patients you suspect may be trafficked, in relation to your experiences with the Human Trafficking Survivor Advocate(s).

## Basic Staff Information

\* 17. At which hospital do you work? (If you work at more than one site, please choose the location where you have most frequently worked with the Human Trafficking Survivor Advocate(s).

- CHMC - California Hospital Medical Center
- NHMC - Northridge Hospital Medical Center
- GMHHC - Glendale Memorial Hospital and Health Center
- SMMC-LB - St. Mary Medical Center-Long Beach

\* 18. What is your role in the hospital? Please check **all that apply**.

- Nurse (RN, LVN)
- Clinical Social Worker
- Physician or Advanced Practice Clinician (NP, PA, CNM)
- ED Tech
- Administrator or manager
- Human Trafficking Task Force Member
- Human Trafficking Task Force Lead or Hospital Human Trafficking Lead
- Other (please specify)

\* 19. How many years of experience do you have in *your profession*?

- 2 years or less
- 3-5 years
- 6-10 years
- 11-15 years
- 16 or more years

\* 20. What is your gender?

- Female (cis-gender)
- Male (cis-gender)
- Female to male transgender
- Male to female transgender
- Non-binary, intersex, gender non-conforming, gender queer, or other

**Thank you for your participation in this survey! Your perspective is valuable and we appreciate your time.**

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## **APPENDIX F: CARE Measure, English**

## CARE Patient Feedback Survey

You were referred to our agency at a visit to a Dignity Health hospital, where health care providers and a Survivor Advocate talked with you. Our agency is part of an evaluation study to learn how clients feel about their Dignity Health hospital experience. We would like you to participate in this study by completing a short survey. There is nothing else you need to do to be in the study.

**You can answer the first 5 survey questions thinking about your hospital experience as a whole. If you would like to share specific feedback about the Survivor Advocate or other hospital staff, you can write your comments in the space below the last question.**

If you choose to be in the study, you will answer the questions on the front and back of this page. The survey will take less than 5 minutes, and your answers will be anonymous. You can skip questions that you do not want to answer or stop the survey at any time

The benefit of answering these questions is that you will help us understand if Survivor Advocates in hospitals can help victims of violence and exploitation feel more comfortable and receive help.

The risk of answering these questions is that you may feel sad, worried, or stressed as you remember your visit to the hospital and what happened to you that made you go to the hospital.

Being in the study is voluntary and answering the questions will be considered consent to participate. Your decision will not affect the services you receive from our agency or your access to any legal services, medical services, or other services.

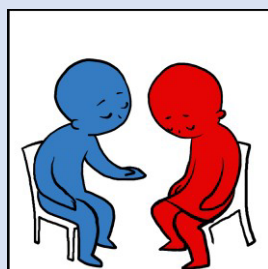
Please tick, circle or mark the scale.

**Think about your visit to the Dignity Health hospital.  
How were the healthcare providers and Survivor Advocate at...**



**1... really listening?**

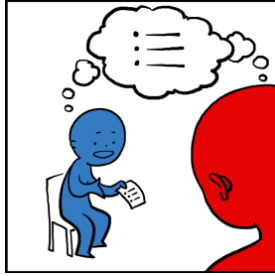
(paying close attention to what you are saying)



**2... showing care and compassion?**

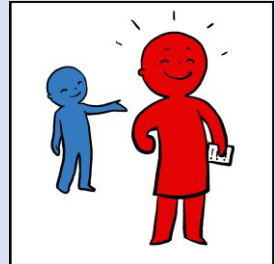
(seeming genuinely concerned)





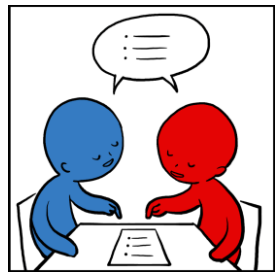
### 3... explaining things clearly?

(fully answering your questions, giving you enough information)



### 4... helping you take control?

(exploring with you what you can do to improve your health yourself)



### 5... making a plan of action?

(discussing the options, involving you as much as you want)



**Please share any comments you have about the Survivor Advocate you met at the Hospital:**

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## **APPENDIX G: Complete list of hospitals served by Survivor Advocate**

### Appendix G: Complete list of hospitals served by Survivor Advocates

Hospital Name	n	%
Cedars Sinai Medical Center	10	16%
MLK Community Healing and Trauma Prevention Center	5	8%
LAC+USC General Hospital	4	6%
St. Francis Center	4	6%
Harbor-UCLA Medical Center	3	5%
Henry Mayo Newhall Hospital	3	5%
Martin Luther King Jr Community Hospital	4	6%
Providence Little Company of Mary Medical Center Torrance	3	5%
Adventist Health Glendale	2	3%
Cedars Sinai Marina Del Rey	2	3%
Centinela Hospital Medical Center	2	3%
St John's Well Child & Family Center	2	3%
Antelope Valley Hospital	1	2%
Aurora Charter Oak Hospital	1	2%
Central San Gabriel Valley AJCC	1	2%
College Medical Center	1	2%
Gateway Healthcare	1	2%
Good Samaritan Hospital	1	2%
Huntington Hospital	1	2%
Kaiser Permanente Sunset Blvd.	1	2%
Kaiser Primary Care Inglewood	1	2%
Lakewood Regional Medical Center	1	2%
Long Beach Memorial Medical Center	1	2%
Memorial Health Gardena	1	2%
Pacifica Hospital	1	2%
Providence - San Pedro	1	2%
Providence Healthcare System	1	2%
St. Agnes	1	2%
St. Francis Medical Center Lynwood	1	2%
UCLA Advocacy office for Sexual and Gender Based Violence and Misconduct	1	2%
UCLA Santa Monica	1	2%
White Memorial Medical Center	1	2%
<b>Total</b>	<b>64</b>	<b>1</b>

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## **APPENDIX H: List of presenting complaints, with examples**



## Appendix H: List of presenting complaints, with examples

Presenting Complaint Category	Example	n	%
Mental Health Unspecified Suicide ideation/self harm	"Mental Health treatment and follow up care"; "Mental Health Services" "Suicidal Ideation and sexual assault"; "SI, self harm, sexual assault"	55	26%
Physical Injury Unspecified injury Physical Assault/Violence Sexual Assault	"Surgery on hand"; "Physical injuries in face and left leg" "Beat up, unconscious on street"; "Patient was thrown out of moving vehicle by trafficker" "CLT was rape"; "Sexual assault. Physical Assault"	40	19%
Unknown/Unspecified	"Medication"; "Unknown"	24	12%
Substance Use	"Methodone overdose, found in an abandoned building"; "Substance Use"	16	8%
Pregnancy-Related	"Maternity Care"; "Patient seen in Labor and Delivery, she is 33 weeks pregnant and was in a motor vehicle accident"	13	6%
Other Physical Health Issue	"headache, numbness in extremities"; "shortness of breath, UTI"	10	5%
Injuries Stemming from Motor Vehicle Accident	"Medical trauma due to jumping out of moving vehicle"	8	4%
HIV/STI-Related	"HIV and vaginal pain"; "STD checkup"	7	3%
Brought In by Law Enforcement	"Found on the highway naked by law enforcement"; "Patient was brought in by law enforcement for being the victim of suspected human trafficking"	7	3%
Pain Abdominal Pain Other physical pain	"pain in lower abdomen"; "stomach pain" "knee pain"; "pelvic pain, foot pain"	7	3%
Seeking Safety	"Fleeing trafficker"; "Patient arrived to the hospital and stated she was a human trafficking victim in need of assistance."	6	3%
Vaginal Issues	"Vaginal bleeding and miscarriage"; "interpersonal violence, vaginal bleeding"	6	3%
Intimate Partner Violence	"Trauma due to being thrown down the stairs from DV"; "PV's boyfriend pepper spraying her face and beating her"	5	2%
Covid-19	"Covid-19"	3	1%
<b>Total</b>		<b>207</b>	<b>100%</b>

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## **APPENDIX I: List of referral reason categories, with examples**

## Appendix I: List of referral reason categories, with examples

Referral Reason	Example	n	%
<b>Self-identified</b>	<i>"Self Identified as HT Sex Survivor"; "Patient described incidences of trafficking to nurse who spoke Portuguese."</i>	40	17%
<b>Prostitution/Sex work</b>	<i>"Patient stated she has been "pimped out" and had to give away all her money."; "Pt stated that she was run over by her pimp"</i>	20	9%
<b>Substance use</b>	<i>"Patient is 31 weeks pregnant with subuse issues."; "Patient described using substances to cope with trafficking."</i>	18	8%
<b>Sexual assault</b>	<i>"Patient reported being sexually assaulted multiple times."; "Patient reported being locked in a room and sexually assaulted by employer."</i>	15	6%
<b>Mental Health</b>	<i>"PT tried to commit suicide to get away from her trafficker/boyfriend."; "Patient has been seen multiple times of mental health. Signs of physical assault/abuse present."</i>	15	6%
<b>Escaping bad situation</b>	<i>"Patient stated she was fleeing from her pimp."; "Patient stated she came to the hospital to escape her trafficker."</i>	13	6%
<b>Law enforcement suspects HT</b>	<i>"Patient was brought in by lawenf who suspected potential trafficking."; "law enforcement alerted hospital staff that they believed patient is part of a prostitution ring, massage parlor, and were jumping to escape."</i>	12	5%
<b>Violence/assault</b>	<i>"Patient reported assault/abuse in the home."; "Patient was shot engaging in street based sex work for not giving over money to trafficker."</i>	12	5%
<b>Unknown</b>	<i>"Unknown"; "Statement"</i>	11	5%
<b>Provider suspects HT</b>	<i>"Nurse suspected Human Trafficking"; "Hospital SW believed patient went home with trafficker and called Survivor Advocate for consult"</i>	10	4%
<b>Exploitation</b>	<i>"Patient stated she has been "pimped out" and had to give away all her money."; "Patient reports living at and being forced to work at massage parlor."</i>	10	4%
<b>Abandonment/neglect</b>	<i>"Patient was found naked in a public space and brought in by law enforcement."; "Patient found outside of ED with wet clothing partially undressed, history of subuse."</i>	9	4%
<b>Pregnancy</b>	<i>"Patient gave birth in tent and had not received prenatal care."; "Patient just found out that she is 10 weeks pregnant and would like to have safe housing so that she doesn't have to return to an exploitive situation."</i>	7	3%
<b>Fear</b>	<i>"PT stated that she was afraid of her boyfriend and felt unsafe at home."; "Patient stated people were following her."</i>	7	3%
<b>Previously Identified as Human Trafficking victim</b>	<i>"Patient has been previously seen at facility and identified as HT."; "Patient was previously assessed as labor trafficking survivor by Cast."</i>	7	3%

<b>Held against will</b>	<i>"Patient reported sexual assault and being held against her will."; "Patient disclosed to staff she had been kidnaped from Iowa."</i>	6	3%
<b>Sexual Health</b>	<i>"Social worker noticed 40+ visits for STIs and talked to patient."; "Patient's untreated vaginal abscess lead medical staff to suspect sex trafficking."</i>	5	2%
<b>Homelessness</b>	<i>"Patient is homeless and reports living in tent with man."; "Pt is struggling with substance use and homelessness"</i>	5	2%
<b>Self Harm</b>	<i>"Patient reported multiple sexual assaults and desire to harm self."; "34 year old woman was brought to the emergency room where she received a 51/50 hold for cutting her wrist."</i>	4	2%
<b>Intimate Partner Violence</b>	<i>"Intimate Partner assault/abuse"; "Client was [admitted] to Glendale Memorial due to her partner pepper spraying her. Client takes medication for her seizures."</i>	4	2%
<b>Suspicious Injury</b>	<i>"Patient had multiple bruises included facial bruising and swelling. Patient stated that she didn't remember how she got the bruising."; "PT jumped out of a moving vehicle driven by her trafficker who was planning to take her to another location. PT was being transported from Las Vegas, Nevada. After exiting the vehicle, PT was later transported to the nearest ER by Long Beach Sheriff [Department]"</i>	3	1%
<b>Parent suspects HT</b>	<i>"Patient brought in by non-offending parent with concerns of potential CSEC."</i>	1	0%
<b>Total</b>		<b>234</b>	<b>100%</b>

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## **APPENDIX J: List of patient indicators, with examples**

## Appendix J: List of patient indicators, with examples

Patient Indicator	Example	n	%
<b>Account of force, fraud or coercion by family, partner or friend</b>	"Patient reported she is from Guatemala and her boyfriend in Los Angeles forces her to use drugs and engage in street based sex work." "Patient stated she "pays" for staying in her mother's home by having sex with men brought over by her mother's boyfriend."	<b>29</b>	13%
<b>Forced Sex Work</b>	"Patient described being forced to engage in webcam based sex work with other women under threat of force."; "Patient stated she has multiple traffickers who force her to have sex with men for money and drugs."	<b>25</b>	11%
<b>Self-Identified</b>	"Patient self identified as trafficking survivor."; "Self Report"	<b>21</b>	9%
<b>Assault/Abuse</b>	"Patient stated a man drugged her, physically and sexually assault her, and forced her to have sex with others."; "Patient stated her husband threw her down the stairs and has injured her in the past and would like safe shelter."	<b>17</b>	8%
<b>Disengaged</b>	"Patient refused to speak to medical staff."; "Patient self identified as trafficking survivor but refused to give additional information"	<b>14</b>	6%
<b>Seeking Support</b>	"I NEED HELP PLEASE"; "Patient stated she escaped from her pimp and wants help."	<b>12</b>	5%
<b>SA did not have contact with patient</b>	Patient did not speak to Survivor Advocate, as DCFS intervened before Survivor Advocate could engage with patient."; "Unknown, not able to speak to PT."	<b>12</b>	5%
<b>Sexual Assault</b>	"Patient stated she was raped at gunpoint."; "Reported sexual assault, stalking, and sex trafficking."	<b>12</b>	5%
<b>Commercial sex trade/Prostitution</b>	"Patient stated she engages in sex work in exchange for food, shelter, and money."; "Patient stated she escaped from her pimp and wants help."	<b>10</b>	5%
<b>Fear</b>	"Patient stated she has multiple traffickers and she is afraid."; "PT was afraid to go home."	<b>8</b>	4%
<b>Held Against Will</b>	"Recorded me having intercourse. Tried to force me to have sex with multiple people. Has held me for days in a room.""; "PT stated she was being held in a motel and ran away."	<b>6</b>	3%
<b>Substance Use</b>	"Patient disclosed she had been hurt and drugged by men who offered to help her."; "Remembers being given a drink then being held in a brothel."	<b>7</b>	3%
<b>Not Enough Information Provided</b>	"Need help getting her children."; "Patient unable to provide any details."	<b>6</b>	3%
<b>Patient Does Not Need Services</b>	"Patient did not describe in engaging in sex work or labor under force, fraud, or coercion."; "Patient stated she is safe and not in need of services."	<b>6</b>	3%
<b>Intimate Partner Violence</b>	"Patient described intimate partner violence. "; "Reported Trafficking and domestic violence from domestic partner."	<b>6</b>	3%
<b>Mention of Different Locations/Migration</b>	"i been with him in different states "; "Patient stated she had been kidnapped from her home state of New Mexico and forced into human trafficking and brought to California."	<b>6</b>	3%
<b>Threats</b>	"Patient described being forced to engage in webcam based sex work with other women under threat of force. "; "Patient described engaging in sex work under threat and physical violence."	<b>5</b>	2%
<b>No Access to Documents/Money</b>	"Patient stated she had to give all of her money from sex work to her pimp."; "Patient stated she is forced to have sex for money and drugs. Patient stated her ID is being withheld."	<b>4</b>	2%

<b>Escape</b>	"Patient stated she jumped out of window to escape her trafficker."; "PT stated she was being held in a motel and ran away."	<b>4</b>	<b>2%</b>
<b>Forced Labor</b>	"Husband said she owes him for ticket here and must work at hotel to pay him back. "; "Patient stated he worked for a man who would control is contact with his family in Serbia, take him to shop in Downtown where he was unfamiliar and threaten him. He would have him work at many hours of the night and constantly tell him he was stupid"	<b>3</b>	<b>1%</b>
<b>Mental Health</b>	"Patient disclosed that she has history of bipolar disorder. Patient also stated she was drugged, beaten, followed and raped cross-country after accepting a "job" from a friend. "; "PT stated she was depressed. Also stated friend turned into a monster."	<b>3</b>	<b>1%</b>
<b>Abduction</b>	"Patient stated that she has been kidnapped when she was four years old from Columbia and brought the US (NY) and then brought to CA and was trafficked by adoptive parents."; "Patient stated she believes she was abducted by potential traffickers."	<b>3</b>	<b>1%</b>
<b>Stalking</b>	"Gang stalking her to use her in gang based trafficking in prostitution."; "Patient self identified as trafficking survivor and stated she had been exploited by multiple men and stalk by her trafficker."	<b>3</b>	<b>1%</b>
<b>Total</b>		<b>222</b>	<b>100%</b>

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## **APPENDIX K: List of Survivor Advocate observations of referred patients, with examples**



**Appendix K: List of Survivor Advocate observations or referred patients, with examples**

<b>Survivor Advocate Observation Category</b>	<b>Example</b>	<b>n</b>	<b>%</b>
<b>Fearful</b>	<i>"Anxious, Fearful"; "Tired, scared, willing to SW options"</i>	<b>28</b>	<b>11%</b>
<b>Self-Identified</b>	<i>Patient stated that she was a victim of human trafficking and needed safe shelter."; "Self Report, Police Report.</i>	<b>20</b>	<b>8%</b>
<b>SA did not have contact with patient</b>	<i>"Survivor Advocate did not speak to patient as patient was quickly discharged."; "Survivor Advocate did not speak to patient but resourced were offered through MD."</i>	<b>16</b>	<b>7%</b>
<b>Disengaged</b>	<i>"Disconnect, scripted."; "Patient was agitated and refused to give information to survivor advocate."</i>	<b>16</b>	<b>7%</b>
<b>Anxious</b>	<i>"Anxious, Distrusting"; "High anxiety that she is unable to manage, PTSD"</i>	<b>16</b>	<b>7%</b>
<b>Assault/Abuse</b>	<i>"Patient described trying to escape from her trafficker and him running her over with his car."; "Patient has visible bruising on feet and stated it was from being forced to wear heels."</i>	<b>15</b>	<b>6%</b>
<b>Requests Support</b>	<i>"Patient requested support groups and mentoring."; "Patient seemed relieved to be speaking with advocate and stated she needed safe housing."</i>	<b>11</b>	<b>4%</b>
<b>Hypervigilant</b>	<i>"Fearful, Hypervigilant"; "Hypervigilant, reactive, self report."</i>	<b>10</b>	<b>4%</b>
<b>Not Trafficked</b>	<i>"Patient did not describe in engaging in sex work or labor under force, fraud, or coercion."; "Survivor advocate observed indicators of sexual assault, not trafficking."</i>	<b>9</b>	<b>4%</b>
<b>Distressed/emotional</b>	<i>"Fearful, tired from trauma, emotional and reactive when sharing story."; "Patient was shaking and had difficulty speaking. Patient's name was engraved in her leg."</i>	<b>8</b>	<b>3%</b>
<b>Not Enough Information Provided</b>	<i>"Patient not able to provide details because of substance use."; "Unknown, not able to speak to PT."</i>	<b>7</b>	<b>3%</b>
<b>Previously Assessed for Human Trafficking</b>	<i>"Patient had previously been assessed by Survivor Advocate for HT."; "Patient is former Cast client and described being involved with a new trafficker."</i>	<b>7</b>	<b>3%</b>
<b>Forced Sex Work</b>	<i>"Patient described not being able to leave the sex trade without harm and threats by trafficker."; "Patient stated she was forced by her trafficker to engage in online and in-person sex work and to give him all her money or her would physically harm her."</i>	<b>7</b>	<b>3%</b>
<b>Substance Use</b>	<i>"Patient is unclear About his age. Do to Him being intoxicated for so long."; "Patient unable to answer further questions due to substance use."</i>	<b>7</b>	<b>3%</b>
<b>Money/Documents Withheld</b>	<i>"Patient disclosed her documents are being withheld and she is afraid."; "Patient stated the trafficker took the money she made, kept her ID, and controlled everything she did and assaulted her."</i>	<b>7</b>	<b>3%</b>
<b>Non-Cooperative</b>	<i>"Patient fearful and non-cooperative."; "Patient fearful, combative, and non-cooperative."</i>	<b>6</b>	<b>2%</b>
<b>Controlling Behavior</b>	<i>"Patient stated the trafficker took the money she made, kept her ID, and controlled everything she did and assaulted her."; "PT"</i>	<b>6</b>	<b>2%</b>

	<i>boyfriend potential trafficker. Has total control of her whereabouts and decision making."</i>		
<b>Threats</b>	<i>Patient described not being able to leave the sex trade without harm and threats by trafficker."; "Patient stated that if she did not do what he said he would beat her unconscious. She stated that she tried to run from him for a year but was unsuccessful. Patient felt "hopeless and drank bleach. Patient got on a greyhound and headed to CA."</i>	<b>5</b>	<b>2%</b>
<b>Branding</b>	<i>"Patient had name of trafficker branded on face and was fearful of being found by her trafficker."; "Patient was fearful, had visible brandings, and was dressed inappropriately for weather."</i>	<b>5</b>	<b>2%</b>
<b>Guarded/Defensive</b>	<i>"Defensive, Hypervigilant"; "Patient was guarded and tearful but refused services."</i>	<b>5</b>	<b>2%</b>
<b>IPV</b>	<i>"Patient described intimate partner violence."; "Survivor advocate observed indicators of sexual assault and intimate partner violence."</i>	<b>5</b>	<b>2%</b>
<b>Trauma</b>	<i>"High anxiety that she is unable to manage, PTSD"; "Patient showed signs of trauma and self identified as a trafficking survivor."</i>	<b>5</b>	<b>2%</b>
<b>Confused</b>	<i>"Patient is crying and afraid but does not remember any details of her life."; "Patient was crying and stated she was afraid of her trafficker. Patient was unaware of where she was being held."</i>	<b>5</b>	<b>2%</b>
<b>Restricted Movement/Held Against Will</b>	<i>"Patient described restricted movement and physical violence from trafficker."; "PT states she was being held against her will and different men were coming to the hotel."</i>	<b>4</b>	<b>2%</b>
<b>Escape</b>	<i>"Patient stated that if she did not do what he said he would beat her unconscious. She stated that she tried to run from him for a year but was unsuccessful. Patient felt hopeless and drank bleach. Patient got on a greyhound and headed to CA."; "Patient was crying and stated she wanted to get to safety."</i>	<b>4</b>	<b>2%</b>
<b>PTSD</b>	<i>"PTSD"; "PTSD, Reactive"</i>	<b>4</b>	<b>2%</b>
<b>Sexual Assault</b>	<i>"Patient described intimate partner violence and sexual assault."; "Survivor advocate observed indicators of sexual assault."</i>	<b>4</b>	<b>2%</b>
<b>Mental Health Issues</b>	<i>"Patient presented with mental health concerns and was unable to accept services."; "PT needs continues emotional support."</i>	<b>4</b>	<b>2%</b>
<b>Total</b>		<b>246</b>	<b>100%</b>