RISE UP

HEALTHCARE EXPERIENCES

INSIGHTS FROM SURVIVORS OF SEX TRAFFICKING

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We would like to express our gratitude to the Survivors who shared their experience and acknowledge how difficult it can be to recount those experiences. It is our hope that hearing and sharing recommendations on areas for improvement will help build a better system for all Survivors navigating health care in the future.

We would also like to thank the social service providers, government and law enforcement officials in Durham region who participated in the study. Your feedback will contribute to an improved understanding of challenges faced by Survivors of sex trafficking and those supporting them.

We extend special appreciation to Lakeridge Health staff who participated despite the insurmountable challenges experienced during the COVID 19 pandemic. The willingness to participate in evaluation and critique of services opens the door for system improvements through collaboration and Survivor led change.

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Victim Services of Durham Region is situated on lands within the traditional territory of the Michi Saagiig and Chippewa Anishinaabeg and the signatories of the Williams Treaties. This includes the Mississaugas of Scugog Island, Hiawatha, Curve Lake, Alderville, the Chippewas of Georgina Island, Rama and Beausoleil First Nations. Understanding the impact of colonization and inter-generational trauma on Indigenous Peoples must be central to any Anti-Human Trafficking efforts. We are committed to understanding the truth of our shared history through ally-ship with First Nations, Metis, Inuit, Innu and all Indigenous Peoples, challenging the legacies of colonialism and taking action beyond acknowledgement.

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INTRODUCTION

Human trafficking is a growing crime in Canada that has gained nation-wide attention. The majority of reported cases in Canada are predominantly domestic in nature and do not involve the crossing of international borders. As the number of human trafficking cases increases, social service agencies are struggling to broaden their scope and services to meet the needs of Survivors. While multiple gaps in services exist across various sectors, a significant gap identified by Survivors of human trafficking is the care and treatment received within the healthcare sector, often resulting from the inability of service providers to identify and therefore, respond to indicators for trafficking.

This 'Rise Up' project entailed a review of the experiences of Survivors of Human Trafficking while accessing hospital-based services, which served as the foundation for additional research and formulation of recommendations on how to enhance trauma-informed identification and intervention services for responding to cases in hospitals. The project occurred over a three-year period and was funded by Women and Gender Equality Canada (WAGE). Research and evaluation was conducted in partnership with Lakeridge Health Corporation. Lakeridge is the sole provider of acute [hospital] health care in Durham Region, Ontario with 5 hospital sites across the region. A primary focus of the project was on amplifying diverse Survivor voices in order to drive direction of the research and inform recommendations using Survivor-led engagement. A Survivor Advisory Panel (SAP) was formed at the beginning of the project, which included Survivors from Indigenous and Black communities. A Survivor of human trafficking with clinical expertise and experience supported with recruitment, formation and facilitation of the SAP. The SAP was essential in shaping the interview process, participant recruitment and research methodology.

Victim Services of Durham Region (VSDR) provides prevention programming, as well as support and crisis intervention to Survivors of violent crime and sudden tragedy. Specialized Case Management services are provided to Survivors of human trafficking given the unique and complex needs of this population. In 2023, VSDR supported 463 Survivors of Human Trafficking representing an increase by more than 7 times since 2019. Given Survivor Interviews were conducted at the beginning of the project in 2021 responses are reflective of the Survivor experiences prior to or during that time. Of 300 Survivors supported by VSDR in 2021, approximately 210 sought medical help from Lakeridge Health at some point during or after trafficking. Yet, VSDR received no human trafficking referrals from Lakeridge Health that year. The medical needs of Survivors are often complex and wide-ranging. It was apparent throughout interviews with Survivors that victims may present with a variety of health issues including but not limited to psychosis, substance use, suicidal ideation, physical trauma, sexual abuse, and STIs and rarely pro-actively disclose trafficking. Survivors did not generally disclose due to safety concerns, stigma or not recognizing that they are being trafficked. Yet, research indicates that when healthcare providers are consistently educated on how to identify indicators of HT, gaps in intervention and links to essential services improve for Survivors. The goal of this project was to develop recommendations on how to improve identification of human trafficking cases within hospitals and inform the development of protocols and training to enhance hospital-based interventions within a Canadian context.

LITERATURE REVIEW

HUMAN TRAFFICKING IN CANADA

Human trafficking is the recruitment, transportation, harbouring, and exercising control of human beings for profit (Government of Canada, 2021; UNODC, 2021). While there are various forms of trafficking, sex and labor trafficking are the most prevalent forms of human trafficking in Canada. In 2020, the majority of reports received by the Canadian Human Trafficking hotline (71%) involved sex trafficking, 7% involved labor trafficking and 23% was unspecified or represented other forms of trafficking (Canadian Centre to End Human Trafficking, 2020). The majority of human trafficking is domestic in nature (over 90%) – meaning victims are recruited, transported, and exploited within Canadian borders (Public Safety Canada, 2022) and 94% of reported victims are women and young girls (Statistics Canada, 2022). From this percentage, 25% of reported victims are girls under the age of 18, and 20% were women aged 25-34 (Conroy & Sutton, 2022). Additionally, women and young girls exposed to intersecting forms of oppression are at an increased risk of being trafficked (e.g. BIPOC women and girls, migrant workers, people with low socioeconomic standings, youth in the foster care system). For example, Indigenous women make up 5% of the Canadian population, yet make up a majority of victims of human trafficking (Canadian Women's Foundation, 2014; Province of British Columbia, 2014; Statistics Canada, 2022; Ontario Native Women's Association, 2019). Survivors of human trafficking often experience life-long physical and psychological trauma.

Increased public awareness of human trafficking has encouraged the Government of Canada and social service agencies to create programs and initiatives to address this growing crime. The 2019 National Strategy to Combat Human Trafficking released by Public Safety Canada is a six-year initiative funded by the federal government to intervene on the growing issue. The strategy operates on five pillars: Empowerment, Prevention, Protection, Prosecution, and Partnerships. Under these five pillars, funding to social service agencies that address human trafficking has increased to support individual communities (Government of Canada, 2019). Under the guidelines of the Prevention pillar, the Canadian government focused on increasing awareness of human trafficking and increasing projects aimed to protect at-risk youth. The increased capacity allowed social service agencies to broaden their scope and provide support for victims of human trafficking. The 2020-2021 Annual Report for the National Strategy to Combat Human Trafficking reported positive results due to increased funding, stating that the federally funded Canadian Centre to End Human Trafficking has established over 900 partners nation-wide to increase awareness and services for victims (Government of Canada, 2020). While the effort made by the Federal government to improve awareness of human trafficking has been successful, there are still barriers to identifying victims of trafficking as highlighted by academics and anti-trafficking agencies (Recknor et al., 2020). As awareness of human trafficking rises, it is imperative that trauma informed approaches be integrated into service provision for victims. Due to the underground nature of human trafficking, we acknowledge that reported numbers often do not represent the number of victims within Canada. Additionally, it is difficult to determine if the increased number of reported cases is due to increased public awareness, improved detection, or actual rise of human trafficking (Conroy & Sutton, 2022).

SURVIVOR-LED, TRAUMA-INFORMED APPROACH

As mentioned, this project's foundation prioritizes an approach that is trauma-informed and survivor-led. Trauma informed care emphasizes the lived experiences of victims of trauma and focuses on healing

rather than recovery (Harris & Fallot, 2001; Hopper et al., 2010; University at Buffalo). There are five key pillars of trauma-informed practice: safety, trust, collaboration, choice, and empowerment (The Institute for Trauma and Trauma Informed Care, 2015). These key components prioritize the needs of a patient over existing programming or procedures in place. This means that trauma-informed approaches to care need to be flexible in their service provision, and not stick to a 'one-size-fits all' approach (Harris & Fallout, 2001).

The need for trauma-informed care arises from reports on the poor care received by victims in crisis settings. In many settings, service providers care for victims without addressing the actual trauma, and in some instances are not aware of the type of trauma that has occurred. The lack of trauma related knowledge often leads to failures from service providers to provide appropriate care and referrals for patients. Additionally, a lack of trauma knowledge can also lead to Survivors experiencing re-traumatization (Harris & Fallout, 2001).

Understanding how Survivors navigate trauma and how it influences their world-view is imperative to providing comprehensive service provision. Survivors who have experienced repeat trauma require flexible, rather than rigid service plans. Harris and Fallout provide an extensive layout for how service providers can apply a trauma-informed approach, noting that it is important to avoid viewing trauma as a single occurrence in someone's life. Trauma is instead, viewed as an organizing experience that impacts an individual's identity (Harris & Fallout, 2001). Survivors of trauma often experience disorganized thought-processes, which causes additional stress if they are unable to validate their thoughts. The recommendations presented include validating the experiences and the thought processes of Survivors in order to provide them the skills to navigate their world-view. The goal of trauma-informed care is to restore a sense of agency in the Survivor, and to teach Survivors how to cope with their new world-views through a skill-building approach (Harris & Fallout, 2001). As mentioned prior, the majority of victims of human trafficking in Canada are women. Therefore, it is important that a trauma-informed approach is mindful of how trauma affects women. Women are at a higher risk of experiencing inequity, but in particular, violent crimes and sexual violence, which leads to disproportionate amounts of sexual trauma. Therefore, a trauma-informed approach needs to use a gendered analysis and be inclusive of these experiences in service provision.

SURVIVOR EXPERIENCES IN HOSPITAL

There is ample data to show that Survivors of human trafficking frequently visit hospitals while being trafficked (Baldwin et al., 2011; Chisolm-Straker et al., 2012; Lederer & Wetzel, 2014; Lumpkin & Taboada, 2017; Richie-Zavaleta et al., 2021). Survivors access hospitals for a variety of medical concerns ranging from neglect of their basic needs to the physical and mental abuse they experience (e.g., STI treatment, substance abuse detox, mental health concerns). The existing literature on the subject shows that many Survivors of human trafficking use emergency departments as a primary source of healthcare while being trafficked (Lederer & Wetzel, 2014; Richie-Zavaleta et al., 2021). Studies show that upwards of 88% of trafficking victims access emergency departments during their trafficking (Richie-Zavaleta et al., 2021) This is because those experiencing human trafficking are not able to access most forms of health care unless it is an absolute emergency (Richie-Zavaleta et al., 2021). The majority of pre-existing literature on the subject is from an American context, however, it provides valuable insight to this project regarding recommendations from survivors on how to make healthcare more accessible. Additionally, the pre-existing literature also addresses what Survivors need from healthcare providers to ensure a comfortable and safe space for potential disclosures. The consensus from the literature is that there are significant deficits in the ability of healthcare services to recognize indicators for trafficking or provide trauma-informed care and intervention for Survivors. Survivors from these studies shared insight on ways healthcare professionals can spot signs of trafficking, and how to provide compassionate care to victims they may encounter (Lederer & Wetzel, 2014; Richie-Zavaleta et al., 2021). Some of the key areas missed by healthcare providers included: overlooking physical injuries or not identifying indicators from a Survivor's medical records, failing to recognize body modifications (i.e. branding tattoos), or not having the necessary training to recognize other obvious indicators of trafficking (e.g. someone answering questions for the victim; Lederer & Wetzel, 2014; Richie-Zavaleta et al., 2021).

The barriers experienced by Survivors of human trafficking when accessing healthcare services are extensive and complicated to navigate. However, it is important to discuss how overlapping forms of oppression can increase the barriers that Survivors experience. Due to factors such as colonialism, institutionalized racism, and other forms of discrimination, marginalized groups often face Inequity in accessing and receiving healthcare (Allan & Smylie, 2015; El-Mowafi et al., 2021; Jacklin et al., 2017; Lyons et al., 2016; Wylie & McConkey, 2019). The mistreatment of Indigenous patients accessing healthcare services has been well documented (Adam & Smylie, 2015; Jacklin et al., 2017; Wylie & McConkey, 2019). Due to ongoing implications of the Indian Act, residential schools, and other forms of colonialism in Canada, Indigenous Canadians have faced numerous barriers in accessing medical services, experience longer wait times, have poorer outcomes and are less likely to undergo lifesaving treatment (J. McVicar et al, 2021). These barriers include factors such as racism experienced within healthcare settings (some Indigenous people have stated that the anticipated racism negates them from seeking medical services; Adam & Smylie, 2015), and benefit programs that exclude certain Indigenous populations (e.g., the Non-Insured Health Benefits program which excludes Metis and First Nations peoples without status; Adam & Smylie, 2015; Wylie & McConkey, 2019). There is an overarching feeling of distrust experienced by Indigenous Canadians towards the healthcare sector due to medical malpractice and colonial practices, which continues today. Given forced sterilization and other forms of reproductive injustice experienced by Black and Indigenous Canadians, many BIPOC folk continue to express feeling unsafe in medical settings (El-Mowafi et al., 2021). It is important to acknowledge the racism and stereotypes experienced by BIPOC populations within the healthcare sector in relation to Survivors of human trafficking given 51% of HT survivors identify as Indigenous (Statistics Canada, 2022).

It is imperative that this work acknowledges the intersecting identities of Survivors who try to navigate the healthcare system. Due to perceived or previously experienced stigma against sex workers, or those who face various socio-economic challenges, Survivors may already feel apprehensive to seek out medical care and this apprehension is amplified if there are additional barriers (ie. racial discrimination, disability, immigration status, 2SLGBTQIA+ etc). For example, homeless youth are among the most vulnerable to trafficking and, tragically, 2SLGBTQI+ youth are more likely to experience homelessness. In fact, as many as 25-40% of homeless youth in Canada identify as 2SLGBTQI+. Homeless youth often experience poverty, unemployment, sexual violence, and mental health challenges, making it easier for a trafficker to target them (Canadian Centre to End Trafficking, 2020; Murphy, 2016; Abramovich, 2012; Canadian Council for Refugees, 2018). Therefore, programs that address the barriers HT survivors face in healthcare settings also need to apply an equity lens and focus heavily on the intersections of ADEI (accessibility, diversity, equity, and inclusion).

Survivors interviewed for these studies stated that lack of compassion and patience from healthcare providers often created barriers to disclosure as there was little to no opportunity to build trust with their healthcare providers (Lederer & Wetzel, 2014; Richie-Zavaleta et al., 2021). Additionally, the emphasis on acute/emergency care coupled with a lack of linkage to appropriate community based supports meant there was little to no follow-up conducted in regard to referrals to external services, mental health check-ins, or ongoing safety planning even in situations where trafficking was identified (Lumpkin & Taboada, 2017).

Certain research studies have explored the perspectives of healthcare providers and identifying their own shortcomings when dealing with Survivors of human trafficking (Chisolm- Straker, 2012; Katsanis et al., 2019; Miller et al., 2019; Recknor et al., 2020; Testa, 2019). The most common barriers identified by healthcare providers included factors such as: lack of knowledge on human trafficking, misconceptions or unconscious bias, discomfort and/or insecurities about providing Survivors with appropriate care, and complexities regarding the patient's unique needs (Recknor et al., 2020). Across all of the referenced studies, the main overlapping theme for healthcare providers was a sense of "practice blindness", otherwise known as an uncertainty about how to proceed with a patient who is a victim of human trafficking (Katsanis et al., 2019; Testa, 2019). Healthcare providers who participated in these studies stated that due to a lack of hospital protocols, they felt ill-equipped to intervene when dealing with a patient who they had identified as a victim of human trafficking. While some could identify red flags related to trafficking, healthcare providers did not take steps to intervene because they did not want

to cause unintentional harm or face potential consequences for responding in the wrong way (Chisolm-Straker, 2012; Katsanis et al., 2019; Testa, 2019). The findings from these studies show a need for consistent hospital training, as well as amendments to hospital policies and protocols, in order to ensure healthcare staff have the ability to respond confidently and consistently, while also reducing risk of re-traumatization and further harm for Survivors.

HEALTHCARE TRAINING PROGRAMS

Primary intervention methods for human trafficking in hospitals rely on an educational intervention approach, which focuses on training healthcare staff of specific departments (ex. Emergency Department (ER), Mental Health and Addictions) on indicators of HT, and appropriate intervention measures (Domoney et al., 2015; Nordstrom, 2020, Powell et al., 2017). There is a wide body of research, which has evaluated the strengths, weaknesses, and overarching gaps of this intervention model - in addition to recommendations to strengthen this approach. Educational interventions for human trafficking have been implemented into hospitals following a variety of studies evaluating healthcare professional's ability/confidence to respond to a patient who is being trafficked (Armstrong et al., 2019; Munro-Krumer et al., 2022; Nordstrom, 2020; Powell et al., 2017; Stoklosa et al., 2016). These interventions are inclusive of various training programs developed to give healthcare professionals the tools to understand the signs of human trafficking, and how to intervene if they believe a patient is being trafficked.

TRAUMA-INFORMED APPROACH

Some hospitals across the globe have made efforts to improve how they respond to cases of suspected human trafficking. In many of the studies, Survivors of human trafficking expressed feeling neglected and overlooked by healthcare providers (Baldwin et al., 2011; Chisolm-Straker et al., 2012; Lederer & Wetzel, 2014; Lumpkin & Taboada, 2017; Richie-Zavaleta et al., 2021), which often led to behaviors associated with mistrust. Recommendations followed three major patterns of behaviour shown by Survivors: avoidant, distrustful, and constrained (Price et al., 2019). While behavior patterns may be evident in situations where distrust is experienced, it is important for training programs to use a trauma-informed approach, which appreciates that the behavior, needs and experiences of each survivor is unique and impacted by a number of intersections experienced. Regardless of behavior patterns, the underlying causes of behavior can vary greatly between survivors based on factors such as race, disability, intergenerational trauma, previous medical trauma or discrimination. It is important that training programs and policy amendments use a trauma informed approach and equity lens so that service providers can learn to adjust their approach depending on the Survivor's unique needs. In interviews with survivors, they [survivors] indicated that healthcare providers taking a more trauma-informed approach would have made their exit and recovery a much easier process (Chisolm-Straker et al., 2012). Therefore, the success of a training program can be determined based on how well it integrates trauma informed and culturally responsive practices.

EXPERTISE OF TRAINING DEVELOPERS

The literature shows that various training methods have already been developed using research from across the globe that addresses the barriers faced by survivors within hospital settings. These training materials include updated screening tool-kits, policy and procedure documents, and training programs developed specifically for staff who work in departments that survivors of human trafficking are more likely to frequent. As such, it is important to highlight the need for training facilitators or those creating training content to have a thorough understanding of the way human trafficking cases may present in healthcare settings, and the unique challenges faced by healthcare workers in identifying and responding to trafficking cases. (Armstrong, 2017; Baldwin et al., 2011; Biffl et al., 2014; Chang et al., 2015; Chisolm-Straker et al., 2012; Cox & Chambers, 2019; Maryland Hospital Association, 2020; Tiller & Reynolds, 2020; Baldwin et al., 2023).

Experts working directly in the field of human trafficking should deliver training, to ensure material consistently reflects updated trends, promising practices, legislative changes and changing service pathways in the community. Where possible, the training could include a trainer who is a Survivor with lived experience (Garg et al., 2021).

TRAINING CONSISTENCY

Evaluations of Educational interventions (within a US context), have been conducted by scholars at HEAL Trafficking, a leading organization of healthcare professionals committed to addressing human trafficking in healthcare settings. These evaluations determined gaps in educational intervention where training programs do not address: knowledge retention and loss over time (Fraley et al., 2019; Nordstrom, 2020; Powell et al., 2017).

The pre-existing research shows that educational interventions that are not inclusive of refresher training see a significant drop in knowledge retention over a 6 month to one-year period (Nordstrom, 2020; Powell et al., 2017; Fraley et al., 2019; Lotzin et al., 2018). In order for educational interventions to make a significant impact, hospital human trafficking prevention policies should be inclusive of refresher training in their action plans. As evidenced in the results from this study's service provider and survivor surveys, a limited number of Lakeridge Health staff have received training on human trafficking or possess the skills to identify and respond to suspected cases successfully and safely. Additionally, the majority of Lakeridge Health staff surveyed indicated that they have not received anti-racism training.

The training programs that show the most tangible results are those that tailor what is required for hospital staff and provide updated screening tools that reflect current trends within human trafficking (Amstrong, 2017; Chisholm-Straker et al., 2012; Kaltiso et al., 2018; Nordstrom, 2020; Testa, 2018). However, it is important to note that the success of training depends on how consistently training programs are implemented and enforced (Recknor et al., 2020). The available research shows that when training programs accompany updated screening tools, identification of trafficking occurs at a higher rate (Kaltiso et al., 2018). The overall goal of training programs within hospitals is to improve the knowledge and skill sets of doctors, nurses, and other health care providers who may have contact with victims of human trafficking. Healthcare providers who participated in training stated an increased comfort in identifying victims of human trafficking and gained a stronger knowledge base of the nuances of human trafficking (Nordstrom, 2020). Additionally, the research shows that the efficacy of training increases when provided frequently rather than once (Nordstrom, 2020; Testa, 2018).

INFORMATION STANDARDIZATION

A study conducted by HEAL scholars found that information standardization is not often considered when developing educational resources (Powell et al., 2017). This gap in development can be detrimental given victims of human trafficking usually have contact with a variety of different healthcare professionals throughout the duration of their trafficking experience. Victims may be moved from one city to another, which is a trend that is evident throughout the Greater Toronto area. This is an important factor to consider because a poor experience at one hospital may deter a Survivor from seeking support at another. This factor opens an avenue to consider the need for consistent, standardized human trafficking education in hospitals across Canada.

Powell et al. (2017) provide a guideline of what should be considered/included when developing an HT educational intervention model:

- Content & Delivery
- Evaluation & Metrics
- Oversight
- Research
- Advocacy
- Collaboration
- Funding

Education models require support and reinforcement by hospital leadership. Training programs developed and facilitated by external service providers are generally under-attended unless strongly supported by hospital leadership, which in turn tends to be higher with information standardization.

MULTI-DISCIPLINARY APPROACH TO EDUCATION

Leading evaluations of educational interventions for human trafficking highlight the lack of multi-disciplinary approaches (MDA) integrated into training. MDAs are interventions that are inclusive of expertise from a variety of healthcare professionals (Taberna et al., 2020). Research supports that while educational interventions can provide healthcare providers with knowledge to understand human trafficking signs in patients, they are unable to provide adequate support due to lack of inter-hospital collaboration; examples of this lack of collaboration can be seen prominently in mental health units and clinics (Domoney et al, 2015; Fraley et al., 2019; Recknor et al., 2019). Two separate studies conducted in the US showed that due to lack of inter-hospital collaboration, and the availability of staff able to provide multidisciplinary support, patients in the mental health unit who were victims of human trafficking were not identified as such until their treatment plans had already begun (Domoney et al., 2015; Recknor et al., 2019). Healthcare providers from these respective studies stated that late identification of a trafficking survivor created complications in altering treatment plans and gaining patient consent for referrals.

In some hospitals, a Human Trafficking task force supported the development of policy and a MDA. Task force members may be comprised of physicians, nurses, and social workers with knowledge of trauma-informed care and experience in supporting Survivors, or at the very least act as liaisons and consultants to support the appropriate provision of care across the organization. Although an internal committee of this nature existed at Lakeridge Health, service provider engagement indicated that the committee dissolved in approximately 2020 and did not have formal support from the Corporation.

It is essential to the well-being and safety of Survivors that those intervening maintain proficiency in trauma-informed care and anti-oppressive practice. Task force members should have sufficient experience with community-based organizations that support Survivors, given that wrap-around supports are critical to successful outcomes. The effectiveness of safety plans often depend on the availability of resources and supports that can meet the unique needs of Survivors. Up-to-date knowledge on available resources, and the ability to effectively network with service providers already linked with Survivors or providing trafficking specific services, are required by those working directly and frequently with Survivors. Those intervening or offering support should also act as advocates to ensure interventions align with trauma-informed practices. With Survivor consent, members should ensure community supports are always included in collaborative care and discharge planning.

Most importantly, the task force should receive formal support from hospital leadership, which is enforced and ensured through the Human Trafficking policy, with reinforced support throughout every level of the organization.

CANADIAN CONTEXT

There is limited available research on Canadian initiatives to implement HT training, policies and procedures in hospitals. There is a growing body of work from US based organizations that highlight the importance and success of Human Trafficking training, policies and procedures. HEAL Trafficking is a US based agency that has developed a tool-kit for healthcare professionals to integrate a holistic anti-trafficking policies and procedures program (Baldwin et al., 2017). The goal of the tool-kit is to provide a standardized framework for healthcare professionals, administrators, or external-service providers to develop a response protocol to human trafficking. Additionally, the United States Department of Health & Human Services' Office on Trafficking in Persons (OTIP) has developed a list of Core Competencies to consider when developing a HT response protocol (National Human Trafficking Training and Technical Assistance Centre, 2021). The HEAL tool-kit was adapted by the Human Trafficking Health Alliance of Canada (HTHAC) to create the 'Health Care and Human Trafficking Curriculum Assessment Tool' (HTHAC, 2023). While both tools can inform the development of a Human Trafficking policy framework

for healthcare systems within Canada, careful additional consideration is required to ensure training, policy and procedures reflect the experiences of diverse Canadian and Indigenous Survivors and that interventions effectively ensure cultural safety and respond to the unique cultural needs of all Survivors.

The HTHAC tool-kit provides a helpful overview of critical content that should be included in hospital based training programs (http://hthealthalliancecanada.org/). However, while touching on the need to discuss targeting factors and social determinants of health that lead to the over-representation of certain groups in Survivor statistics, the Curriculum Assessment tool did not emphasize the need to collaborate with and involve diverse Survivors in the development of training (for example, those living with disability, newcomers, BIPOC and gender-diverse individuals).

The unique barriers faced by Indigenous women, girls and 2-spirited folk and other BIPOC Survivors demands that training programs also include a fulsome overview of the continued impacts of colonization and systemic discrimination in Canada so that continued harmful practices within the healthcare sector that remain barriers for diverse Survivors are acknowledged and changed. Failure to acknowledge the connection between human trafficking and the continued impact of colonization and the Indian Act, negates the precipitating factors that have led to the severe over-representation of Indigenous victims, which currently reflects 51% of Human Trafficking Survivors in Canada (Public Safety Canada, 2020). Until the systemic harm perpetuated by healthcare institutions is acknowledged and addressed, hospitals will continue to be an unsafe space for many Human Trafficking Survivors. Therefore, training programs that attempt to explain the precipitating factors for over-representation without providing adequate training on culturally responsive intervention and the need for culturally appropriate supports will perpetuate the underlying factors that led to this over-representation to begin with.

RESEARCH METHODS

DATA COLLECTION

This research study adopted a qualitative design with interviews and surveys conducted to gather in-depth information about the experiences of Survivors of sex trafficking accessing health care services. Interviews with survivors included experiences both in Durham region and other parts of Canada. However, with regard to data gathered from service providers and health care providers, the geographical scope was limited to Durham region and executed through a partnership with Lakeridge Health Corporation. A Survivor advisory panel was created consisting of five diverse Survivors. A clinical staff member at VSDR with lived experience as a survivor of human trafficking facilitated the panel. The panel examined and informed the research design, administration protocol, and instruments to ensure the process was survivor centric and trauma-informed. Quantitative data reflected identity-based demographics, strength and validity of themes identified in survivor and service provider experiences, to determine hospital departments utilized, and identify knowledge gaps.

Data collection occurred from February 2022 to September 2022. An invitation to participate in the research was shared with clientele of Victim Services of Durham Region and to clients of agencies belong-

ing to the Durham Human Trafficking Coalition, Women's Multicultural Resources and Counseling Centre, and AIDS Committee Durham. Survivors chose a method to participate – verbal interviews through video, phone call or written format with open-ended questions. Once a survivor expressed interest the research/clinical team assessed their preferred mode of participation, their ability to participate safely and their accommodation needs to ensure suitability. This included access to VSDR Human Trafficking Crisis Intervention Counsellors to ensure ongoing support so participants felt comfortable with the interview process. Survivors had the opportunity to review interview questions in advance and provide feedback. This allowed the opportunity for a Survivor centered and trauma informed approach to reduce the risk of triggering, or identify questions that may require omission, and to ensure informed consent.

Seventeen Survivors participated in the interview process. The duration of each interview was between 30 to 60 minutes. Participants returned written responses at their convenience . Victim Services of Durham Region provided access to crisis intervention counselors who were available to support any Survivor participant that may have required support before, during or after their participation in the interview.

The initial phase of eliciting service provider participation entailed participant interviews with both hospital staff (internal service providers), and community based service providers (external service providers). A survey was later developed and distributed through community partners and regional coalitions to increase participation. Interview questions changed to multiple-choice answers, yes/no responses, Likert scale and open-ended questions to increase consistency between the interview and survey questions. External service providers invited to participate included staff from provincial government services, outpatient healthcare services, non-profit service providers and law enforcement, with both frontline and managerial experience. While health care providers in any inpatient setting could participate, recruitment targeted interdisciplinary staff from key departments within Lakeridge Health hospitals more likely to engage Survivors, such as Emergency departments, mental health and addiction units and critical care. Invitations were extended to Internal and external service providers based on their likelihood to intersect and work with human trafficking survivors (ie. member agencies of the Durham Region Human Trafficking Coalition). Internal and external service provider surveys were collected until September 2022.

Respondent themes identified from the interviews used a coded schematic via Quirkos software. Broader themes focused on area of research and overall validity across all participant responses. Each theme was coded and cross evaluated against other responses to determine whether the experience shared was widely prevalent or not.

INTERNAL POLICY REVIEW

To supplement the data collected from service provider and Survivor engagement, it was determined that a review of internal policies and procedures at Lakeridge Health would allow additional insight into current practices and how those existing practices may be impacting the way Survivors experience hospital services. As such, it was determined that a review of specific and relevant policies would provide additional opportunity to highlight where there may be gaps in service and identify existing strengths. Multiple inquiries were directed to Lakeridge Health on the existence of policies relating to the following areas: human trafficking, trauma informed care, anti-racism/anti-oppression, gender inclusion, affirming language, violence prevention, or policies specific to the provision of services through DVSACC (Durham Region Domestic Violence/Sexual Assault Care Centre). The purpose of this process was to establish an understanding of what steps Lakeridge is already taking to strengthen internal practices, and to explore and identify any key areas where additional policies, processes or education would be beneficial. Despite communication with multiple Directors and representatives at Lakeridge Health over a ten-month period, no policies were located or shared on the above-mentioned themes. As such, should such policies exist one recommendation would be to ensure that all staff are familiar with how to locate policies as needed. However, based on the reported information by multiple staff throughout the project timeline, the project operated under the assumption that Lakeridge Health does not currently have any [available or existing] policies and procedures related to the aforementioned topics.

[1]All survivors received an honorarium of $180 for their time and shared expertise on the research topic. No information about compensation was included on the advertisement flyer based on the survivor advisory panel's feedback. This helped to avoid participation being transactional, which could be triggering to survivors. It also helped to ensure participation was voluntary, rather than a result of financial circumstance.

FINDINGS

SURVIVOR INTERVIEWS

DEMOGRAPHICS

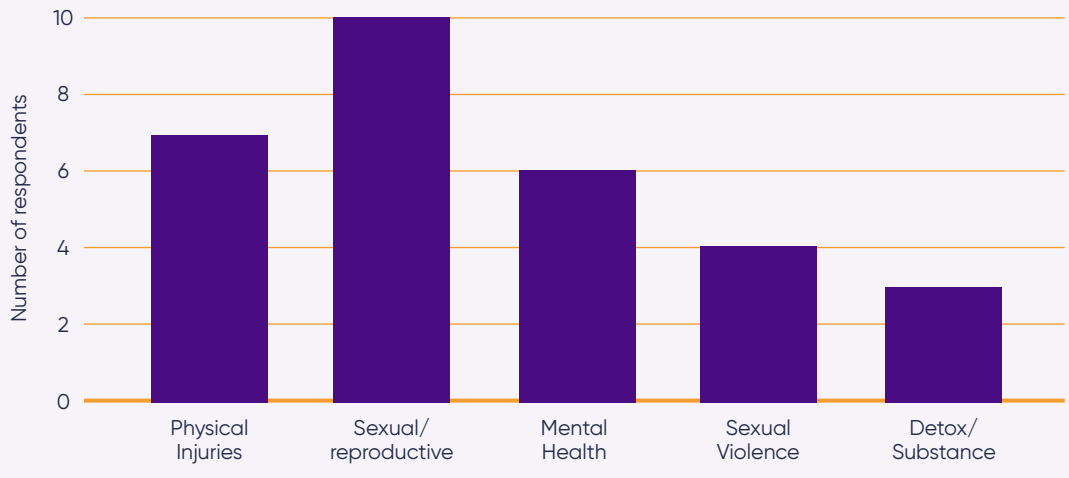
Seventeen Survivors participated in the interviews. Among those who revealed their current age and the age at which they were trafficked (n=16), the current average age of Survivor participants was 30 years, ranging from 20 to 47 years. The average age at which they were trafficked was 19 years old, ranging from 15 to 35 years. A vast majority of the Survivor participants identified as being White (n=11, 65%), followed by Indigenous (n=2, 12%), Inter-racial (n=2, 12%, identified as Indigenous and White, French, or Black), Latin American (n=1, 6%) and South Asian (n=1, 6%). While Indigenous Peoples represent only 4% of the total Canadian population according to 2016 census , they are overrepresented in human trafficking statistics across Canada. This over-representation was consistent in the study (24% identifying as Indigenous).

Almost all of the Survivor participants were Canadian citizens (n=16, 94%), with one exception who held a permanent resident status (n=1, 6%). The majority of Survivor participants shared having visited various health care settings in Durham either in the past or recently (n=9, 56%). Two participants (13%) were unsure if they had interacted with health care facilities in Durham and shared that it was difficult to recall locations they frequented while being moved from location to location by their traffickers. However, some participants specified never having accessed health care specifically in Durham region but drew on their experiences in other parts of Ontario and Canada (n=5, 31%, which included Greater Toronto Area, Sudbury, Ottawa, Vancouver).

ACCESSING HEALTH CARE

The most common precipitating factors that lead Survivors to access the hospital were physical injuries (n=7), sexual and reproductive health, including STI screening and pre-natal care (n=10), mental health concerns, sexual violence care (n=4), and detox/substance abuse supports (n=3). It is important to note that all Survivors interviewed experienced the factors mentioned, however not all sought treatment for every concern.

REASONS FOR ACCESSING HEALTHCARE SERVICES



[2]https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm?indid=14430-1&indgeo=0

DEPARTMENTS AND SPECIALISTS SEEN BY SURVIVORS (TABLE 1).

DEPARTMENTS	NUMBER OF SURVIVORS
Emergency	13
X-Ray, CAT Scan	2
Mental health support	7
Psychologist	4
Detox	4
Sexual Health Clinic	3
Walk-in Clinic	8
Specialist (Endocrinology, Plastic Surgeon, Orthopaedic)	3
Women's clinic + Gynaecology	3
Family doctor	1
Sexual assault/Domestic Violence centre within hospital	4

While discussing the comfort and frequency of accessing health care when needed, more than half (53%, n=9) of the Survivors shared not feeling comfortable or specifically avoiding visiting health care facilities. Among those who shared mostly having accessed health care services (47%, n=8), two Survivors highlighted having used it only to address physical health issues and never mental health or trafficking concerns. Survivors expressed greater comfort accessing sexual health clinics compared to hospitals as they felt staff were less judgmental. Similarly, many Survivors preferred to use walk-in clinics.

Hospitals or clinics were most often located through word of mouth from other girls working in the sex industry or examining the rating and reviews on google. Some Survivors also accessed health care services through advocates or staff at non-profits.

The challenges to accessing health care identified by Survivors is understood as originating from two sources as displayed (Table 2):

EXTERNAL FACTORS	INTERNAL FACTORS
Fear of trafficker (65%, n=11)	Approach by Health Care professionals (HCPs) (88%, n=15)
Survivor anxiety (n=4)	Barriers to Disclosure (ie. lack of privacy) (80%, n=12)
Lacking resources (n=3)	Practice Approach (ie. trafficking not explored by staff, lengthy wait times) (100%, n=15)

31% of Survivors indicated that they were re-traumatized and felt judged.

As shown in Table 2, the factors that influence a survivor of sex trafficking to access healthcare services is broken down into two categories: external and internal factors. External factors are defined as factors outside of a healthcare setting that influence a Survivor's decision to access healthcare, and internal factors are occurrences within a healthcare setting that influence this decision.

EXTERNAL FACTORS THAT INFLUENCE SURVIVOR EXPERIENCE

FEAR OF TRAFFICKER

Of Survivors interviewed, 65% described their trafficking situation as being an impediment to freely access health care facilities whenever they needed. Survivors expressed fear that their visit to the hospital could get them into trouble with their trafficker. One Survivor described, "During the trafficking I never accessed a health care setting because I was not allowed, as my trafficker feared I would talk and get him in trouble, which I would have".

Survivors expressed belief that the hospital authorities would involve the police without their consent and compel the Survivor to provide a statement or to record the incident in their files. Many Survivors mentioned that going to the hospital also meant taking time away from providing sexual services to clients. This would often impede business for their trafficker, especially if the visit to the health care facility involved multiple visits within a short period. Survivors expressed fear for themselves and their family members due to threats made by their trafficker(s). Some Survivors shared having injuries caused by their traffickers but could not seek medical help for fear of being implicated.

SURVIVOR ANXIETY

Four participants (24%) in the study stated that their own anxiety often limited their willingness to access health care services. The reasons cited by Survivors included poor experiences with health care providers before and during being trafficked, feelings of guilt and shame, and one Survivor shared trauma related to being trafficked by a healthcare provider. Survivors shared those negative experiences within the hospital prior to being trafficked also influenced their anxieties when accessing healthcare services.

Survivors discussed how feelings of shame and guilt from being raped, trafficked, or addicted to substances, heightened their anxiety about accessing services. Survivors also expressed that a fear of the unknown (ie. finding out they are pregnant, fear of repercussions of pregnancy if their trafficker finds out, or fear of learning that they have STIs) also prevented them from seeking care. Survivors expressed that they may feel triggered if they experience stigma associated with these issues upon attending hospital, which would be enough to turn down the services and return to the trafficker. One of them narrated,

> **SOMETIMES KNOWING YOU'VE BEEN RAPED, CARRIES A LOT OF SHAME AND FEAR. TO DEAL WITH THE ENTIRE RAPE KIT AT A HOSPITAL AND BEING TOO AFRAID TO PRESS CHARGES. IT CAUSES AVOIDANCE OF THE ENTIRE PROCESS. IF YOU HAVE BEEN BEATEN BADLY, OR WERE USING DRUGS FOR LONG PERIODS, DURING THE TIME YOU ARE TRAFFICKED, VICTIMS FEEL A LOT OF SHAME, GUILT AND FEAR AROUND ACCESSING HEALTH CARE. THEY ALSO FEEL UNWORTHY. AND THEY CAN ALSO BE VERY FATIGUED.**

LACKING RESOURCES

A few Survivors shared that one reason for not visiting health care facilities (although requiring healthcare), was due to lack of access to resources such as not having someone to accompany them to hospital, or not having the money for transportation to the hospital. During the time of their trafficking most Survivors lacked consistent care as they never had a family physician or visited one hospital for continuous care. One Survivor shared how lack of safe, reliable housing prevented her from being able to seek regular prenatal care:

> **I WENT THROUGH MOST OF MY PREGNANCY WITH JUST HAVING SEEN MY DOCTOR AND I GOT TWO ULTRASOUNDS AND THAT WAS PRETTY MUCH IT. MY DOCTOR LISTENED TO THE HEARTBEAT ONCE. AT THAT TIME MY LIFE WAS KIND OF CRAZY. I NEEDED A PLACE TO LIVE THAT WAS SAFE FOR ME AND MY BABY. SO I BOUNCED AROUND, AND EVENTUALLY ENDED UP IN A SHELTER FOR DOMESTIC VIOLENCE**

INTERNAL FACTORS THAT INFLUENCE SURVIVOR EXPERIENCE

The approach by healthcare professionals was the most common theme that arose in responses from Survivors when asked about factors that influenced their access to healthcare services. Although some Survivors (12%) shared some positive experiences with caring healthcare providers, the majority of Survivors (88%) described their experiences as being awkward, uncomfortable and inducing stress. They indicated that healthcare professionals lacked knowledge on how to support a victim of sex trafficking or focused only on physical care while missing other strong indicators of concern. The Survivors described feeling judged, made to feel "dirty" and stressed feeling that staff viewed them and treated them negatively.

Most Survivors reported refusal by healthcare staff to provide care. This included an experience of failure to complete a rape kit after a rape, or denied support with addiction and mental health concerns related to trafficking. Of Survivors interviewed, 35% shared how their comfort with accessing health care declined further over the course of time. The factors that influenced these Survivors' comfort included poor treatment and practices that were re-traumatizing for Survivors. As a result, they would often avoid attending for subsequent rape kits. One Survivor shared about her experience of sexual assault (by her trafficker). The hospital staff made her feel so uncomfortable that she never returned. She narrated:

> **I USED TO HAVE NO PROBLEM CONTACTING HEALTHCARE, EVEN WITH MY MENTAL HEALTH DIFFICULTIES. I ALWAYS FELT COMFORTABLE UNTIL I WAS SEVERELY SEXUALLY ASSAULTED BY MY TRAFFICKER, AND THE CARE I RECEIVED IN HOSPITAL, WHILE WAITING AND GOING THROUGH MY RAPE KIT WAS TRAUMATIZING. THE EXPERIENCE I WENT THROUGH WITH THOSE MEDICAL PROFESSIONALS IS SOMETHING I WILL NEVER FORGET. I HEARD THE NURSES LAUGHING AND MAKING FUN OF ME. I WAS ACCUSED OF "ASKING FOR IT". I WAS ASKED NUMEROUS TIMES, "ARE YOU SURE THIS WASN'T BROUGHT ON BY YOUR OWN ACTIONS?". I LEFT THE HOSPITAL THAT DAY DEFEATED, AND I FELT MORE VICTIMIZED THAN WHEN I HAD INITIALLY ENTERED THE HOSPITAL WITH THE POLICE.**

Survivors emphasized that long wait-times to conduct tests (examples of up to 12 hours were shared), and the experience while waiting was especially challenging. Survivors recanted having to wait for lengthy periods in populated, uncomfortable areas to seek support after a sexual assault. Survivors highlighted how emergency departments were "notorious for their wait times", however this can be especially concerning to Survivors whose safety may be impacted by the length of time they are away from their trafficking situation, or who may not receive another opportunity to seek healthcare again. One Survivor shared how she attended the emergency department between 3 to 5 am when there were fewer patients because she was unable to manage the lengthy wait times otherwise. She described this time to be one where she was able to get more resources (such as intravenous fluids, steroids, nourishment) and care from the nurses but had to give up the very few permitted hours of sleep in order to attend.

Survivors shared how the experience of being moved a lot between different departments within the hospital was challenging for them, as they were unable to establish trust or build relationships with the HCPs. For Survivors of human trafficking, building trust is essential for the provision of trauma-informed care. While hospital-based services experience understandable challenges relating to bed shortages

and the movement of patients across units, the lack of consistency in care made it incredibly difficult for Survivors to establish rapport. One Survivor spoke about feeling judged as a person with substance abuse issues and domestic violence concerns. The lack of rapport and relationship building due to staff inconsistency prevented her from disclosing her experiences or concerns as a trafficked victim. 31% of Survivors identified that feeling judged by HCPs was a common experience, and did not feel comfortable discussing sexual health concerns or approaching health care providers when needed.

Survivors who sought healthcare services for mental health issues reported leaving hospital without linkage to appropriate services. Survivors noted issues such as judgemental interactions with triage nurses, stringent rules that limited their ability to self-soothe, and fear of involuntary admission into the mental health unit. Two Survivors shared that upon presenting to the ED in a calm and respectful manner were denied a bed on the mental health unit despite being unwell (suicidal ideation/intent, mania, or severe Post Traumatic symptoms). Survivors expressed belief that they needed to present in an extreme state of distress and draw significant attention in order for their concerns to warrant an admission.

Transition into adulthood was another concern. Two Survivors had challenges finding mental health support upon turning 25. Trying to find low-cost or free therapy, a psychiatrist, or counseling in Ontario was a challenge, where some Survivors have even explored therapy in Quebec due to lack of availability in Ontario. While lack of funding and access for mental health supports is a common occurrence for all Canadians, it is worth noting in this study due to the heavy impact HT has on the emotional and mental health and well-being of Survivors.

RE-TRAUMATIZATION

Throughout the interviews, a variety of re-traumatizing practices arose as influencing factors for Survivors who avoided accessing healthcare services. Practices on administering of rape kits was a concern for most Survivors. The experience for many Survivors was scary, which may have included taking photos of all the marks inflicted by the trafficker or perpetrator on the body, physical examination and often included giving the victim a relaxer prior to the examination. Survivors expressed concern that explanations about the process were inadequate and that service providers did not take the time to build adequate rapport prior to examination. Survivors also shared that post examination they had to cope with trauma and re-triggering without any support. One Survivor shared leaving from the hospital in the middle of the night and that she felt very unsafe. Many Survivors indicated that the Sexual Assault Nurse did not connect them to a Social Worker.

Another issue of concern identified was having no choice regarding the gender of the physician they interacted with within the hospital. Survivors had no option to choose even when explicitly requesting a female doctor and one was working. In other instances, Survivors simply did not feel comfortable expressing their preference.

Survivors highlighted additional examples of re-traumatizing procedures such as running pregnancy tests on individuals without consent or having to take off their shirt for an ECG without preparation time and explanation. One Survivor shared how practices at certain teaching hospitals caused re-traumatization. Resident doctors and those still studying to be medical professionals often become involved with the care of a trafficked person as they are looking to gain experience in providing treatment to this particular patient population. This leads to Survivors feeling bombarded with questions even before building therapeutic and trusting relationships with members of their health care team. It is likely that HCPs do not have sufficient knowledge of trauma informed care and may not realize the re-traumatization caused by having a Survivor share their lived experience to multiple care members. Survivors shared that the frequent questions left them to feel disrespected and "shut down" with the examination. Survivors expressed that services providers saw them as uncooperative if they failed to participate. Survivors reported that the Resident should not enter the room until the primary practitioner has obtained their prior consent and that questions should be minimal to ensure the comfort and safety of Survivors. A single staff that the Survivor felt comfortable with was preferred.

TRIAGE AND SCREENING PROCESS

Survivors indicated that there did not appear to be screening processes in place to determine if a patient presenting to the ED is a victim of sexual assault and has experienced trafficking and required additional support by hospital staff. Survivors shared how responding 'yes' to certain existing screening questions such as, "do you have multiple sexual partners?" should raise a red flag for the HCPs to follow up on and identify if the individual needs additional support. However, most Survivors shared they were never asked questions by HCPs that may identify they were a victim of human trafficking/experienced sexual/physical or emotional trauma and therefore were not referred to agencies that support trafficked victims. The responses on the forms are often treated "more like a checkbox that they're just checking but not consciously seeing if you're answering, 'yes' to something then do follow up with that". Survivors reported HCPs missed most warning signs and were "in a rush to push people out of the space very quick" and did not take the time to ensure they had a safety plan. For example, Survivors noted that nobody took the time to ask if an abuser was outside or if they needed a safe place to rest for the night. Nobody offered to make referrals to community partners or internal service providers such as a social worker, who could connect them to such supports. Survivors did not see the hospital as a place to seek support and would usually go there only if they had an acute physical injury. Similarly, with recurrent UTIs and STIs, visiting the hospital did not provide an opportunity for intervention or support relating to the trafficking so continued attendance at hospital increased risk to Survivors without a permanent solution to resolve their concerns. Therefore, Survivors would resort to online searches to remedy physical concerns rather than seeking healthcare. This can be detrimental for Survivors whose only opportunity to seek healthcare or supportive intervention would have been through the ER.

According to Survivors interviewed, they indicated that there are no processes or procedures in place that they were aware of that ensures a victim who has left the trafficking situation feels safe in the lobby or restroom within the hospital. One Survivor shared how the television in the waiting area in emergency department played sexual assault news that was triggering for her to watch while waiting to be treated. This became so overwhelming that she left the hospital, forgoing treatment. Another major concern for Survivors was the lack of privacy in emergency departments or walk-in clinics. Survivors had to share highly personal information at the front desk/ triage or from a hallway chair/stretcher while other patients/onlookers could hear. Similarly, using public restrooms within crowded spaces (much like hospital ED's) have been traumatic for Survivors who have exited trafficking and have a lot of negative memories associated with restrooms as they are a common place of recruitment.

APPROACH BY HEALTH CARE PROFESSIONALS

Survivors shared having to interact with HCPs, including staff from mental health departments, not trained in how to deal with human trafficking and were unaware of how to support Survivors. The HCP's direction was usually to refer them to someone else who also lacked training, yet increasing the number of times Survivors had to share their stories. Survivors shared that HCPs were unaware of community support available to Survivors of human trafficking so their needs went unmet. Another concern raised by Survivors was the lack of follow up by health care after any interaction or the lack of flexibility to assist with booking another appointment if the Survivor missed one. For many, being in a trafficking situation means having no control over time or schedules, which impacted their ability to consistently make it to appointments.

> **A FEW MONTHS AGO, THE GUY I WAS DEALING WITH GAVE ME A VERY BAD BLACK EYE, HALF MY FACE WAS BRUISED AND SWOLLEN UP. THE PARAMEDICS AND POLICE CAME TO THE SCENE, AND I WAS TAKEN TO THE ER. AFTER BEING ASSESSED I WAS DISCHARGED TO THE STREETS WITH NO COMMUNITY FOLLOW UP. THE POLICE CHECKED UP ON ME A WEEK AFTER, BUT I DIDN'T FEEL COMFORTABLE DEALING WITH THE POLICE. BUT THE HEALTH CARE PEOPLE THEY NEVER CHECKED ON ANYTHING AFTER.**

Multiple Survivors with substance abuse histories shared that whenever they have visited an emergency department they received "very poor" treatment. One Survivor shared that even an on-call staff at the sexual assault and domestic violence centre reprimanded her for disturbing them and said, "If I hadn't been smoking crack, I wouldn't have been assaulted". Survivors explained there was significant stigma and prejudice from HCPs on how they presented that would determine the services and support they received. Often, if the Survivor presented as irate, difficult or unkempt, discharge occurred quickly, often without care. Some Survivors shared feelings of anger, discouragement or feeling "small". One Survivor shared, "I heard them [HCP] numerous times making fun of my situation and me. They made me wait with no one to talk to while dealing with all of these emotions [after being rescued from a trafficking situation]."

DISCLOSURES TO HEALTH CARE PROFESSIONALS

Survivors shared how interactions with HCPs or certain health concerns they brought forward to the HCPs should have raised a red flag but were often overlooked. For example, it is very common for Survivors to visit healthcare settings with another girl working with their trafficker, whose role is to ensure the Survivor does not disclose any details about the trafficking situation or the trafficker. Survivors noted that the HCP did not find "it was weird or anything like that, they would talk to her and they would also talk to me".

Even when the HCP was kind and non-judgemental, Survivors shared they do not often feel comfortable to share anything about their trafficking history or situation with their physician, even though they might be experiencing symptoms or illnesses related to it. For some HCPs who might have had some suspicion of the trafficking situation, Survivors described feeling as though the physician did not know what to say or do, so often did nothing about it. One Survivor reported:

> **THIS IS NOT A NORMAL THING FOR 16-YEAR-OLDS, YOU [HCP] SHOULD HAVE SOME FOLLOW UP QUESTIONS. I TOLD THEM THAT I WAS WORKING OUT OF A MOTEL. I GAVE THEM ENOUGH INFORMATION THAT I THINK THAT THEY [HCP] FIGURED IT OUT. THEY ASKED ME IF I WAS SEXUALLY ACTIVE, AND I DIDN'T REALIZE THIS WAS WRONG AT THE TIME. I WAS JUST MUCH MORE NONCHALANT ABOUT IT. I SAW THE CLINIC THERE, BUT THERE WAS NO FOLLOW UP. THEY JUST DID SOME SAFETY PLANNING WITH ME. THEY TOLD ME TO DOWNLOAD THE PTSD APP, AND THEY TOLD ME TO BE AWARE OF MY SURROUNDINGS. AND IT DIDN'T REALLY MAKE SENSE TO ME, BECAUSE I DIDN'T SEE THAT THERE WAS AN ISSUE HAPPENING HERE. SO I WAS LIKE, OKAY, I'LL BE AWARE OF MY SURROUNDINGS. BUT I DIDN'T KNOW WHAT I WAS SUPPOSED TO BE AWARE OF. YEAH. AND SO JUST GOT RIGHT BACK INTO IT [TRAFFICKING SITUATION].**

One Survivor discussed fears of further harm and described how the behavior of the HCP was inappropriate. Another Survivor shared how when she disclosed her trafficking history to her family physician after 20 years of interaction, the dynamics of their interactions changed. He was not empathetic, and instead was disrespectful and treated her differently. She described, "Even the way he treated me when I had to tell him about it [her past trafficking situation], he just treated me really badly. I ended up leaving his office in tears". Similarly, she shared that a mental health provider that she interacted with after disclosing her trafficking situation became completely inappropriate and made triggering comments surrounding his viewpoints on the sex industry. The National Task force on Human Trafficking reported that approximately 70% of Survivors recalled having to have sex with doctors during their trafficking (Canadian Women's Foundation, 2014). It is important to consider how these experiences can influence the way Survivors trust and engage with HCPs, the potential for triggering and why it is essential for those providing patient care to have training in trauma informed care.

While discussing if HCPs were able to identify and support Survivors of human trafficking, almost all Survivors confirmed that the HCPs had the opportunity to do so, especially since many presented to a health care setting with injuries, concussions, sexual assault disclosures, sexually transmitted infections (STIs), and drug overdose, among other signifiers. They shared how Survivors are often overlooked by multiple health care providers. One Survivor described how the HCPs "see people at their very vulnerable points [in life]", which puts them in a unique position to intervene. The ambiguity was more about their willingness to help when they are hard pressed for time and there is a backlog of patients waiting to be seen. One Survivor shared:

> **"I FEEL AS THOUGH THE DOCTORS AND HEALTH CARE PROVIDERS HAVE ZERO IDEA WHAT THEIR DOING WHEN IT COMES TO HUMAN TRAFFICKING AND SEXUAL ABUSE, AND OFTEN TIMES THE WOMEN END UP BEING BLAMED OR RE-VICTIMIZED ALL OVER AGAIN. SO A LOT OF THEM DON'T BOTHER TO EVEN ASK FOR THE HELP".**

IMPACT OF STEREOTYPES

For over half of the Survivors interviewed (n=9, 53%) the alternate coping mechanism if they did not want to (or could not) visit the hospital was to use substances to provide pain relief from inflicted injuries, and to cope with the traumatic experiences of being trafficked. Survivors spoke about "sucking it up" as they did not have much choice to seek help, especially if they were still minors. For physical health concerns, Survivors shared using google searches for remedies, or some reported using only over the counter medicines – Tylenol, ice and heat packs, wearing wrist braces, first aid kits to stitch up injuries - many of which were financially inaccessible to many of the survivors.

Almost all Survivors shared "brushing it under the rug" in terms of their mental health challenges given seeking a therapist or counselor was not feasible. One Survivor shared having called crisis lines and posted on sexual abuse Survivor forums for advice and emotional support. Survivors felt comfortable accessing sexual health clinics as opposed to hospitals as they felt staff were less judgmental and awkward when discussing sexual health. One Survivor reported, "Sex wasn't a taboo topic for them. They would ask you questions like; how many partners have you had? Are you safe? Whereas in the hospital, those weren't the types of questions that they would ask". Walk-in clinics were preferred over hospitals by most Survivors. When talking about the processes at sexual health clinics, Survivors had mostly positive experiences and felt safe within these spaces. They were not required to provide their real name, age or identification. The hospitals or clinics were most often located through word of mouth from other girls working in the sex industry or examining the rating and reviews on google. Another mode of accessing health care was through the support of advocates or staff at non-profits who assist survivors by connecting them to these facilities.

IMPACT OF THE COVID-19 PANDEMIC

The health care system experienced particular challenges due to the COVID-19 pandemic. Some Survivors felt that having access to online or telephone support without having to go to the hospital helped them to feel safer and that interactions felt less invasive. Having the option to consult with the doctor over a video/phone call was beneficial in terms of convenience. However, the loss of in-person visits made it much more difficult to detect trafficking due to strict protocols and the loss of personalization, connection, relationship building, or the ability to identify indicators of trafficking that might otherwise be visible. Some of the programs within the hospitals were also affected by the pandemic which meant Survivors could no longer access these services either in-person or virtual. While healthcare challenges affected the entire population in numerous ways, those who typically face increased barriers, such as human trafficking Survivors (particularly those from marginalized communities who also face racial or systemic discrimination) experienced heightened barriers to their health and safety.

POSITIVE SURVIVOR EXPERIENCES

Despite the challenges noted in accessing health care, Survivors also identified a number of practices that improved their experience. Identifying practices that have been helpful to Survivors is also important to enhancing trauma-informed care and building on existing successes, which can save time and make strategies or protocols easier to implement.

The 24/7 service offered by hospitals increased accessibility for Survivors who were unable to seek support during typical business hours of clinics and other services. Additionally, Survivors appreciated hospitals that specialize in issues related to women as they often provided an opportunity for them to access diagnostic testing, results, and treatments on a walk-in basis.

While the COVID-19 pandemic had a devastating impact on our healthcare sector, COVID-19 precautions at some hospitals allowed for increased privacy and safety for Survivors to meet with a healthcare team member. Protocols that prohibited patient visitors allowed for the separation of Survivors from traffickers or those connected to their trafficker. However, this eliminated access to healthcare for some Survivors whose traffickers would not permit them to attend the hospital alone.

Some Survivors noted that posting contact numbers for resources in the washrooms provided needed information to individuals in a private space without the pressure to act on it. One Survivor shared how it was comforting to have access to a shower and items to meet her basic needs. She further described the nurse at this sexual assault unit as kind and appreciated how the nurse followed up with her to see if she had been able to connect with resources in the community after her visit at the unit.

One Survivor emphasised the importance of having a long-term relationship with a HCP. She described how her interaction with her psychiatrist and general physician helped her process the trauma that she had experienced during trafficking and the court process. Another Survivor shared how critical it was for HCPs to be trauma-informed in their interaction, stressing how it affected her positively. She narrated:

> **HE [HCP] WAS VERY KIND. HE WAS DEFINITELY TRAUMA INFORMED AND MADE ME FEEL COMFORTABLE TO OPEN UP. EVEN THOUGH I WAS BEING A BITCH. I WAS VERY ON EDGE AFTER WAITING FOR THAT LONG. HE WAS VERY OPEN AND UNDERSTANDING AND APOLOGIZED FOR EVERYTHING [LONG WAIT AND CONFUSION AT THE TRIAGE DESK]. I DID GET HOOKED UP WITH A LADY FROM LAKERIDGE TO DO PHONE CALLS WITH AND SHE'S BEEN WONDERFUL AS WELL. SHE ALSO HAS LIVED EXPERIENCE, WHICH IS VERY HELPFUL, AND TOLD ME HOW TO DO SOME SELF-CARE.**

The most prevalent theme identified by Survivors with positive experiences was the presence of Social Workers. Survivors spoke about how the approach by Social Workers compared to other healthcare providers changed their entire experience and feeling of safety. One Survivor shared how the social worker recognized that she was a victim of trafficking and ensured she went to an appropriate unit within the hospital. She received appropriate services she could access upon discharge. The Social Worker continued to check on the Survivor even after she left the ER. The reassurance that she would not get into trouble and did not have to involve the police had a drastic impact on her experience.

> **I REMEMBER BEING VERY WORRIED THAT I WOULD GET US [TRAFFICKER AND HER] IN TROUBLE. IF I GAVE THEM NAMES OR ANYTHING. THEY SAID... YOU'RE NOT GOING TO GET IN TROUBLE WITH THE POLICE. SO THAT WAS A BIG WORRY THAT THE INFORMATION WOULD BE SHARED OR THAT I WOULD GET IN TROUBLE. BUT THEIR FOCUS WAS JUST ON GIVING THE MEDICAL CARE I NEEDED. SO THEY WERE VERY REASSURING. THEY WERE REALLY, REALLY GREAT!**

Another survivor narrated:

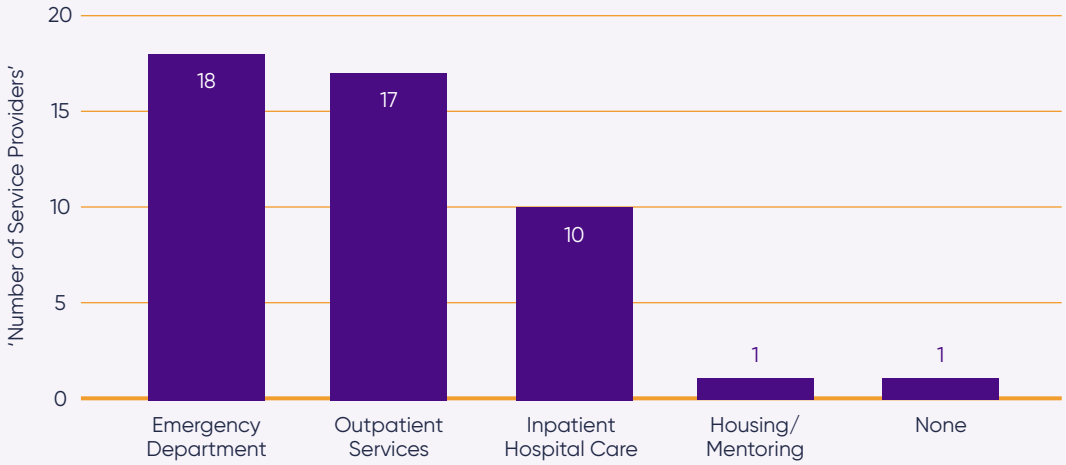
> **I WAS JUST LAYING DOWN AFTER MY SURGERY. I HAVE BEEN IN HOSPITAL A FEW TIMES. AND THEY'VE CONNECTED ME TO SOCIAL WORKERS. I FEEL LIKE SOMEONE CARES. IT JUST MADE ME FEEL LIKE SOMEONE IS LOOKING OUT FOR ME. THE FEELING OF SOMEONE BEING CONCERNED FOR ME.**

Outside of the hospital, one of the things that assisted Survivors was the low barrier environment created by sexual health clinics. Survivors shared that there was no necessity to provide their identity or details about their current situation to receive services during their trafficking situation. Survivors shared how the non-judgemental, non-hierarchical and non-authoritarian relationship that physicians at a sexual health clinic displayed made them feel welcomed, respected and safe within the clinic. This led to repeat visits and rapport building with the health care team. Survivors spoke to the impact of interactions with a counselor who shared their lived experience of human trafficking within an addiction treatment centre. This unique relationship helped one Survivor with exiting her trafficking situation. The treatment centre went on to even accommodate her longer than her specific program days to facilitate her exit given she was unsheltered. The Survivor highlighted that having staff at the facility who were aware of human trafficking issues, and willing to go out of their way to support her made her exit from trafficking possible.

EXTERNAL SERVICE PROVIDER SURVEYS

In addition to Survivor interviews, surveys completed by external service providers also provided additional data. External service providers often act as connectors or mediators between Survivors of human trafficking and healthcare providers or other community resources. The purpose of collecting the perspectives of this population was to fill gaps in information regarding what Survivors of human trafficking experience when attempting to access health care services or the experiences of external service providers in trying to support Survivors who are accessing or navigating hospital supports. In situations where Survivors are acutely unwell, they may not recall some or all of the experience, which other service providers may have been privy to (i.e. overdoses, psychosis etc.). Survivors may be unaware of whether or not the support they received is indicative of a trauma-informed approach or may even have skewed perceptions of their treatment if they are using their trafficking experiences as a comparison.

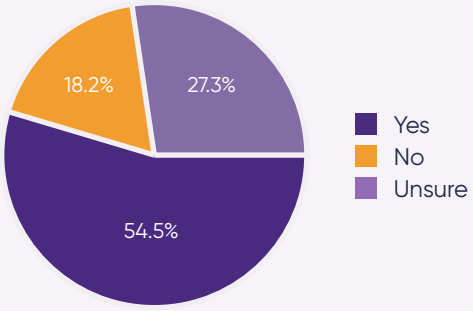
Of the 23 external service providers (ESP) who responded to the survey, 91.3% worked within Durham Region, with the remaining 8.7 working within the GTA. Respondents reported working at various social service agencies such as rape crisis centres, addictions and mental health agencies, multicultural counselling centres, and other social service agencies. The roles of respondents within their respective agencies spanned from addictions counselors, outreach workers, social workers, management staff, and nurses. The years of work experience ranged from 3 months to 10 years, with a median number of 5 years of experience.



The questions included on the survey gauged external service providers' knowledge base on the experiences of the Survivors of human trafficking that they work with at their respective agencies. Of the 23 who responded to the survey, 78.3% reported that they have worked with Survivors of human trafficking (8.7% stated they had not, and 13% reported they were unsure if any of their clients had experienced human trafficking). 60.9% of participants had experience referring their HT clients to healthcare services (see graph for services/departments referred to). When discussing their experiences working with the hospital, the majority of ESPs stated they had negative experiences attempting to refer their clients and found the process "disjointed" and "time-consuming". Due to long wait-times, unclear or lack of follow through, and stigmatizing practices from healthcare providers, ESPs shared frustrations regarding partnerships with hospital services. ESPs stated that the clients they worked with were also hesitant to visit the hospital due to previous negative experiences.

HAVE YOU SEEN ANY SPECIFIC PRACTICES WITHIN THE HOSPITAL SYSTEM THAT YOU HAVE REFERRED CLIENTS TO THAT COULD BE RE-TRAUMATIZING OR TRIGGERING TO A SURVIVOR OF HUMAN TRAFFICKING?

22 RESPONSES

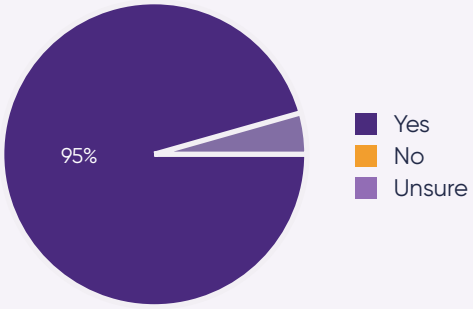


Percentage of External Service Providers

54.5% of ESPs stated that they had witnessed their clients experience re-traumatization during their hospital experience (18.2% said no, 27.3% said unsure). These triggering practices included physically restraining Survivors, Survivors being forced to re-share their story to multiple providers, judgment from staff regarding substance use, lack of privacy, victim blaming or not believing Survivors, Survivors receiving treatment in crowded rooms or the hallway, and a lack of trauma informed care.

ARE YOU AWARE OF ANY BARRIERS MARGINALIZED COMMUNITY MEMBERS FACE IN ACCESSING HEALTH CARE

20 RESPONSES

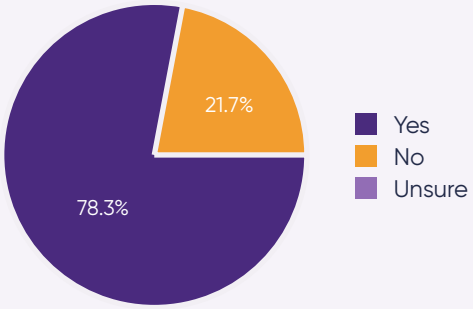


Percentage of External Service Providers

As mentioned earlier, patients who belong to marginalized groups (e.g., Indigenous, Black, racialized minorities, 2SLGBTQ+) face amplified barriers when trying to access medical services. Of ESPs surveyed, 95% were able to identify various barriers experienced by marginalized Survivors within hospital settings. ESPs highlighted the barriers experienced especially by racialized patients, noting that Survivors who had language barriers experienced discrimination and poor treatment by hospital staff. Additionally, respondents noted that due to historical systemic racism, racialized clients reported receiving poor treatment from healthcare providers. This included assuming racialized patients were "med-seekers", assumed to be over-exaggerating their medical symptoms, and a lack of cultural sensitivity or knowledge from healthcare providers (e.g., a lack of understanding on the impacts of colonization, no understanding of culturally sensitive supports). Additionally, participants noted that clients who identified as 2SLGBTQ+ received poor treatment within the hospital, with staff refusing to use their pronouns, as well as other discriminatory practices.

HAVE YOU RECEIVED ANY TRAINING IN IDENTIFYING AND RESPONDING TO SUSPECTED INCIDENCE OF SEX TRAFFICKING?

23 RESPONSES



Percentage of External Service Providers

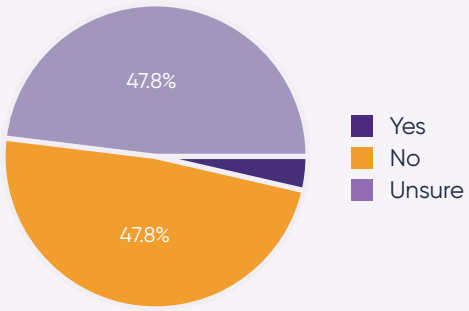
Of the 23 ESPs who participated in the survey, 78.3% had received training on how to identify and support Survivors of human trafficking. The frequency of the training varied between a one-time seminar, and continuous on-going training. ESPs provided recommendations on required training content, which included:

- HT indicators
- Trauma informed practices to mitigate re-traumatizing patients
- Supports and resources available within the community
- How to challenge personal biases and stigma
- The history of Colonization, Anti-Black racism
- Compassion training, and
- How to support patients unable to leave their situation (HT harm reduction)

The most prevalent theme from the responses showed that a trauma-informed approach to working with Survivors within the hospital is essential. When asked if they think healthcare providers are well equipped to identify victims of human trafficking 47.8% responded no, and 47.8% responded unsure. Only 4.3% responded yes. 73.9% of respondents reported receiving training on trauma-informed care (13% responded no, and 13% responded unsure). It is important to note that the vast majority of ESPs who participated in the survey work in the social services field such as social workers, counsellors, and other mental health roles. Therefore, these types of training are often included in onboarding practices for social service agencies.

DO YOU THINK HEALTH CARE PROVIDERS ARE WELL EQUIPPED TO IDENTIFY VICTIMS OF HUMAN TRAFFICKING?

23 RESPONSES



Percentage of External Service Providers

ESPs who responded to the survey provided an extensive list of recommendations to ensure that health care services are more trauma informed. Suggestions included:

- Client-centred care (allowing patient autonomy)
- Acute mental health support
- Rapport building, emphasis on need to establish trust
- Ensuring that the most well-equipped staff member is working with the Survivor
- Establishing open lines of communication with other departments within the hospital to create a circle of care
- Building effective community partnerships
- Attending on-going trainings to ensure retention

Overall, the responses from ESPs show that ESPs believe there are extensive gaps in knowledge and service provision from healthcare providers. ESPs shared they are often then left to fill these gaps to ensure the safety of their clients.

INTERNAL SERVICE PROVIDER SURVEYS

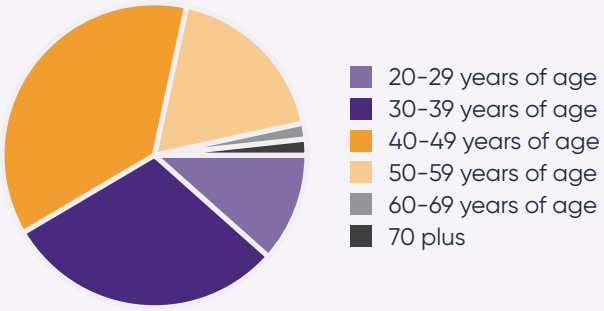
As mentioned earlier, knowledge on human trafficking and trauma-informed care by healthcare providers increases identification and accessibility of services for Survivors of human trafficking. In order to gauge the knowledge level of healthcare providers (HCP) who work internally within the hospital, a survey was distributed to all staff across Lakeridge Health Corporation, which included 5 hospital sites. The purpose of the survey was to determine the HCPs knowledge base on human trafficking, their capacity to support and identify Survivors, and their knowledge of any relevant policies, practices or procedures that are in place regarding human trafficking or trauma-informed care.

Hospital departments that were represented among the participants included: addictions and mental health, psychiatry, emergency, crisis, Intensive Care Unit (ICU), Post Anesthesia Care Unit (PACU), medicine unit, surgical inpatient, security, oncology, radiology, respiratory therapy, clinical nutrition, infection prevention and control, and case management and community mental health workers.

Participants who responded to the survey included: registered nurses (RN), registered practical nurses (RPN), physicians, addictions counsellors, case managers, discharge planners, clinical coordinator, child and youth worker, crisis intervention, core guard, personal support worker (PSW), management, respiratory therapist, registered dietitian, psychiatrist, infection and prevention control, physiotherapist, support staff, secretary, and social workers. 54 participants identified as female, 6 as male, and 2 chose not to identify gender. The graph below depicts age demographics.

AGE GROUP

60 RESPONSES



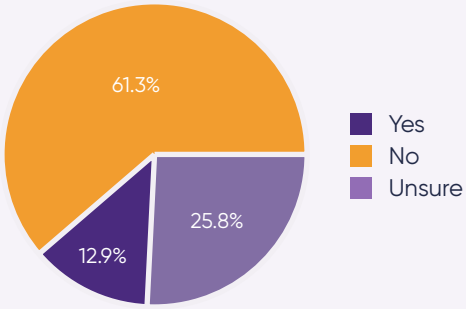
Percent of Internal Hospital Staff per age group

The first question intended to gauge respondents' understanding of a "trafficked person". All respondents were able to identify key elements of trafficking, stating key factors of exploitation, blackmail, grooming, and coercion that lead to exploitation for sexual and manual labour. However, multiple participant responses exactly replicated/copied definitions retrieved online using a search engine, such as Google. When asked why Survivors of trafficking access medical services, respondents identified the following: sexual health and reproductive care, mental health and addictions support, treatment for physical injuries, and other acute health concerns. Some responses to this question reflected stereotypes. For example, multiple participants referenced "med-seekers" or "drug seekers" when referring to Survivors. These terms describe substance abusers who fake ailments to obtain prescription narcotics (James, 2016). Such terms can lead to stereotypes without fully appreciating factors that led to substance abuse and can lead to a lack of compassion or understanding essential for the provision of trauma informed care.

When asked if they had encountered a victim of human trafficking in their professional duties, 54.5% of HCPs said yes (29% said no, and 16.1% said unsure). HCPs drew these conclusions from a variety of sources. HCPs encountered Survivors in various ways including direct report by the patient, report by other staff, or drawing conclusions based on information given by the patient/observations. Of HCPs interviewed, 61.3% said they were unsure if specific procedures were in place to support Survivors. For the participants who responded yes, their frame of reference for next steps included contacting external agencies such as Victim Services (VSDR) or contacting the unit social worker. As mentioned, the majority of HCPs responded that they were unsure of procedures in place, stating that if there are, they are not well enforced or known about due to lack of staff and training.

ARE THERE PROCESSESS IN PLACE WITHIN THE HOSPITAL TO IDENTIFY AND CARE FOR SURVIVORS OR VICTIMS OF SEX TRAFFICKING?

62 RESPONSES

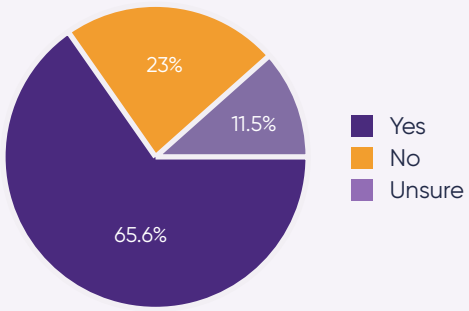


Percentage of Internal Hospital Staff response per answer

"I WOULD HAVE TO LOOK UP THE POLICY ON THE WAVE TO KNOW THE ACTUAL POLICY AND PROCEDURES. IN MY CASE, I APPROACHED THE SW ON UNIT AS I WAS UNSURE WHAT TO DO NEXT ON MY ACUTE MEDICAL FLOOR. WE ARE NOT SPECIFICALLY TRAINED IN THIS AREA."

HAVE YOU SEEN ANY SPECIFIC PRACTICES WITHIN THE HOSPITAL SETTING THAT COULD BE RE-TRAUMATIZING OR TRIGGERING TO A SURVIVOR OF HUMAN TRAFFICKING?

61 RESPONSES



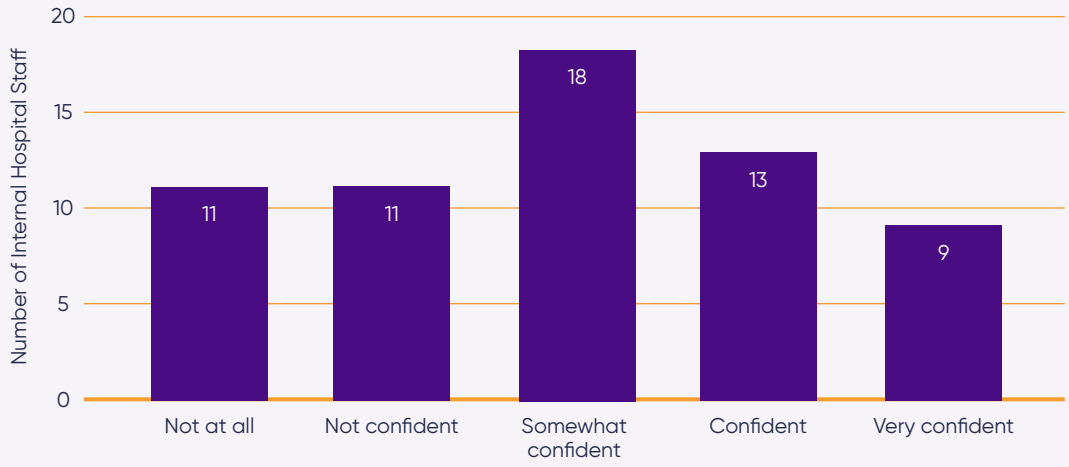
Percentage of Internal Hospital Staff responses per answer

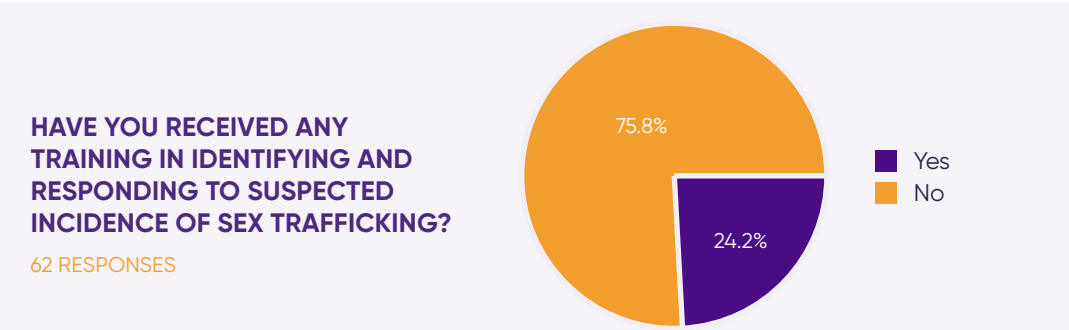
Surveys asked if HCPs had seen any practices within the hospital that could be triggering or re-traumatizing to Survivors. 65.6% said yes (23% said no and 11.5% said unsure). Responses from HCPs of re-traumatizing practices included statements such as:

"THERE IS STIGMA ATTACHED TO THEM THAT IS APPARENT IN INTERACTIONS WITHIN THE HOSPITAL SETTING. ALTHOUGH I FELT THIS IS GETTING BETTER BEFORE COVID. NURSES AND DOCTORS DON'T HAVE TIME TO GIVE THE LEVEL OF CARE THAT IS NEEDED AND AGAIN IF THEY ARE DIRTY, ADDICTED TO DRUGS OR HAVE SIGNIFICANT MENTAL HEALTH. THE STIGMA IS AT THE HIGHEST LEVEL. I HAVE HEARD HORROR STORIES OF TREATMENT. MEANING THAT VICTIMS HAVE A HESITATION WHEN THEY DO NEED HELP."

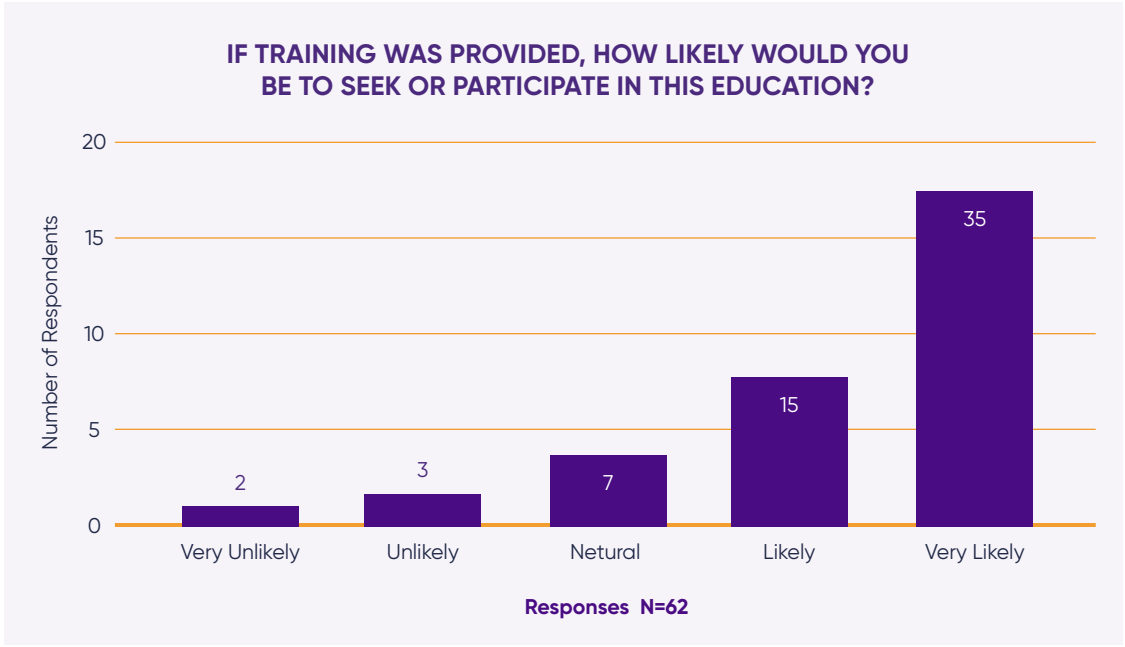
"STAFF, AT TIMES IN THE ED, CAN BE VERY BUSY AND RUSH PEOPLE FROM PLACES WHICH COULD BE A TRIGGER FOR POTENTIAL PAST-TRAUMA. AS WELL, STAFF ARE NOT WELL-TRAINED IN ADDRESSING TOPICS OF SEXUAL ASSAULT AND DOMESTIC VIOLENCE (WHICH WOULD ENCOMPASS TRAFFICKING) AND CAN HAVE DIFFICULTY IN PERFORMING THESE ASSESSMENTS IN A TRAUMA-INFORMED WAY."

"ANY FORM OF AGGRESSION, LOUD NOISES, TAKING AWAY THEIR SELF-DETERMINATION, NOT BELIEVING THE PATIENT WHO DISCLOSES CONCERNS, ASKING THEM TOO DIRECT OF QUESTIONS RE: IF THEY ARE BEING TRAFFICKED AS THEY MAY NOT IDENTIFY AS BEING TRAFFICKED"





When asked about experiences of in-hospital training, 75.8% of HCPs said they had not received any sort of training on how to identify a victim of human trafficking (24.2% said yes). The majority of those who did receive training said it was a one-time training with no refresher courses.



HCPs identified the following topics of interest: an overview of trafficking in Ontario, how to spot signs of trafficking, how to support Survivors, legal obligations/duty to report laws, available community support, the impact of trauma, examples of what to ask patients, and compassion and ethics training.

Regarding training on trauma-informed care, 61.3% of HCPs stated they had not received training on this topic (33.9% said yes, 4.8% said unsure). Similar to responses regarding training on human trafficking education, those who have received it stated that the programs were infrequent. When asked if they see trauma-informed practices adopted into hospital policies and procedures, the majority of respondents

> **"NOT REALLY. WITH THE UNDERSTAFFING AND OVERWORKED NATURE OF MOST HEALTHCARE SETTINGS MEANS THE CARE PROVIDED TO PATIENTS IS OFTEN RUSHED AND/OR CORNERS ARE CUT, AS STAFF ARE UNABLE TO PROVIDE THE MOST APPROPRIATE SPECIALIZED/TAILORED CARE NEEDED FOR TRAUMA-INFORMED CARE."**

stated that they had not seen this.
It is critical for service providers to have an understanding of the barriers faced by individuals who experience marginalization and to understand which systemic practices perpetuate harm. Human Trafficking disproportionately affects those from racialized or marginalized communities, so interventions must occur from trauma-informed, anti-racist and anti-oppressive lens. As such, the survey questions also explored HCPs knowledge of Diversity, Equity and Inclusion (DEI) practices and culturally sensitive services within the hospital. 70.2% of HCPs stated that they could identify barriers experienced by Black, Indigenous, and racialized communities within the healthcare system (8.8% said no and 21.1% said unsure). The participants listed barriers such as generational trauma, systemic racism, mental health barriers, direct racism and biases held by staff members, unequal access to treatment, and many more. For example:

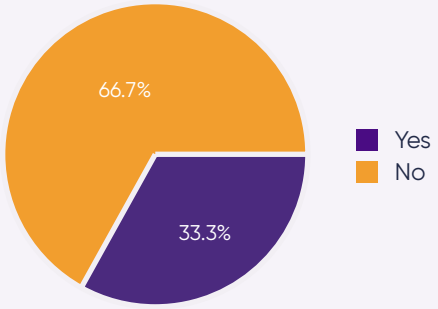
"I FEEL THAT THE WHITE PRIVILEGE THAT IS OFTEN NOT IDENTIFIED BY INDIVIDUALS IS A BIG PART OF SYSTEMS, THAT HAVE FAILED MARGINALIZED PEOPLE. OFTEN, THEY ARE NOT TAUGHT HOW TO NAVIGATE THESE SYSTEMS, THAT HAVE NOT BEEN A PART OF DESIGNING. THEY HAVE EXPERIENCED TREATMENT THAT IS UNIMAGINABLE FOR ANY HUMAN. THIS TREATMENT HAD LED TO MISTRUST AS PEOPLES."

"HESITANCY TO ACCESS CARE OUT OF FEAR GIVEN YEARS OF ABUSE/TESTING ON SOME OF THESE POPULATIONS IN THE PAST. LACK OF LANGUAGE INTERPRETATION SERVICES TO ENSURE ADEQUATE UNDERSTANDING. LACK OF UNDERSTANDING OF CULTURAL NORMS/TREATMENTS USED WITHIN THEIR OWN COMMUNITY AS AN INITIAL TREATMENT"

"OSHAWA IS HOME TO MAJORITY CAUCASIAN PEOPLE, THE STAFF THAT WORK THERE ARE MOSTLY WHITE. THEY HAVE BEEN ACCUSTOMED TO PRIVILEGES THAT THEY CANNOT EVEN RECOGNIZE ARE NOT ALSO AFFORDED TO OTHER BIPOC PEOPLE BOTH IN THE COMMUNITY AND IN THE HEALTH CARE SYSTEM. STAFF REPORT LANGUAGE BARRIERS FOR PEOPLE WHO REALLY HAVE AN ACCENT, AND CAN COMMUNICATE QUITE EFFORTLESSLY, DESPITE AN ACCENT. ACCENTS ARE AN EASY WAY FOR MANY STAFF TO STOP COMMUNICATION, LABEL PATIENTS OR FAMILIES AS HAVING LANGUAGE BARRIERS AND SIMPLY REPORT DIFFICULTY COMMUNICATING. THE INTERPRETER PHONE, THOUGH AVAILABLE, IS RARELY USED FOR THESE PATIENTS. STAFF LACK TIME AND PATIENCE TO ACCESS THIS SERVICE."

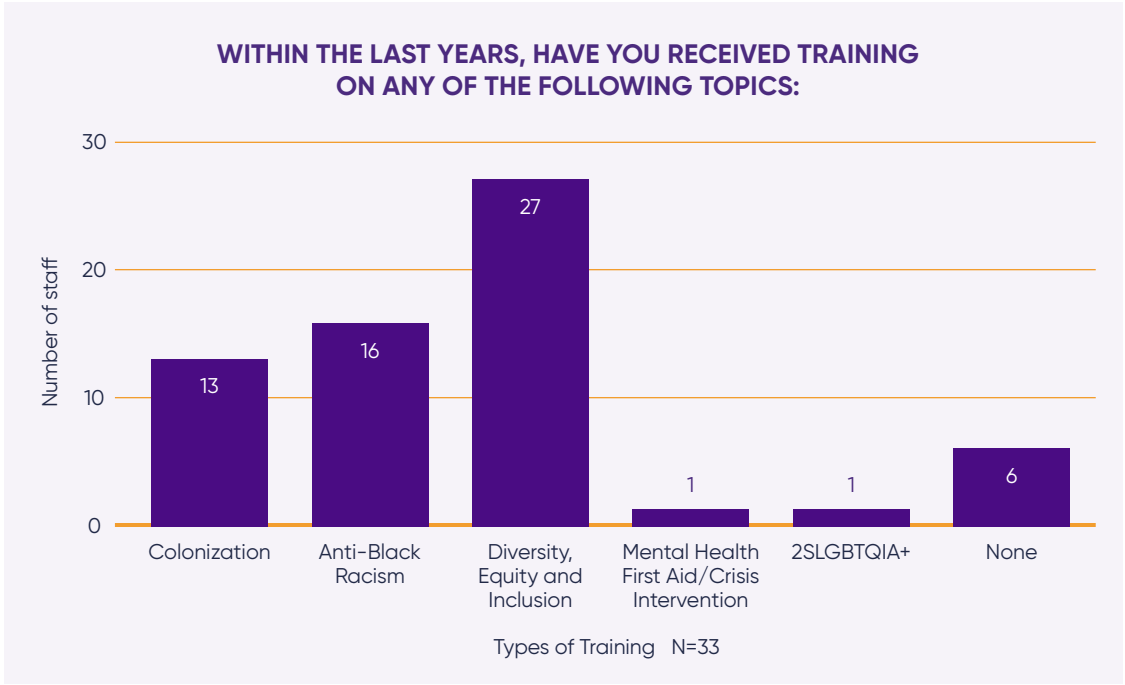
ARE YOU AWARE OF WHERE TO ACCESS A LIST OF CULTURAL SPECIFIC SERVICES FOR INDIGENOUS, BLACK AND RACIALIZED PATIENTS?

57 RESPONSES



Percentage of Internal Hospital staff per response

When asked what practices Lakeridge Health has in place to reduce barriers in accessing healthcare for marginalized populations, the majority of participants were not able to provide any examples. Additionally, only 33.3% of HCPs were aware of any cultural specific services for Indigenous, Black, and racialized patients (66.7% of participants did not know any services).



While participant HCPs from Lakeridge Health showed a willingness to learn about human trafficking and adjust their practices in order to become more trauma-informed, most had not received training despite the availability of it. Staff shortages and caseload constraints not only affect the quality of care but also limits the ability of staff to attend training unless the training is mandatory and prioritized. Adjusting practices to better support Survivors often requires changes to protocols and pathways. As such, to enhance the practice of HCPs to better support Survivors, it is important to have clear pathways and protocols that support those practices. Corresponding policies and procedures assist in ensuring consistency and effective implementation as well as accountability to ensure appropriate care.

TRAINING EVALUATION

Upon completion of the research portion of this project, the next step was to utilize this information to create a trauma-informed training program for healthcare staff with the goal of facilitating the presentation to at least 200 Lakeridge Health staff members. In collaboration with the Survivor Advisory Panel and senior management from VSDR, a 2-hour training was created. VSDR's clinical team consisted of two staff with healthcare experience who could support the training development. While VSDR expressed concern about the inclusion of critical content in a short 2-hour training, this adjustment was required due to staffing challenges across the healthcare sector.

The early development stages of the training program began with a consultation with the Survivor Advisory Panel (SAP) to determine key topics the training should cover from the perspective of survivors.

The training consisted of information on human trafficking in Canada, trauma-informed health care, and trauma-informed approach when working specifically with Survivors in healthcare settings. Using the shared experiences of Survivors and healthcare staff, a number of healthcare-specific indicators were identified that would likely indicate trafficking in settings such as the ER or inpatient mental health unit. Training programs designed for healthcare workers needed to tailor information to the healthcare

sector and accurately reflect the indicators likely to be present in various healthcare settings, which could vary from indicators in a youth's home or school for example. The combination of different topics would ensure that healthcare providers received an in-depth understanding of human trafficking and while also providing practical skills on how to integrate a trauma-informed approach into service provision unique to the healthcare sector. The learning objectives of the training were to provide comprehensive skills and knowledge to healthcare providers so that they are able to identify patients who are being trafficked. The training also needed to include information on introducing multi-disciplinary team members such as social workers or DVSACC nurses.

Collaboration with Lakeridge Health and respective departments within the hospital when determining training dates and times showed that due to staffing shortages, various hospital departments were only able to allot 45 minutes to 1 hour for staff to participate in training. This resulted in VSDR's training staff having to reduce the training to fit within the 45 minute time-frame, missing crucial elements of practical intervention. As stated throughout the research, effective human trafficking training includes proponents of trauma informed care as well as the need for ADEI training and consideration. However, the time constraints associated with this project did not allow for the inclusion of all required topics. This posed a significant challenge to ensuring the initial training followed recommendations from the literature review and research outcomes.

The training schedule was developed in collaboration with Lakeridge Health and VSDR's senior management. A VSDR HT Prevention Facilitator, a clinically trained Survivor of human trafficking and a VSDR Clinical Team member with healthcare expertise delivered the training. Training sessions had an average of 50 staff members in attendance per session.

From the project's initial start date in 2021, VSDR met the project target for trained staff members, eventually exceeding the target (total 300 participants) by 2024. Learning indicators and post-survey results from the in-person training saw a 40% knowledge increase in healthcare workers who participated. Healthcare workers stated that they felt more confident in their knowledge regarding human trafficking, and felt that they had a better understanding on how to recognize red flags in patients. While the success in numbers was a substantial accomplishment, there were concerns from VSDR staff regarding the efficacy of the training and sustainability beyond the funding provided through the project. With the training cut to half the intended length, the training course removed a significant amount of critical content. In addition, the time constraint did not allow training on application of practical skills to be included in the training. The feedback received from healthcare workers who did participate in the training echoed these concerns.

The overarching feedback from training participants shared that there was a need for longer trainings. Healthcare workers felt that the content delivered within the 45 minute time-slot did not allow for topics discussed to be effectively elaborated on. While learning indicators for knowledge regarding human trafficking and trauma-informed care increased 40%, healthcare workers expressed there was a gap with respect to applying the education and knowledge into practical engagement techniques and intervention. While knowing and understanding the red flags for human trafficking in a hospital patient was vital information, healthcare workers still felt unsure on how to work with a patient who is being trafficked or what to say to them.

E-COURSE DEVELOPMENT

Utilizing training participant feedback and having consideration for the limitations of shorter training sessions, it was determined that a self-paced online learning tool would work best for the specific needs of healthcare workers. With this feedback in mind, the project pivoted to consider the creation of converting the in-person training into a self-guided e-course. The e-course would provide healthcare workers the opportunity to review the content at their own pace, alleviate the burden on hospital departments to determine when healthcare workers could participate in the in-person training, and address the feedback that the in-person training did not provide the space for topics to be covered in-depth. The success of a previous e-course developed by VSDR for parents provided additional rationale for this change. As that e-course had seen monumental success and participation with a substantial knowledge increase from 37-97%, it was determined that an e-course for healthcare workers would produce the most sustainable and successful training program. The E-course would also support the need for consistent refresher training without additionally straining agencies that typically deliver training and would align with the current training method already utilized by Lakeridge Health.

In 2023 VSDR made the decision to create a Healthcare focused E-course using a digital platform that aligned with the Learning and Development Infrastructure already in place at Lakeridge Health Corporation. Taking into account the feedback from healthcare workers and the Survivor Advisory Panel, the E-course is inclusive of two primary education modules: Trauma-informed Care and Human Trafficking Education. The program includes a Case Study that shows practical implementation of a trauma-informed approach to supporting a human trafficking survivor. The training includes intersectionality but also highlights the need for all healthcare providers to have supplemental education on ADEI (accessibility, diversity, equity and inclusion), which is also being developed by Lakeridge Health.

A key component of knowledge translation was to convert the in-person training portion dedicated to skills development when working with human trafficking victims into an online format. The initial in-person content focused on the importance of building rapport with patients who were victims and focused on helping healthcare workers develop these skills. The Case Study/scenario enactments were designed based on feedback from initial survivor interviews which stated that the lack of rapport building from healthcare workers, whether that be inappropriate questions asked or in some cases the right question, asked the wrong way, had a negative effect on patients and ultimately impacted their [the patient's] decision to disclose.

> **"IT'S IMPORTANT THAT THEY [HEALTHCARE WORKERS] UNDERSTAND THAT EVERYTHING CAN BE GOING REALLY WELL, AND THEN ASKING AN INAPPROPRIATE QUESTION, OR PHRASING A QUESTION IN A CERTAIN WAY CAN COMPLETELY RUIN THE RAPPORT THEY'VE BUILT".**

After finalizing content, the course developer began production, meeting with VSDR Clinical staff and Survivors to align content with online formatting and AI tools. Since the educational content in the trauma-informed care and human trafficking modules were previously developed, additional content heavily centred on script development and interactive components of the program that would test knowledge. An important piece of feedback received from the sample group discussed that healthcare

workers who do successfully participate should have the opportunity to see the outcomes of negative choices and the impact it can have for Survivors when supported by staff who are untrained. With this in mind, and based on training participant feedback, it was determined that a primary goal of the e-course was to ensure it would include a portion that showed practical application of trauma-informed questioning and intervention that would reflect a case scenario typical of the Emergency Department. The goal of the module was to place healthcare workers in an immersive setting to not only identify where traditional practices have caused re-traumatization or failed to identify human trafficking, but would also provide a realistic case example of how trauma-informed care is utilized.

> **"FROM AN EDUCATIONAL STANDPOINT, EVEN IF SOMEONE SELECTS ALL OF THE RIGHT ANSWERS, THEY SHOULD STILL BE SHOWN WHAT HAPPENS WHEN SOMEONE DOESN'T. I THINK IT WILL MAKE THEM MORE AWARE OF WHAT CAN HAPPEN BETWEEN A PATIENT AND PROVIDER, AND MAYBE MAKE THEM PAY MORE ATTENTION TO HOW THEIR COLLEAGUES MIGHT TALK TO PATIENTS".**

The scenarios in the course show common examples of healthcare approaches that lack a trauma-informed approach and the impact of such approaches. The module then shows alternate scenarios that demonstrate implementation of a trauma-informed approach.

VSDR ensured consultations from various healthcare workers to provide their insights to ensure the content was relevant to the experiences of hospital employees. The consultants hired were selected based on the importance of including an Accessibility, Diversity, Equity, and Inclusion lens within the e-course so the voices of both BIPOC and gender-diverse healthcare workers were included, as well as those with exceptionalities. With the combined feedback, the e-course was developed and completed in accordance with these recommendations. The creation of the E-course allowed for engagement of key stakeholders in this project throughout the development process, providing key insights and feedback on improvements needed, prior to implementation. The diverse Survivor Advisory Panel was consistently engaged throughout this process to ensure that the course would be survivor-lead and trauma-informed.

PROMISING PRACTICES - RECOMMENDATIONS

POLICY AND PROCEDURES

DEVELOP AND IMPLEMENT A STAND-ALONE ANTI-HUMAN TRAFFICKING POLICY AND PROTOCOL THAT INCLUDES MANDATORY TRAINING AND WITH INTEGRATION THROUGHOUT ALL HOSPITAL DEPARTMENTS.

There is ample research that shows that education programs for healthcare professionals are not enough to confront human trafficking within healthcare systems. The completed research in the literature review, and conducted qualitative study have both equally shown the need for HT specific policies, education and protocols within hospitals. A holistic response must be consistent across all hospital departments, spearheaded by supported policy and procedures. Limitations with the current models to address HT in hospitals relies on the responsibility of individual departments (ex. ER, mental health) to integrate education programs and HT screening protocols. While educational interventions within hospital departments are essential, this model does not take into account the limitations these departments face, as well as the need for structural and often financial support that allows these programs to succeed. It also negates the need for consistency in support throughout a hospital stay regardless of which unit Survivors are on, as evident throughout the Survivor interview responses. HT policy should also reflect the need for a multi-disciplinary approach to working with HT victims, and the need for reinforced involvement from hospital leadership teams to support all staff working with HT victims.

DEVELOP AND IMPLEMENT POLICIES PERTAINING TO: ACCESSIBILITY, DIVERSITY, EQUITY AND INCLUSION; TRAUMA INFORMED CARE; ANTI-RACISM/ANTI-OPPRESSION; CULTURAL SAFETY; GENDER INCLUSION; AFFIRMING LANGUAGE, AND VIOLENCE PREVENTION.

Policies and protocols provide guidance, consistency, accountability, efficiency, and clarity on how an organization operates. When policies and procedures are well established and consistently followed, an organization can refute allegations of unfairness or legal violations and improve overall organizational function and service provision (CMHC, 2018).

In terms of supporting survivors of human trafficking, clearly defined policies and processes can help by offering standards and guidelines to staff that ensure they are equipped to deliver consistent care based on evidence-based practices. The absence of these tools can lead to wide variance in care provided and may even include practices that are harmful or triggering to survivors. This is particularly important when considering survivors from marginalized communities affected by the intersections of system discrimination and colonial influences in healthcare. Furthermore, when informal resources and guidelines are not enforced within an organization there is often a lack of accountability in ensuring best practices or evidence-based practices are followed. In light of this and having considered the findings from the Survivor and service provider surveys, the creation of these additional policies at Lakeridge Health would likely improve the ability of staff to respond to the needs of trafficking survivors.

ACCESSIBILITY, EQUITY, DIVERSITY, AND INCLUSION POLICIES

There is ample evidence to show that increased efforts towards Accessibility, diversity, equity, and inclu-

sion (ADEI) improve experiences in healthcare settings for both patients and healthcare providers (Chun et al., 2021; Pino-Jones et al., 2021; Rudman et al., 2022). The key component to improving institutions' ADEI practices is through infrastructure changes that will improve the culture of said institution (Chun et al., 2021). These changes include establishing a committee to address the needed ADEI improvements, improving hiring practices to better reflect the population served, creating a culture that prioritizes the retention of staff members, and creating sustainable change through supportive leadership (Chun et al., 2021; Pino-Jons et al., 2021).

Research shows that survivors of human trafficking who identify as Black, Indigenous, or other racialized, gender diverse, and other minority groups experience more challenges/barriers to accessing healthcare, including culturally appropriate healthcare. There are also more challenges for survivors with other social identities, e.g. lower income, disability, immigrant/English as a second language. Therefore, having ADEI policies can help to ensure the most marginalized Survivors of human trafficking receive appropriate support. Within a Canadian context, there have been some efforts to implement ADEI frameworks within healthcare systems. However, it must accompany Human Trafficking training, policies and procedures to ensure healthcare providers responding to the needs of human trafficking Survivors understand the complexities and intersections of these issues.

SAFER SPACES POLICY

Hospitals often have a 'Code of Conduct' policy, which often outlines what it means to foster respect in the organization. This may include what it means to treat all patients, staff and others with respect. Relevant points include ensuring patients are cared for with respect, dignity and equitable treatment and have a right to an environment free from discrimination. However, ensuring safety for Survivors of trauma warrants additional training and considerations that may extend beyond typical "respectful" behavior. Hospitals may wish to consider the addition of a "safer spaces" policy that highlights the unique needs of those who have experienced trauma.

It would be helpful for a policy to include definitions that can help staff better understand the social identities of Survivors as well as their experiences of oppression. For Example, this may include definitions for levels of racism (systemic, institutional, interpersonal and internalized), homophobia and transphobia. It would also include definitions for gender identity, gender-neutral/affirming language and the affect of mis-gendering. Some policies include the definition of BIPOC (Black, Indigenous, People of Colour). There is debate within the equity community as to use of the acronym BIPOC as the argument against it is that it generalizes communities without recognizing their unique lands, cultures, ethnicities, etc. On the contrary, including the definition of BIPOC in an equity policy targeted to Survivors may help with understanding and addressing shared experiences of oppression.

It is important to define, quickly identify and address inappropriate behaviour. Given unique forms of discrimination faced by Survivors of sex trafficking, a comprehensive definition of sexual harassment would be important. Current definitions of sexual harassment in policies focus on conduct because of sex, sexual orientation, identity or gender expression. This could be expanded to include appropriate conduct of staff towards individuals working in the sex industry as this has often been a reason Survivors have experienced poor health care. Another important definition is microaggressions, which refers to common daily instances of hostile, negative and/or derogatory insults towards a member of a marginalized group, in this case, Survivors with marginalized identities. Microaggressions can lead to significant harm, especially for Survivors who have already experienced significant trauma.

ANTI-OPPRESSIVE, ANTI-RACIST PRACTICE AND CULTURAL SAFETY

In recent years there has been an increased pressure and need for hospitals to incorporate anti-oppressive practices that highlight safety for marginalized groups. As discussed above, Black and Indigenous groups face outrageous health disparities due to colonization and racist healthcare practices. In order for ADEI policies to operate holistically, they must incorporate anti-oppressive and cultural safety practices.

Anti-oppressive practices in healthcare create a framework that recognizes and understands structures of power and institutionalized racism, and incorporates this knowledge into nursing practices (Hutchison, 2015). These practices include, but are not limited to, increasing awareness of behaviours, beliefs, and attitudes that are common in healthcare, which may negatively affect patients disenfranchised by the healthcare system (Hutchinson, 2015).

Anti-oppressive models promote uplifting patient's agency in their healthcare; one method of which is the incorporation of cultural safety. Cultural Safety (CS) practices aim to bridge the gap between the healthcare system and historically disenfranchised populations by integrating the traditional cultural practices of these groups into their service provision (Curtis et al., 2019; Yeung, 2016). An example of such practice could include the hiring of an Indigenous patient navigator, or hiring practitioners that are skilled in two-eyed seeing approach, which incorporates Western Medicine and Indigenous worldviews/healing practices.

TRAUMA INFORMED CARE

Extensive research shows that a cultural shift to integrate trauma informed care within hospital settings can drastically improve patient and provider experiences (Huo et al., 2023; Stillerman et al., 2023; Trauma-Informed Care Implementation Resource Centre, 2021). Trauma-informed care (TIC) is an approach to healthcare that acknowledges patients past and present life experiences, whether or not they have disclosed. The goal of TIC is to incorporate policies that integrate TIC into healthcare practices, recognize the trauma experienced by patients, understand the impact of trauma, and to incorporate practices that reduce the opportunity for re-traumatization (Trauma-Informed Care Implementation Resource Centre, 2021).

In recent years, there has been a strong push to integrate TIC policies and practices into hospital protocols to improve both patient and provider experiences. Patients who have experienced trauma, stress, or PTSD are often at a higher risk for health complications; healthcare practices that do not acknowledge this can often exacerbate these risks (Hamberger et al., 2019; McKinnish et al., 2019). TIC approaches can improve patient and provider experiences by providing a framework and support system for healthcare providers to navigate challenging patient interactions, while also decreasing the need for repeat visits from patients (Hamberger et al., 2019; Huo et al., 2023; Stillerman et al., 2023).

While TIC practices have yielded positive results, it is important to understand the various barriers that healthcare systems face when integrating these practices. An effective TIC implementation may require a system overhaul of a healthcare institution (Huo et al., 2019; Oral et a., 2020). Systematic reviews of implementation strategies carried out in the United States found that healthcare institutions faced barriers in regard to funding allocation, limited staffing, and program inflexibility (program delivery and engagement) (Huo et al., 2019). Solutions suggested for healthcare systems include taking a collaborative approach to TIC implementation through establishing partnerships with educational development organizations to help facilitate program integration (Huo et al., 2019; Stillerman et al., 2023).

COMPILE AND MAINTAIN A RESOURCE LIST OF EXTERNAL SUPPORTS AND RESOURCES FOR SURVIVORS.

In order to ensure that service provision does not end once the patient leaves the hospital, healthcare providers should be aware of the various community supports available for victims of human trafficking and have resources to relay this information to patients. Where possible, healthcare providers should engage in opportunities to build relationships with community service providers. This will enable a warm transfer for Survivors to avoid them having to repeat their story.

The listed recommendations are just some of the improvements Lakeridge Health, and other hospitals can make to enhance their intake practices for victims of human trafficking who access these services. The implementation of these policies and procedures provide a starting point to foster positive patient-provider relationships, and many of these recommendations can provide transferable skills that HCPs can bring to their practices.

PROTOCOLS AND SERVICE PATHWAYS

The provision of clear internal processes can:

- Reduce opportunity for triggering or re-traumatization
- Increase staff ability to identify trafficking
- Ensure intervention is provided by those most qualified
- Improve health outcomes for Survivors by offering specialized supports based on their unique needs rather than the presenting issue (ie. STI screening)
- Reduce repeat hospital visits by ensuring linkage with appropriate community-based supports

Consistency in the provision of support is critical for Survivors, particularly given establishment of trust and rapport are key components of trauma-informed care. Where possible, it is ideal to have specialized staff skilled in HT assessment and intervention dedicated to working with Survivors who can support them consistently throughout their time at hospital regardless of unit transfers.

A process map is designed to work as a Flow-Chart for healthcare providers to use as a quick reference when they suspect a patient may be trafficked. Such a tool can be included in an integrated service plan established within Lakeridge Health. The Service Pathway Map and Screening Tool (Appendix 1) was created through the collaborative efforts of Survivors, the SAP, Lakeridge Health and VSDR leadership staff with healthcare experience. The goal of this toolkit is to create a streamlined action plan that is accessible for healthcare workers, and provides a clear route of appropriate service provision (always with the consent and choices of the Survivor being paramount.

The Screening tool and process map are supplemental to training on human trafficking, trauma-informed care and associated ADEI training as referenced throughout the report. The process map can be adjusted to reflect the services available within each hospital. However, where possible or available it is preferred that hospitals have specialized staff skilled in Human Trafficking assessment and intervention who can consistently support Survivors throughout their time at hospital regardless of location.

TRAINING

As previously mentioned, Training programs should be developed in conjunction with Policies, Procedures, Screening Tools and Protocols to ensure standardization across all departments and levels of the organization. Yet, must reflect the need for flexibility and tailored anti-oppressive and culturally responsive interventions as an essential component. Programs should reflect relevant legislation, a multi-disciplinary approach and demographics of the areas and patients served. Intersectionality and the unique needs of diverse Survivors must be a core component with consideration to the unique barriers and needs of all Survivors. Training development and delivery should include the involvement of healthcare professionals, human trafficking field professionals, and diverse Survivors, and must include those with specialized knowledge in gendered analysis, equity, trauma-informed care and Survivor-centric practices. Training should include all staff working in hospitals who may encounter or interact with Survivors, particularly security, who are often required to perform tasks such as applying restraints, known to cause re-traumatization for Survivors.

The efficacy of training programs relies on the consistent and repeat participation from healthcare staff and all staff coming into contact with Survivors (including hospital security). To ensure healthcare staff are equipped to identify and adequately respond to cases of human trafficking, training programs must be mandatory, championed by seniors leaders across the healthcare sector, and accompanied by supported policies and protocols. Key Performance Indicators (KPIs) should measure training completion/compliance, knowledge increase and retention, and case identification numbers, at a minimum. Training programs should undergo regular updates to reflect human trafficking trends, and address concerning trends noted in KPIs.

CONCLUSION

Human Trafficking continues to be a significant public health issue with devastating affects on victims, including acute and long-term physical and mental health impacts. To effectively prevent re-traumatization and ensure appropriate intervention for Survivors, targeted efforts by the institutions that are most likely to encounter victims is essential. To enact effective policies and practices that will address the existing gaps in healthcare for supporting Survivors of human trafficking, the healthcare sector first needs to recognize the magnitude of challenges that exist in institutions that have not shifted to a trauma-informed approach. As recounted throughout the 'Rise Up" project, trauma-informed care cannot exist without the inclusion of ADEI policies and training to ensure intersectionality is well understood and reflected in all healthcare interventions.

Human Trafficking Survivors have unique and complex needs that require specialized attention, training by service providers and coordination of wrap-around supports only possible through strong community partnerships and a commitment to addressing disparities in care. While hospitals often consider social determinants of health in their discharge and health prevention programs, hospital responses have not recognized the need to identify and respond to human trafficking as a critical deterrent to poor health outcomes and admission recidivism. While patient discharge plans usually include safety measures that address factors such as falls risk or other things likely to result in poor health outcomes, failure to identify the risk to Survivors of human trafficking and ensure adequate supports reflects inequitable outcomes for Survivors. With a strong commitment from senior leaders across healthcare institutions, effective policy and training programs could, if implemented consistently, have a significant impact on the way Survivors experience the healthcare sector in Canada.

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EMERGENCY DEPARTMENT FLOW CHART FOR HUMAN TRAFFICKING CASES

RED FLAGS IDENTIFIED
No ID, unsheltered, drug use, sexual assault, history unexplained physical injury/abuse, source of income unclear, anxious etc

SERVICE PROVIDER REFERRAL
HT previously identified/confirmed, escorted by police/Victim Services, Mobile Crisis, etc or a HT Survivor known to ER

ASSESS IMMINENT SAFETY/BASIC NEEDS/ACCESSIBILITY
(consider need for HT informed Security)

HT SCREENING CONDUCTED
(if safe and stable)

- acutely stable/able to be interviewed?
- Accompanied? Can you safely get them alone without endangering or causing suspicion?
- Ensure confidential location for interview
- Basic needs – offer food/drink
- Cultural Considerations

HT screening should be completed by 1 Trauma Informed HT trained staff to reduce repeated questioning, re-traumatization

(see HT Resources List if requiring support)

INTERNAL REFERRALS TO CONSIDER:
- ER Social Worker
- Sexual Assault Care Team
- Addictions Support
- Crisis team (if acute MH crisis)
- CIT/CYW (child/youth)

Avoid multiple interviews that require re-telling of trauma or unwanted referrals that will overwhelm. Basic Needs, safety and client wishes to take priority.

- SW: basic needs, crisis supports, external referrals, safety plan
- Sexual health, STI/pregnancy screen, safety
- Addictions support (if identified)
- Crisis: if acute mental health concerns

HT Confirmed

Reporting:
- CAS (under 18)*

Immediate Referrals:
- Victims Services*
- Income Support*

See Appendix for list of more extensive community partners

As soon as possible:
Referrals (with consent*) to HT community partners

PRIOR TO DISCHARGE:
- Arrange shelter/safe location
- Referrals: basic needs, community supports
- Safety Plan (crisis, HT contacts)

HT Not Confirmed

PRIOR TO DISCHARGE:
- Arrange shelter/safe location
- Referrals for basic needs, supports (SW)
- Safety Plan (Crisis, HT contacts)

*Child, Youth & Family Services Act now considers reporting for suspected trafficking for youth under 18. This differs from other cases of suspected abuse/neglect which has mandatory reporting for cases involving children/youth under age 16.

INDICATORS FOR HUMAN TRAFFICKING

[SEX/LABOR TRAFFICKING]

ANY age, gender, race/ethnicity, and nationality; may be 2SLGBTQIA+ or of any immigration status

WHERE THEIR SITUATION IS THE RESULT OF: **FORCE, FRAUD, OR COERCION:**
(feeling they cannot leave job/situation at will or under 18 in sex trade)

- With a person who speaks for them or will not leave
- Moves frequently, homeless, "visiting"
- Not in control of / has no identification
- Story is vague
- Owes a debt
- Signs of multiple sexual partners
- Evasive/afraid to answer
- Substance abuse
- No family/supports
- Tattoos/branding- ownership
- Exhausted, hungry
- History of physical or sexual assaults, STIs
- Lack of health care access
- Inappropriate clothing for venue or weather

It is important not to ask direct questions that could potentially re-traumatize. If you require support for a patient who you suspect may be trafficked, please contact Victim Services of Durham Region Monday-Friday 8:30am-5pm at 905-721-4226.

24/7 NATIONAL HUMAN TRAFFICKING HOTLINE:

1-833-900-1010

SCREENING TOOL FOR SUSPECTED VICTIMS OF HUMAN TRAFFICKING

TO CONSIDER PRIOR TO INTERVIEWING:

- Private space
- Use staff with appropriate skill (Trauma-informed interviewers)
- Do not provide unrealistic reassurances or promise outcomes
- Basic Needs (offer food, clothing)
- Accessibility needs (ie. interpreter required etc)
- Cultural Considerations/Supports

SAFETY CONSIDERATIONS:

- Assess for imminent danger
- Establish rapport/trust
- If accompanied, ask the person to step outside (ie. for a test, procedure etc). Do not assume female friend is not a trafficker.
- AVOID raising suspicion with potential trafficker – if refuses to leave, assess risk to patient's safety (history of violence? state of victim? Previous assaults?)

SAMPLE SCREENING QUESTIONS:

- Where do you sleep and eat?
- Are you reliant on someone else to provide for you?
- Are you connected with family? Who are your supports?
- Do you have access to your identification (health card, ID, bank card etc)? Where are they?
- Do you pay rent?
- How do you get money? Are you on Ontario Works? Ontario Disability?
- Do you work for anyone else?
- Are you required to share or give your money to anyone else?
- Are your movements controlled or restricted by anyone? Can you come/go as you please?
- Can you leave your job/situation if you want?
- Are there times when you feel pressured to do things you do not want to do?
- Are there times when you do not feel safe?
- Can we talk about ways to increase your safety?

HELPFUL TIPS IF TRAFFICKING IS SUSPECTED:

- Reassure the person that the info is being requested to offer support
- Info will be kept confidential (exception: duty to report)
- Consider offering comprehensive sexual health services (pregnancy screen, STI screen, HIV screen); **See process map for pathways**
- Ask about willingness to be linked with services/individuals who can help them
- Reassure them that they can return for help later if not ready to leave their situation at this time
- **Focus should be on developing a relationship, not "rescuing". Ask the patient what you can do to help them?**

DURHAM REGION RESOURCES		
VICTIM SERVICES DURHAM Do not need to be reported/linked with police	Call Main intake line M-F 8am-5pm (available 24/7 to police only)	905-721-4226
HUMAN TRAFFICKING HOTLINE	Canada-Wide (24/7)	1-833-900-1010
DURHAM REGIONAL POLICE – HUMAN TRAFFICKING UNIT	Mandatory reporting under 18) If not mandated, refer with patient consent only	905-579-1520 x 5600
WOMEN'S SHELTERS	Herizon House Denise House Bethesda Y's Wish	905-426-1064 905-728-7311 905-623-6045 905-576-6743
MOBILE CRISIS TEAM (Durham Mental Health Services) **DURHAM DISTRESS CENTRE**	Durham Region	905-666-0483 905-452-0688
CHILDRENS AID SOCIETY	Durham Region	905-433-1551
DNAAGDAWENMAG BINNOOJIIAG (Indigenous Child/Family Well-being)	Durham and York Region [Under 18 years of age]	(705) 295-7135
ONTARIO WORKS (if on OW already, should recommended they request to be assessed for ODSP) **ONTARIO DISABILITY SUPPORT (ODSP)**	Whitby Branch: Oshawa Branch: Ajax Branch:	905-666-6239 905-436-6747 905-428-7400
REGION OF DURHAM-HOUSING	Special Priority Eligibility Assistant	905-666-6222 x 2457 Fax: 905-666-6225
DURHAM RAPE CRISIS CENTRE	24/7 support	905-668-9200
SEXUAL HEALTH CLINICS	Oshawa Centre (North end) Suite 180, upper level Town Scugog Bldg (Port Perry)	1-800-314-8533 1-866-845-1868
MENTAL HEALTH MOBILE TEAM (DRPS + MHSU)	Durham Region – police + mental health nurse	911
PRIMARY CARE OUTREACH TEAM (PCOT)	Durham Region – mobile unit with paramedic + Social Worker	289-979-9428
PINEWOOD DETOX		905-721-4747 (Press 1)
DURHAM FAMILY SERVICES (counselling) **DURHAM CATHOLIC FAMILY SERVICES** ROSE OF DURHAM (young parents/ pregnancy)	QUICK ACCESS/TRAUMA	905-666-6240 X 2464 905-725-3513