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Kimberly S.G. Chang MD, MPH
ksghang@gmail.com

Hamida Yusufzai
hyusufzai@ahschc.org

Anna Marjavi
amarjavi@futureswithoutviolence.org

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MEDICAL–LEGAL COLLABORATION AND COMMUNITY PARTNERSHIPS: PRIORITIZING PREVENTION OF HUMAN TRAFFICKING IN FEDERALLY QUALIFIED HEALTH CENTERS

**Kimberly S.G. Chang, MD, MPH, Hamida Yusufzai &
Anna Marjavi***

ABSTRACT

Human trafficking (HT) is increasingly recognized as a public health issue, and its severe consequences affect some of society's most vulnerable members. Prioritizing prevention is a critical component of a public health framework when addressing HT, and the health care delivery system plays a crucial role in operationalizing primary, secondary, and tertiary prevention interventions. As a significant part of the primary care system in the U.S., Federally Qualified Health Centers (FQHCs) are uniquely positioned to be the first point of contact with the health care system for people at risk for and affected by HT. FQHCs provide many preventive services, health education programs, and community outreach initiatives; therefore, FQHCs have a great reach into the populations at risk of and affected by HT. Furthermore, FQHCs recognize the importance of leveraging legal expertise and services to address their communities' health-related social needs. There are many models for medical legal collaboration, including formal co-located medical–legal partnerships, as well as broader, community-based relationships. This Article will discuss types of medical–legal efforts and highlight individual patient and organizational case studies from Banteay Srei (a youth development program for Southeast Asian young women and girls at risk of commercial sexual exploitation, a program of Asian Health Services (AHS), an FQHC in Oakland, California). Finally, there will be a discussion about the intersection of HT with intimate partner violence (IPV), and how community partnerships and legal partnerships have

* Kimberly S.G. Chang, MD, MPH, Asian Health Services; Hamida Yusufzai, Banteay Srei; Anna Marjavi, Futures Without Violence.

played an important role in prevention efforts, with an organizational case study from Futures Without Violence, a national nonprofit providing training, technical assistance, and policy advocacy across the country for violence prevention.

INTRODUCTION

A public health framework to address HT enables social systems of care and protection to prevent HT by strengthening both individuals and communities.¹ Where criminal justice and law enforcement systems may reach people who are being actively victimized, public health and community health systems have the capacity to extend into vulnerable populations, preventing and combatting HT before victims reach a crisis point. Prioritizing prevention in HT innovation entails a multidisciplinary approach to address root causes of vulnerability and violence, a critical component of a public health framework. Furthermore, the health care delivery system plays a crucial role in operationalizing primary, secondary, and tertiary prevention interventions. The public health framework encompasses the collaboration between direct health care delivery, legal services, and other social services to reach individuals at risk of and actively being trafficked.

As a significant part of the primary health care system in the U.S., FQHCs are uniquely positioned to be the first point of contact with the health care system for people at risk for and affected by HT.² FQHCs provide many preventive services, health education programs,

1. See generally KATHERINE CHON, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF TRAFFICKING IN PERS., THE POWER OF FRAMING HUMAN TRAFFICKING AS A PUBLIC HEALTH ISSUE (2016); JONATHAN TODRES & ANGELA DIAZ, PREVENTING CHILD TRAFFICKING: A PUBLIC HEALTH APPROACH 9, 12–13 (2019); Katherine Y. Chon et al., *Moving Forward: Next Steps in Preventing and Disrupting Human Trafficking*, in HUMAN TRAFFICKING IS A PUBLIC HEALTH ISSUE: A PARADIGM EXPANSION IN THE UNITED STATES 415 (Makini Chisolm-Straker & Hanni Stoklosa eds., 2017); Jonathan Todres, *Moving Upstream: The Merits of a Public Health Law Approach to Human Trafficking*, 89 N.C. L. REV. 447, 453 (2011).

2. Kimberly S.G. Chang et al., *The Role of Community Health Centers in Addressing Human Trafficking*, in HUMAN TRAFFICKING IS A PUBLIC HEALTH ISSUE: A PARADIGM EXPANSION IN THE UNITED STATES, *supra* note 1, at 347.

community outreach initiatives, and a range of enabling services (services that assist a patient in access to care, such as interpretation, transportation, health education, and eligibility counseling), and therefore, have a great reach into populations at risk for and affected by HT.³ Furthermore, FQHCs recognize the importance of leveraging legal expertise and services to address their communities' health-related social needs. There are many models for medical–legal collaboration, including formal co-located medical–legal partnerships, as well as broader, community-based relationships.⁴ This Article will discuss types of medical–legal efforts and highlight individual and organizational case studies in addressing HT from a community health center and Futures Without Violence. Finally, there will be a discussion about the intersection of HT with IPV and how community and legal partnerships have played an important role in prevention efforts.

I. Public Health Framework and Prevention of HT

A public health framework emphasizes the prevention of HT. When addressing violence, including HT, from a prevention standpoint, it is important to develop interventions based on primary, secondary, or tertiary prevention levels. Primary prevention involves stopping human trafficking issues before they ever occur. Methods to this end include fostering healthier relationships, reducing or eliminating risks in a potential victim's environment, and developing buffers to violence.⁵ Primary prevention also encompasses increasing people's

3. ASS'N OF ASIAN PAC. CMTY. HEALTH ORGS., BUILDING THE CAPACITY OF COMMUNITY HEALTH CENTERS TO ADDRESS HUMAN TRAFFICKING (2015), https://www.aapcho.org/wp/wp-content/uploads/2015/10/AAPCHO-Human-Trafficking-Policy-Brief_103015.pdf [<https://perma.cc/UC4V-QYV6>].

4. MARSHA REGENSTEIN, JENNIFER TROTT & ALANNA WILLIAMSON, NAT'L CTR. FOR MED.-LEGAL P'SHIP, THE STATE OF THE MEDICAL-LEGAL PARTNERSHIP FIELD 29 (2017), <https://medical-legalpartnership.org/wp-content/uploads/2017/07/2016-MLP-Survey-Report.pdf> [<https://perma.cc/Z29T-HY2T>]; *Directory of Medical-Legal Partnership Programs*, A.B.A., https://www.americanbar.org/groups/probono_public_service/projects_awards/medical_legal_partnerships_pro_bono_project/directory_of_programs/ [<https://perma.cc/5378-UZL6>] (last visited Jan. 8, 2020).

5. U.S. DEP'T OF HEALTH & HUMAN SERVS., ADMIN. FOR CHILDREN & FAMILIES, DOCUMENT NO. OTIP-IM-19-01.01, INFORMATION MEMORANDUM DEFINITIONS AND PRINCIPLES TO INFORM HUMAN

knowledge of their legal and civil rights. Secondary prevention aims to intervene in the earliest stages of exploitation, whether through universal education or screening within the health care setting. Secondary prevention methods also provide immediate emergency and medical responses to violence, which address more short-term consequences.⁶ Tertiary prevention offers long-term responses that take place after violence has occurred—these include rehabilitative services such as long-term housing, job training, counseling, and support services. These particular methods seek to prevent sequelae, or revictimization.⁷ FQHCs and the health care delivery system can cooperate with community partnerships and medical–legal collaborations to implement all levels of prevention. Application of the social-ecological model is another important aspect of the prevention framework to address HT. Social-ecological models help practitioners and policymakers understand the complex relationships among individual and environmental factors to analyze potential prevention strategies.⁸ It is important for the strategic alignment of policy and services, the design of effective health promotion, disease prevention, and control strategies.⁹ The model allows for an analysis of the range of risk or protective factors for those experiencing or perpetrating violence.¹⁰ The four levels of the social-ecological model in violence prevention are (1) the individual within the context of relationship, (2) relationships within the context of community, (3) community within the context of society, and (4) the broader societal environmental factors.¹¹ The individual level of the model highlights the biological,

TRAFFICKING PREVENTION 4 (2019).

6. *Id.*

7. Chang, *supra* note 2; U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 5; V. Jordan Greenbaum et al., *Multi-Level Prevention of Human Trafficking: The Role of Health Care Professionals*, PREVENTIVE MED., Sept. 2018, at 164, 165.

8. See generally Etienne G. Krug & Linda L. Dahlberg, *Violence - A Global Public Health Problem*, in WORLD REPORT ON VIOLENCE & HEALTH 1 (Etienne G. Krug et al. eds., 2002).

9. FRANKLIN WHITE, LORANN STALLONES & JOHN M. LAST, GLOBAL PUBLIC HEALTH: ECOLOGICAL FOUNDATIONS 34 (2013).

10. CTRS. FOR DISEASE CONTROL & PREVENTION, NO. CS221239A, THE SOCIAL-ECOLOGICAL MODEL: A FRAMEWORK FOR VIOLENCE PREVENTION 1.

11. *Id.*

personal, and historical factors that might make an individual more likely to become a victim or perpetrator of violence.¹² Age, education level, income, substance abuse history, disability, or history of abuse are all factors considered at the individual level.¹³ The relationship level focuses on interpersonal relationships and explores how relationships may increase or decrease the risk of becoming a victim or perpetrator of violence.¹⁴ Relevant relationships include family members, friends, partners, and peers.¹⁵ The third community level analyzes the settings in which interpersonal relationships occur and identifies the setting characteristics related to becoming a victim or perpetrator of violence.¹⁶ Settings in the community level might include schools, places of work, or neighborhood areas.¹⁷ The societal level looks at the broadest social and cultural factors that might encourage or prevent violence.¹⁸ Factors here include social norms or cultural beliefs involving health and other social policies affecting the economy or education.¹⁹ Preventing HT requires intervention across multiple levels of the model at the same time. The FQHC health care delivery infrastructure is conducive to interventions across prevention levels and across the social-ecological model.

II. FQHCs in Health Care Delivery and HT

The United States' health care system is vertically organized, from a large primary care base to increasingly specialized levels of care. Primary care is an entry level for new medical issues; it provides person-focused rather than disease-oriented care, provides care for all issues except for the most uncommon or rare conditions, and “coordinates and integrates care, regardless of where the care is

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 10.

17. *Id.*

18. *Id.*

19. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 5, at 5.

delivered and who provides it.”²⁰ The two main priorities of any health service system—optimization and equity of health status—are achieved mainly through primary care.²¹ FQHCs operate at the primary care level. At the request of a primary physician, a consultant physician provides secondary medical care.²² Tertiary care is consultative care that requires high specialization, such as specialized equipment or expertise. Tertiary care usually requires referral from either a primary or a secondary care provider, and typically involves medical specialists working in a facility with special investigation and treatment capabilities.²³ Quaternary care is highly specialized care, including care such as experimental medicine and procedures, as well as uncommon, specialized surgeries, typically provided at academic systems.²⁴

The health care system offers potential interaction and engagement with patients throughout all stages of life—from pregnancy, to childhood, through adulthood; from acute emergency or urgent care, to long-term, chronic care; from public health community outreach, to hospitalizations. All of these points of care are opportunities to prevent, intervene in, and start the process of ending exploitation of trafficked patients so that the healing process can begin. With the growing recognition that HT is a health care and public health issue²⁵ and that the health care system may be the only social system with which trafficking victims may come into contact, FQHCs play a vital role in prevention, assessment, intervention, long-term care, and care coordination for patients who are at risk or have been affected.²⁶

20. *Definitions*, JOHN HOPKINS BLOOMBERG SCH. PUB. HEALTH, <https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html> [https://perma.cc/F5E9-CC4U] (last visited Jan. 8, 2020).

21. *Id.*

22. *Tertiary Care Definition*, JOHN HOPKINS MED., https://www.hopkinsmedicine.org/patient_care/billing-insurance/insurance_footnotes.html [https://perma.cc/R3CN-DDBY] (last visited Jan. 8, 2020).

23. *Id.*

24. Trisha Torrey, *Differences Between Primary, Secondary, Tertiary, and Quaternary Care*, VERYWELL HEALTH (Nov. 22, 2019), <https://www.verywellhealth.com/primary-secondary-tertiary-and-quaternary-care-2615354> [https://perma.cc/JKJ4-KX68].

25. Chon, *supra* note 1.

26. Chang et al., *supra* note 2, at 347–62.

FQHCs serve a disproportionate share of the nation's poor and uninsured. Most patients are members of racial or ethnic minorities, and millions of health center patients are served in a language other than English.²⁷ Trafficked persons may disproportionately share these characteristics.²⁸ FQHCs serve as key contact points for trafficked individuals, as they provide high levels of cultural competency and continuing care.²⁹ Victims encounter a variety of health care providers while being trafficked. One study showed that 87.8% of trafficked victims had contact with any type of health care provider, and 57.1% had treatment in a clinic setting while trafficked.³⁰ Survivors in another study noted that the clinical specialties they sought care from while trafficked were pediatrics (3.4% of victims), dentistry (26.5%), primary care (44.4%), and emergency departments (55.6%)³¹—all types of care that FQHCs provide (with urgent care as a proxy for emergency departments).³² Health care providers across the country are now being trained to recognize the signs of HT and to treat individual patients.³³ Further, there are models of care being developed in FQHCs across the country to address HT.³⁴

27. *Federally Qualified Health Care Centers: An Overview*, CTR. FOR HEALTH & RES. TRANSFORMATION (July 22, 2013), <https://chrt.org/publication/federally-qualified-health-centers-overview/> [<https://perma.cc/DT86-VQTA>] [hereinafter *Federally Qualified Health Care Centers*]; see also Christie Lancaster Palladino et al., *Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System*, 118 *OBSTETRICS & GYNECOLOGY* 1056, 1056–63 (2011); Elizabeth M. Shadigian & Samuel T. Bauer, *Pregnancy-Associated Death: A Qualitative Systematic Review of Homicide and Suicide*, 60 *OBSTETRICAL & GYNECOLOGICAL SURV.* 183, 183–90 (2005).

28. AM. PSYCHOLOGICAL ASS'N, REPORT OF THE TASK FORCE ON TRAFFICKING OF WOMEN AND GIRLS 31 (2014), <https://www.apa.org/pi/women/programs/trafficking/report.pdf> [<https://perma.cc/5LEU-T2P7>]; see also Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources*, 20 *J. WOMEN'S HEALTH* 1743, 1743–49 (2011).

29. ASS'N OF ASIAN PAC. CMTY. HEALTH ORGS., *supra* note 3.

30. Laura J. Lederer & Christopher A. Wetzel, *The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities*, 23 *ANNALS HEALTH L.* 61, 77 (2014).

31. Makini Chisolm-Straker et al., *Health Care and Human Trafficking: We Are Seeing the Unseen*, 27 *J. HEALTH CARE FOR POOR & UNDERSERVED* 1220, 1227 (2016).

32. *Federally Qualified Health Care Centers*, *supra* note 27.

33. *SOAR to Health and Wellness Training*, OFF. ON TRAFFICKING PERSONS (Sept. 24, 2019), <https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training> [<https://perma.cc/3KKW-L83L>].

34. *Special Edition: Intimate Partner Violence and Human Trafficking*, HRSA PRIMARY HEALTH CARE DIG. (Oct. 10, 2018), <https://content.govdelivery.com/accounts/USHSHRSA/bulletins/2134f6b> [<https://perma.cc/CZS4-966G>].

The federal government mandates that FQHCs operate in medically underserved areas (MUAs) and for medically underserved populations (MUPs).³⁵ Further, the federal statute that authorizes the FQHC Program incorporated a community ownership concept and requires all FQHCs to have a consumer (patient) majority board of directors.³⁶ This means that board members with an understanding of the culture, language, and community can identify issues like HT to inform health services; health centers are accountable to the communities they serve. In addition to community ownership, a distinguishing hallmark of FQHCs is the provision of enabling services—services that address the root cause of some of the most challenging problems related to health and health care utilization and enable a patient to access care. HT victims experience numerous access barriers, such as limited English proficiency, health illiteracy, transportation issues, and complex physical, mental health, and social needs, amongst many others.³⁷ Many FQHCs mitigate these barriers through enabling services. Enabling services are special, nonclinical functions that help vulnerable patients increase their access to care, and can include things such as outreach, case management, language translation and interpretation services, transportation or logistical assistance, health education and literacy services, environmental risk reduction, and most recently, civil litigation assistance.³⁸

FQHCs are primed and optimized to serve as vehicles of prevention and intervention of HT. FQHCs' mandated structure, their roots in the community, focus on high-risk patients in MUAs and MUPs, and

35. James Hennessy, Note, *FQHCs and Health Reform: Up to the Task?*, 9 NW. J.L. & SOC. POL'Y 122, 122–23 (2013).

36. *Id.* at 132.

37. *Id.*

38. ASS'N OF ASIAN PAC. CMTY. HEALTH ORGS., ENABLING SERVICES BEST PRACTICES REPORT 1 (2014), http://www.aapcho.org/wp/wp-content/uploads/2014/06/2014-ES-Best-Practices-Report_FINAL.pdf [https://perma.cc/S6C3-DRDJ]; HEALTH RES. & SERVS. ADMIN., HEALTH CENTER PROGRAM TERMS AND DEFINITIONS, <http://www.hrsa.gov/grants/apply/assistance/Buckets/definitions.pdf> [https://perma.cc/57C8-ZLWA]; *HRSA Recognizes Civil Legal Aid as "Enabling Services," Allows Health Centers to Use Funding for MLP*, NAT'L CTR. FOR MED.-LEGAL PARTNERSHIP (Oct. 27, 2014), <https://medical-legalpartnership.org/enabling-services/> [https://perma.cc/8LJL-T34Y] [hereinafter *HRSA Recognizes Civil Legal Aid as "Enabling Services"*].

expansive clinical (primary care, dental care, integrated behavioral health care) and enabling services, ensure a comprehensive whole-person approach to addressing HT. FQHCs are at the center of care coordination for patients with complex medical, behavioral health, and social needs and are well situated to include patients who have been trafficked. There are many examples of robust best practices addressing HT across all prevention levels, and through every level of the social-ecological model within FQHCs.³⁹ An examination of medical–legal collaborations and community partnerships within FQHCs reveals how prevention can be operationalized in health care delivery.

III. The Need for Social and Legal Services to Prevent HT: Social Determinants of Health

Violence is a social determinant of health (conditions in which people are born, grow, live, work, and age that shape health).⁴⁰ Whether a patient experiences violence or abuse directly or through passive exposure, there are very real health effects. HT, even though it is legislatively defined as a crime and is not a true medical illness, causes health harms due to the dangerous, dirty, and degrading living and working conditions in which people are frequently deprived of health care and food, socially restricted, coerced into substance use and dependence, and subjected to physical, sexual, psychological, emotional, behavioral, and spiritual abuse.⁴¹ The intersection with other vectors of violence, including for example IPV, child physical

39. ASS'N OF ASIAN PAC. CMTY. HEALTH ORGS., ESTABLISHING POLICIES AND BUILDING CAPACITY OF COMMUNITY HEALTH CENTERS TO ADDRESS HUMAN TRAFFICKING (2015), http://www.aapcho.org/wp/wp-content/uploads/2015/10/AAPCHO-Human-Trafficking-Education-Brief_103015.pdf [<https://perma.cc/QX8F-R3QM>] [hereinafter ESTABLISHING POLICIES AND BUILDING CAPACITY]; Irene Bruce, *Community Health Centers: Identifying and Responding to Human Trafficking*, CHRONICLES (Sept. 28, 2018), <https://chcchronicles.org/stories/community-health-centers-identifying-and-responding-human-trafficking?fbclid=IwAR3JyVzksz3KeV4d2RKXhJyzAW7zUw-dAaJwqqO9ysQd9HQnPAv4Mnnrjpc> [<https://perma.cc/NP53-2FJC>].

40. *Social Determinants of Health*, WORLD HEALTH ORG., http://www.who.int/social_determinants/sdh_definition/en/ [<https://perma.cc/98NL-X6M6>] (last visited Jan. 15, 2020).

41. Susie B. Baldwin et al., *Identification of Human Trafficking Victims in Health Care Settings*, HEALTH & HUM. RTS., June 2011, at 36, 40.

and sexual abuse, and sexual assault, causes health harms that fall into three categories: (1) physical harms; (2) mental health harms; and (3) social harms.⁴²

While violence negatively impacts health (as well as social harms noted above), one must also understand that the most socioeconomically disadvantaged groups and communities have the greatest risks of exposure to violence.⁴³ In this way, social disadvantage increases risks to violence, and violence leads to additional social disadvantage. By addressing social disadvantage (the social determinants of health) and attending to concrete needs at the social level, risks for violence, and by extension, risks for being exploited and trafficked can be interrupted. Likewise, attending to the concrete needs and inadequate resources for trafficked survivors is critical for treatment and healing processes.

FQHCs can interrupt violence across the different levels of the social-ecological model. Individual treatment plans include addressing medical and behavioral health needs, as well as addressing concrete social needs, including those surrounding safety and domestic violence (DV), housing and shelter, food security, education services, transportation, and other social services.⁴⁴ In fact, some FQHCs are

42. INST. OF MED. & NAT'L RESEARCH COUNCIL, CONFRONTING COMMERCIAL SEXUAL EXPLOITATION AND SEX TRAFFICKING OF MINORS IN THE UNITED STATES 288–90 (Ellen Wright Clayton, Richard D. Krugman & Patti Simon eds., 2013); CATHY ZIMMERMAN ET AL., THE HEALTH RISKS AND CONSEQUENCES OF TRAFFICKING IN WOMEN AND ADOLESCENTS 45–59 (2003), https://childhub.org/en/system/tdf/library/attachments/zimmermann_2003_health_risks_consequences_trafficking_1.pdf?file=1&type=node&id=16989 [<https://perma.cc/P8K9-F5EK>]; Patricia A. Crane & Melissa Moreno, *Human Trafficking: What Is the Role of the Health Care Provider?*, J. APPLIED RES. ON CHILD., no. 1, 2011, at 1, 12–17; Tiffany Dovydaitis, *Human Trafficking: The Role of the Health Care Provider*, 55 J. MIDWIFERY & WOMEN'S HEALTH 462, 463–65 (2010); Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTATIVE MED. 245, 245 (1998); Reena Isaac, Jennifer Solak & Angelo P. Giardino, *Health Care Providers' Training Needs Related to Human Trafficking: Maximizing the Opportunity to Effectively Screen and Intervene*, J. APPLIED RES. ON CHILD., no. 1, 2011, at 1, 8–10; Brian M. Willis & Barry S. Levy, *Child Prostitution: Global Health Burden, Research Needs, and Interventions*, 359 LANCET 1417, 1418–20 (2002).

43. SUSAN EGERTER, COLLEEN BARCLAY, REBECCA GROSSMAN-KAHN & PAULA BRAVEMAN, HOW SOCIAL FACTORS SHAPE HEALTH: VIOLENCE, SOCIAL DISADVANTAGE AND HEALTH 7 (2011), <https://www.preventioninstitute.org/sites/default/files/publications/How%20Social%20Factors%20Shape%20Health.pdf> [<https://perma.cc/43M5-UG73>].

44. Laura M. Gottlieb, Damon E. Francis & Andrew F. Beck, *Uses and Misuses of Patient- and*

now screening for how social determinants of health impact their patients using the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) tool.⁴⁵ The goals are to understand factors impacting their patients’ health and ability to act on care recommendations, to inform clinical care decisions, and to complete referrals to community resources to address identified needs.⁴⁶ Furthermore, FQHCs can use the information obtained from screening for social determinants to influence policy and the allocation of resources at the community or societal level to better serve their impacted patients. Policies that decrease social disadvantage and increase peoples’ ability to meet basic needs are paramount to the prevention of HT. To this end, FQHCs are creating community partnerships across the country to address the needs in their specific communities.⁴⁷ Medical–legal collaboration and community partnerships are essential for interrupting and preventing violence and HT through FQHCs. Policy solutions that affect entire communities are often formulated when a medical–legal partnership discovers patterns in their patients’ needs.⁴⁸

Neighborhood-Level Social Determinants of Health Data, PERMANENTE J. (SUPPLEMENTAL ISSUE), Fall 2018, at 58, 58–59.

45. See generally NAT’L ASS’N OF CMTY. HEALTH CTRS., ASS’N OF ASIAN PAC. CMTY. HEALTH ORGS. & OR. PRIMARY CARE ASS’N, PRAPARE IMPLEMENTATION AND ACTION TOOLKIT (2019), http://www.nachc.org/wp-content/uploads/2019/09/NACHC_PRAPARE_ALL.pdf [<https://perma.cc/NJ6M-4LP9>].

46. Arvin Garg et al., *Addressing Social Determinants of Health at Well Child Care Visits: A Cluster RCT*, 135 PEDIATRICS 296, 301 (2015); Laura Gottlieb, Megan Sandel & Nancy E. Adler, *Collecting and Applying Data on Social Determinants of Health in Health Care Settings*, 173 JAMA INTERNAL MED. 1017, 1018–19 (2013); Sheila V. Kusnoor et al., *Collection of Social Determinants of Health in the Community Clinic Setting: A Cross-Sectional Study*, 18 BMC PUB. HEALTH 550, 554 (2018).

47. See NAT’L ACAD. OF SCIS., ENG’G, & MED., EXPLORING DATA AND METRICS OF VALUE AT THE INTERSECTION OF HEALTH CARE AND TRANSPORTATION 37, 40–41, 43 (2016) <https://www.ncbi.nlm.nih.gov/books/NBK402420/> [<https://perma.cc/ETZ4-V8B9>] [hereinafter EXPLORING DATA] (see Chapter 4 on Cross-Sector Collaboration to Provide Transportation Services in Rural/Small Urban/Suburban Settings).

48. *Impact*, NAT’L CTR. FOR MED.-LEGAL PARTNERSHIP, <https://medical-legalpartnership.org/impact/> [<https://perma.cc/S53C-KR3N>] (last visited Feb. 25, 2020).

*IV. Medical–Legal Collaboration and Community Partnerships:
Individual Patient Case Studies*

Below are three case studies of patients demonstrating the importance of medical–legal collaboration and community partnerships in the prevention and intervention of HT at the individual level. Note that each case study represents a composite of several patients, and some facts have been changed to ensure patient confidentiality.

A. Number One—Eighteen-Year-Old Female Patient

An eighteen-year-old female patient received several referrals to Banteay Srei at AHS, an FQHC in Oakland, California. Banteay Srei is a youth development program that specializes in prevention and intervention programs for youth at risk of or affected by commercial sexual exploitation. The patient’s referral to Banteay Srei originated from youth program consultants of a local community-based organization, as well as from the director of a high school’s clinic. The process from referral to services took multiple conversations over the span of one year. The patient disclosed that an older male family member had sexually assaulted her within her home and the first assault occurred five years prior to disclosure. Upon disclosure, behavioral health counselors filed a Child Protective Services (CPS) report. The CPS report resulted in an inconclusive investigation. As a result, the patient continued to live in the same residence as the perpetrator. When sexual assault reoccurred, the patient reported it to the police, decided she could not continue to live at her family home and required social and legal services from Banteay Srei and the local Family Justice Center.

The Alameda County Family Justice Center consists of dozens of onsite and offsite agencies and programs, all designed to provide support services to the victims of various forms of exploitation and abuse, as well as their families.⁴⁹ She needed a number of services:

49. *About Us*, ALAMEDA COUNTY FAM. JUST. CTR., http://www.acfjc.org/about_us/ [<https://perma.cc/2S4J-5TSU>] (last visited Feb. 25, 2020).

(1) a Civil Standby to enable her to retrieve her belongings from the house upon moving out; (2) the Family Justice Center to assess and assist with filing a temporary restraining order; (3) the Family Justice Center to assist with hiring a trusted private process server; and (4) the Family Justice Center's help in serving the restraining order, which required a private process server, because the Sheriff's Office would only serve between the hours of nine and five and the perpetrator was at work during those hours. When the perpetrator failed to show up to court, the patient won a five-year permanent restraining order. Banteay Srei accompanied the patient to court and provided advocacy and emotional support, while AHS provided funding for emergency expenses—including emergency shelter. The patient enrolled in college, obtained stable housing, and received treatment for anxiety and trauma at AHS.

B. Number Two—Seventeen-Year-Old Female Patient

Law enforcement located a seventeen-year-old female youth, frequently reported by her mother as a runaway, in various cities away from her home—this raised red flags for the possibility of HT. Legal partners with the district attorney's office referred the youth to Banteay Srei. At the same time, a doctor at AHS consulted with Banteay Srei about a mother who was concerned for her daughter (both patients of the health center) because the daughter ran away from home and was self-harming. The youth referred from law enforcement and the patient were the same person.

AHS put a system-wide alert on her electronic health record so that if and when the patient called or made an appointment, both the doctor and Banteay Srei would immediately be notified. Banteay Srei also arranged a conference with the patient's school principal and counselor. The counselor noted the patient's behavior change over two years and that the patient's mother filed a Child Protective Services report over two years ago. The patient was raped at that time, aligning with the behavior change. Points of success in this case are the multiagency meetings and collaboration, the FQHC interdepartmental

communication, the physician's ability to identify exploitation, and referral processes working seamlessly.

C. Number Three—Twenty-Eight-Year-Old Pregnant Patient

A twenty-eight-year-old pregnant refugee patient experienced severe nausea and vomiting from hyperemesis gravidarum (morning sickness), requiring repeated visits to AHS for intravenous fluids to treat her symptomatic dehydration. She worked at a local restaurant and could not carry out her responsibilities due to her condition. Her employer fired her when she presented a physician's note detailing sick leave requirements. Upon returning to AHS for further treatment, the visibly upset and scared patient disclosed her termination of employment. Knowing that job termination was an illegal action, the physician wrote another letter to the employer detailing the disability and pointing out the illegal action. On the next visit to AHS, the patient was further distraught, sharing that her employer was upset with the physician letters and threatened to fire her husband, her brother-in-law, and all the other employees from her refugee community who worked at the restaurant in retaliation for the physician letters. With this disclosure, the physician enlisted case management at the FQHC and made referrals to civil legal partners for assistance. Ultimately, the restaurant was investigated and fined for several wage and labor violations. In this case, although not a definitive instance of HT, there were glaring warning signs of labor exploitation, and possible risks for labor trafficking for this particular refugee community. Medical–legal collaboration was critical in providing prevention and protections for this patient and other employees from this refugee community.

V. Types of Legal Services Needed by Those at Risk for or Affected by HT

The three cases above demonstrate various types of legal assistance patients may need when interfacing with the health care system. Legal services that may be necessary for those at risk for or affected by HT

include immigration legal services,⁵⁰ criminal justice legal aid,⁵¹ and civil legal aid—including civil litigation, family law, employment law services, and public benefits eligibility assistance.⁵²

Broadly categorized, civil legal aid may be the most important service required to help prevent HT on an individual level through the health care intersection. Because civil legal aid improves access to health care, housing, benefits, and employment or educational services,⁵³ its role in prevention entails addressing the social determinants of health and decreasing risks for violence (and HT) in socioeconomically disadvantaged communities. On the community and societal level of the social-ecological model, it is imperative to advocate for policies that increase access to civil legal aid for underserved communities.

For those identified as HT victims and who are foreign nationals, immigration legal services are a crucial component for securing safety and stability, whether they prefer to remain in the U.S. or to return to their country of origin. Immigration options specifically for trafficking victims include Continued Presence and T visas; whereas U visas, Special Immigrant Juvenile Status, Violence Against Women Act self-petitions, and asylum may be options for victims of other types of crimes (as well as HT victims).⁵⁴ If a victim prefers to return to their country of origin, legal services providers can assist with safe repatriation.

In terms of criminal justice legal assistance, victims may sometimes have criminal charges or a past criminal record, possibly due to force

50. *Immigration Needs*, OFF. FOR VICTIMS CRIME TRAINING & TECH. ASSISTANCE CTR., <https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/44-comprehensive-victim-services/legal-needs/immigration-needs/> [<https://perma.cc/TEB7-NFSW>] (last visited Jan. 20, 2020).

51. *Criminal Defense*, OFF. FOR VICTIMS CRIME TRAINING & TECH. ASSISTANCE CTR., <https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/44-comprehensive-victim-services/legal-needs/criminal-defense/> [<https://perma.cc/2DDM-F2FT>] (last visited Jan. 20, 2020).

52. *Civil Legal Needs*, OFF. FOR VICTIMS CRIME TRAINING & TECH. ASSISTANCE CTR., <https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/44-comprehensive-victim-services/legal-needs/civil-legal-needs/> [<https://perma.cc/766E-D3V6>] (last visited Jan. 20, 2020).

53. *Civil Legal Aid 101*, U.S. DEP'T JUST. (Oct. 24, 2018), <https://www.justice.gov/olp/civil-legal-aid-101> [<https://perma.cc/93C4-G5T9>].

54. *Immigration Needs*, *supra* note 50.

or coercion to commit crimes while trafficked. Defense attorneys (whether private or public) may require technical legal assistance in this area. Expunging or vacating criminal records may also be part of the needs for victims.

VI. Discussion of Medical–Legal Partnerships and Collaboration

The National Center for Medical-Legal Partnership⁵⁵ (NCMLP) promotes the use of legal services as a standard response to patients' social needs by providing education, research, and technical assistance to health organizations in the U.S. A formal Medical–Legal Partnership (MLP) entails co-location or embedding of lawyers within the health care setting.⁵⁶ Lawyers act as on-site specialists on the health care team who participate in care planning, treatment meetings, and consultation regarding laws and policies that may impact the patient. They also provide trainings to health care staff regarding relevant laws, policies, and systems. The NCMLP specifically notes examples where legal services can address social needs to improve health status and outcomes in various social determinants of health (income, housing and utilities, education and employment, legal status, and personal and family stability),⁵⁷ of which all of these domains affect people at risk of or affected by HT.⁵⁸

Importantly, the Health Resources and Services Administration (HRSA) added civil legal aid as an enabling service in 2014.⁵⁹ With this designation, many FQHCs can incorporate formal MLPs into their scope of work, with possibility for reimbursement for the service. As of January 2016, 113 FQHCs operated MLPs, and 38 FQHCs were

55. *About the National Center*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <https://medical-legalpartnership.org/about-us/> [<https://perma.cc/QBB8-L7H9>] (last visited Feb. 25, 2020).

56. *The Response*, NAT'L CTR. MED.-LEGAL PARTNERSHIP, <https://medical-legalpartnership.org/response/> [<https://perma.cc/96H2-U6V7>] (last visited Feb. 25, 2020).

57. KATE MARPLE, NAT'L CTR. FOR MED.-LEGAL P'SHIP, FRAMING LEGAL CARE AS HEALTH CARE 3 (2015), <https://medical-legalpartnership.org/wp-content/uploads/2015/01/Framing-Legal-Care-as-Health-Care-Messaging-Guide.pdf> [<https://perma.cc/SSH6-286Y>].

58. *Civil Legal Needs*, *supra* note 52; *Immigration Needs*, *supra* note 50.

59. *HRSA Recognizes Civil Legal Aid as "Enabling Services,"* *supra* note 39.

planning new MLPs.⁶⁰ “More than one third (38%) of health centers with MLPs report using enabling services funding for legal aid for their patients.”⁶¹

While formal co-located MLPs may be a best practice for addressing needs for patients at risk for or affected by HT, it is clear that not every FQHC may be able to sustain a formalized partnership, and there are other types of effective medical–legal collaboration. These collaborative relationships span many different types of agreements, ranging from memorandums of understanding (MOUs), informal, bidirectional referral partnerships, subcontracting agreements on grant funding, to other types of working relationships. The common goal is patient or client support and benefit. Recognizing the importance of the legal profession in addressing the social determinants of health, and the importance of medical–legal collaboration, formal MLPs (and informal relationships) and the American Bar Association (ABA) passed a resolution in 2007, encouraging “lawyers, law firms, legal services agencies, law schools and bar associations to develop medical–legal partnerships with hospitals, community-based health care providers, and social service organizations to help identify and resolve diverse legal issues that affect patients’ health and well-being.”⁶² Of particular note in the ABA resolution is the inclusion of social service organizations in these partnerships as well.⁶³

VII. Medical–Legal Collaboration and Community Partnerships: Organizational Case Studies

Below are two case studies of organizations demonstrating the importance of medical–legal collaboration and community partnerships in the prevention and intervention of HT.

60. ALANNA WILLIAMSON, JENNIFER TROTT & MARSHA REGENSTEIN, HEALTH CENTER-BASED MEDICAL-LEGAL PARTNERSHIPS 3, 5 (2018).

61. *Id.* at 8.

62. Paul R. DeMuro, *Report to the House of Delegates*, 2007 A.B.A. HEALTH L. SEC. REP. 120A, at 1.

63. *Id.*

A. #1—Banteay Srei at Asian Health Services and Asian Pacific Islander Legal Outreach

Through MOUs and subcontracting agreements with Asian Pacific Islander Legal Outreach (APILO), Banteay Srei was able to formalize and maximize resources for survivors of sex trafficking, HT, and family violence in Oakland, CA.⁶⁴ These goals were accomplished by activities related to several larger grants secured by APILO.

APILO is a 501(c)(3) nonprofit corporation founded in 1975:

[T]o promote the development, empowerment, and self-reliance of the community through the provision of culturally competent and linguistically appropriate legal, social, and educational services to those with extraordinary needs. Through these community-based services, [APILO] works to break the cycle of violence against women, youth and seniors, to advocate for the rights of immigrants and those with disabilities, to promote the dignity and independence of seniors and advocate for the basic rights such as affordable housing and the rights of tenants.⁶⁵

Through a bidirectional referral process, APILO and Banteay Srei work together to address the needs of youth affected by sex trafficking and exploitation.⁶⁶

APILO initiated the Anti Trafficking Collaborative of the Bay Area (ATCBA).⁶⁷ This organizing collaborative served as the pre-cursor to the medical–legal collaboration with Banteay Srei. ATCBA (in operation from 2003) was originally conceived by APILO, and two DV programs in the San Francisco Bay Area (Asian Women’s Shelter

64. See *Who We Are*, ANTI-TRAFFICKING COLLABORATIVE BAY AREA, <http://www.endtrafficking.org/who-we-are/> [https://perma.cc/32BX-QWRP] (last visited Feb. 25, 2020).

65. *About Us*, API LEGAL OUTREACH, <https://www.apilegaloutreach.org/about-us/> [https://perma.cc/3P9V-FC4X] (last visited Feb. 25, 2020).

66. See *Who We Are*, *supra* note 64.

67. *Anti-Human Trafficking Project*, API LEGAL OUTREACH, <https://www.apilegaloutreach.org/programs/anti-human-trafficking-project/> [https://perma.cc/E29X-XMTC] (last visited Feb. 25, 2020).

and Narika) after decades of partnership.⁶⁸ Through the collaborative, human trafficking survivors received legal and social services appropriate to their culture and to their language, regardless of the survivor's gender, race, ethnicity, nation of origin, or document status.⁶⁹ APILO invited partner organizations, including Banteay Srei, to participate.⁷⁰ Monthly meetings with all partners, strategic retreats, and trusted connections founded a culturally aligned collaboration resulting in many working partnerships in the form of subcontracts. This collaboration was rich in networking opportunities, resource sharing, pooling staff talent and expertise, and providing familiarity with services. Thus, efficiency in referral ensued when a patient–client needed services at any of the organizations.

B. #2–The Alameda County District Attorney's Office SafetyNet

The Alameda County District Attorney's Office hosts SafetyNet meetings intended to deliver immediate services to Commercially Sexually Exploited Children (CSEC) within Alameda County, California.⁷¹ These multidisciplinary team meetings seek to ensure victim safety for youths at the moment of their identification and throughout any interface they may have with any system.⁷² This includes, but is not limited to, youths who are involved in the juvenile justice system, social services, other government agencies, law enforcement, health care, and community-based agencies as either being at risk for or a victim of HT.

Banteay Srei was asked to provide and receive information about identified CSEC currently receiving case management support services while also protecting information to ensure client confidentiality.⁷³ Through a bidirectional referral process, Banteay

68. *Id.*

69. *Id.*

70. *See Who We Are*, *supra* note 64.

71. *SafetyNet*, H.E.A.T. WATCH, http://www.heatwatch.org/heat_watch/supporting_victims/safetynet [https://perma.cc/386P-YD5B] (last visited Mar. 9, 2020).

72. *Id.*

73. *See* Elizabeth Sy et al., *Responding to Commercially Sexually Exploited Children (CSEC): A Community Health Center's Journey Towards Creating a Primary Care Clinical CSEC Screening Tool*

Srei refers identified youths to SafetyNet partner agencies to provide follow-up services⁷⁴ and also receives client referrals from SafetyNet partners.⁷⁵ Banteay Srei has presented at the SafetyNet multi-agency meeting and is respected as a well-established, well-resourced Southeast Asian centered anti-sexual assault service.⁷⁶ Banteay Srei's position and reputation within the CSEC community is uplifted through the voices of the practitioners connected to SafetyNet and it has been considered for grant opportunities and other subcontracting agreements. An unexpected, positive impact of this collaboration was building solid relationships with high-ranking law enforcement officers who are based in units such as the Victim's Crime Unit; client-patients who are victim-survivors engaging with the criminal justice system need these types of specialists. The trusted relationship with law enforcement has helped expedite solutions, answer questions, and provide client-patient support.

VIII. Intersections of HT with IPV: Building Community Partnerships with DV Programs to Facilitate Medical and Legal Services for Those at Risk for or Affected by HT

IPV victims and human trafficking victims share several health-related impacts, including bodily harm from physical or sexual abuse; significant weight loss from food deprivation and malnutrition; increased risk of HIV/AIDS, cervical cancer, and STIs; and dental or oral issues.⁷⁷ Additionally, respiratory and other physical injuries function as indicators for labor trafficked victims—particularly because of their exposure to chemicals or pesticides and because of their dangerous working conditions.⁷⁸ The health impact of female sex trafficked victims manifests as an increased exposure to human papillomavirus, as well as to other STIs, which increases their risk for

in the United States, INT'L J. SOC. SCI. STUD., June 2016, at 45, 46.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.* at 333.

cervical cancer and HIV. Additionally, unintended pregnancies and the accompanying limitation on their pregnancy decision-making affect the health of sex trafficked women.⁷⁹ Given the overlap of health-related impacts between IPV and HT, health care providers may struggle to distinguish between the specific abuse (IPV) from the exploitation (HT) experienced by their patients.

Nevertheless, health care providers may refer their patients to resources that provide more in-depth assessments and targeted support.

Often, the perpetrator in federal trafficking cases is the victim's romantic partner, husband, or boyfriend.⁸⁰ Sometimes, human trafficking starts with grooming and the initiation of an intimate relationship between trafficker and victim. DV programs often serve as a source for primary referrals from health care providers for patients who experience either HT or IPV. While many communities maintain a community-based DV advocacy program or shelter, fewer communities offer distinct HT programs or shelters.⁸¹ Across the U.S., DV programs increasingly work to educate their staff and restructure their services to better meet the needs of HT survivors, including for clients with intersectional IPV/HT experiences. DV advocates maintain client confidentiality and operate 24/7 hotlines. They also are experts in planning for short- and long-term safety, assessing for fatality risk, and offering safety supports.⁸² Many are able to accompany clients to court and forensic (rape) exams.⁸³ They closely coordinate with other local, state, and federal partners, including legal,

79. Melissa Soohoo et al., *Cervical HPV Infection in Female Sex Workers: A Global Perspective*, 7 OPEN AIDS J. 58, 58 (2013).

80. THE HUMAN TRAFFICKING LEGAL CTR., HUMAN TRAFFICKING AND DOMESTIC VIOLENCE FACT SHEET 2 (2018), <https://www.htlegalcenter.org/wp-content/uploads/Human-Trafficking-and-Domestic-Violence-Fact-Sheet.pdf> [<https://perma.cc/G9KK-33LT>].

81. *The Role Domestic Violence Shelters Play in Supporting Human Trafficking Survivors*, POLARIS: BLOG (Oct. 30, 2018), <https://polarisproject.org/blog/2018/10/the-role-domestic-violence-shelters-play-in-supporting-human-trafficking-survivors/> [<https://perma.cc/Q3YU-28RF>].

82. *Our Advocates*, NAT'L DOMESTIC VIOLENCE HOTLINE, <https://www.thehotline.org/about-the-hotline/advocates/> [<https://perma.cc/H9PV-UNXD>] (last visited Mar. 9, 2020).

83. Diane, *How Can a Legal Advocate Help?*, NAT'L DOMESTIC VIOLENCE HOTLINE (Sept. 5, 2018), <https://www.thehotline.org/2018/09/05/how-can-a-legal-advocate-help/> [<https://perma.cc/E3LJ-YW6K>].

criminal justice, housing assistance, health care, and education and employment partners, among others.⁸⁴ In this respect, DV advocates serve as an essential bridge for referred clients to access a wealth of advocacy and other supportive services, including health care and legal resources (criminal, civil, and immigration), sometimes co-located on-site and other times through their collaborative networks. Further, given the intersectional nature of HT and IPV, screening protocols for HT developed by FQHCs are often modeled on existing IPV protocols.⁸⁵

It is therefore important to examine examples and intersections from the DV movement to understand how medical–legal partnerships can effectively function to serve patients at risk of or who have experienced trauma, violence, and abuse—including HT—to provide prevention and intervention services. One key takeaway is to understand that legal actions take time, and there are many steps in the process that may be overwhelming or confusing to a patient–client. The DV movement revealed the fact that advocates play a critical role in guiding patient–clients or victim–survivors through both medical and legal processes, serving as a vital bridge for prevention, intervention, and ultimately, healing. Below is a case study from Futures Without Violence (FUTURES), a health and social justice nonprofit, which has led the National Health Resource Center on Domestic Violence since 1993.⁸⁶ This case study demonstrates the importance of DV advocates in connecting people affected by DV or HT with medical care and other services, including legal advice. It also demonstrates the power of statewide leadership across public health, FQHCs, and DV coalitions in driving policy change to address social determinants at the societal level.

84. Ryan C. Shorey, Vanessa Tirone & Gregory L. Stuart, *Coordinated Community Response Components for Victims of Intimate Partner Violence: A Review of the Literature*, 19 *AGGRESSION & VIOLENT BEHAV.* 1, 4 (2014).

85. Sy et al., *supra* note 73, at 48.

86. *See infra* pp. 1097–1102.

IX. Case Study: Futures Without Violence, Project Catalyst: State/Territory-Wide Transformation on Health, Intimate Partner Violence, and Human Trafficking

Project Catalyst is a national initiative that focuses on fostering leadership and collaboration at the state and territory level to improve the health and safety outcomes for survivors of IPV and HT and promote prevention efforts.⁸⁷ Project Catalyst receives support from cooperation of agencies within the U.S. Department of Health and Human Services, which specifically includes the Administration for Children and Families’ (ACF) Family and Youth Services Bureau, Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care, and HRSA’s Office of Women’s Health.⁸⁸ FUTURES provides training and technical support and the University of Pittsburgh Medical Center conducts the evaluation.⁸⁹ ACF’s funded National Health Resource Center on Domestic Violence has been at FUTURES since 1996. As such a resource, FUTURES promotes “model health responses to IPV and HT,” and it provides tools for patient and provider education.⁹⁰

Given their enormous reach and overarching goals to promote health and safety, FQHCs are uniquely positioned to be leaders in violence prevention across the U.S. in partnership with domestic violence programs (DVPs) that offer support, safety planning, and coaching to address social determinants of health and promote wellness.⁹¹ Through Project Catalyst, leadership teams—comprised of

87. See generally *National Health Initiative Kicks Off to Support Survivors of Abuse*, FUTURES WITHOUT VIOLENCE (Jan. 15, 2019), <https://www.futureswithoutviolence.org/project-catalyst-health-support-survivors-abuse/> [https://perma.cc/H9MQ-UD4W]; *Project Catalyst: Statewide Transformation on Health and IPV*, FUTURES WITHOUT VIOLENCE (Jan. 23, 2018), <https://www.futureswithoutviolence.org/project-catalyst-press-release/> [https://perma.cc/Z5D5-FXU6]; *Project Catalyst: State-Wide Transformation on Health, IPV, and Human Trafficking*, FUTURES WITHOUT VIOLENCE, <https://www.futureswithoutviolence.org/health/project-catalyst/> [https://perma.cc/9QES-JKBA] (last visited Mar. 2, 2020).

88. *Project Catalyst: Statewide Transformation on Health and IPV*, *supra* note 87.

89. *Id.*

90. *Id.*

91. ESTABLISHING POLICIES AND BUILDING CAPACITY, *supra* note 39; EXPLORING DATA *supra* note 47, at 43; Chang et al., *supra* note 2.

leads from state and territory Primary Care Associations, Departments of Health, and DV Coalitions—demonstrated their significant and meaningful role in supporting FQHCs and DVPs partnering on IPV and HT practice change. The Project Catalyst national initiative began in 2016, and runs through 2020, with ten partners at the state and territory level and over one hundred participating FQHC and DVP sites.⁹² One of the lessons learned was to understand the value and partnership of advocates as part of the care team who make the work of medical and legal professionals easier by helping patient-clients with safety planning and victim resources. As a result, DV advocates bolster safety and health outcomes, reduce social isolation, and increase the stamina and wellness of patient-clients and staff. The result is that DV advocates can improve health access for clients entering DV advocacy programs and offer a menu of support to those referred by health centers and legal programs. Other components to achieving justice for those affected by violence include being ready for court, knowing options, making paths for next steps, court accompaniment, support groups, shelter, job readiness, employment, and education resources.

Project Catalyst developed upon the earlier work of FUTURES, HRSA, and the ACF Family Violence Prevention and Services Act (FVPSA) program.⁹³ In 2014–2016 as part of the Improving Health Outcomes Through Violence Prevention Pilot Project, FUTURES offered training and workflow redesign services to ten health centers and ten DVPs throughout the United States.⁹⁴ FQHC and associate DVPs tested effective methods of responding to IPV.⁹⁵ These findings

92. See generally *National Health Initiative Kicks Off to Support Survivors of Abuse*, *supra* note 87; *Project Catalyst: Statewide Transformation on Health and IPV*, *supra* note 87; *Project Catalyst: State-Wide Transformation on Health, IPV, and Human Trafficking*, *supra* note 87.

93. FUTURES WITHOUT VIOLENCE, PROJECT CATALYST: STATEWIDE TRANSFORMATION ON HEALTH, INTIMATE PARTNER VIOLENCE, AND HUMAN TRAFFICKING 5 (2018), <https://www.futureswithoutviolence.org/wp-content/uploads/FUTURES-Project-Catalyst-Bidders-Webinar-10.18.pdf> [<https://perma.cc/5TJD-HHD9>].

94. *Id.* at 9.

95. FUTURES WITHOUT VIOLENCE, PREVENT, ASSESS, AND RESPOND: A DOMESTIC VIOLENCE TOOLKIT FOR HEALTH CENTERS & DOMESTIC VIOLENCE PROGRAMS 3 (2018), <http://www.nnoha.org/nnoha-content/uploads/2018/12/IPV-Health-Partners-Toolkit-4.24.pdf>

became tools adaptable for use in the respective settings for various actors such as “health care providers, administrators, DV advocates, and community partners.”⁹⁶ With the support of FVPSA, local DVPs provide extensive services and support to victims, including “crisis counseling, information and referrals, legal and other advocacy, [as well as] shelter and additional support services.”⁹⁷ FQHCs’ partnerships with these community-based programs are a critical component to a comprehensive response to IPV and HT.⁹⁸ “Social service organizations” are crucial to an integrated health care and social service approach to IPV and HT.⁹⁹

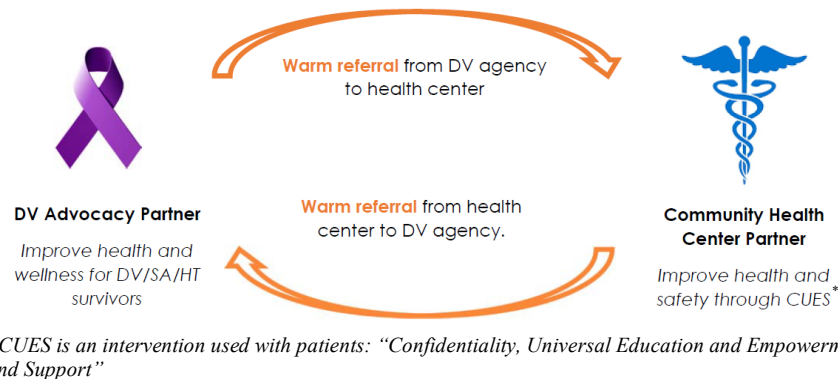


Figure 1. Building Sustainable and Fruitful Partnerships Between Community Health Centers and Domestic Violence Advocacy Organizations¹⁰⁰

[<https://perma.cc/8UWN-3KEK>] [hereinafter DOMESTIC VIOLENCE TOOLKIT].

96. *Id.*

97. See generally FAM. & YOUTH SERVS. BUREAU, FVPSA FACT SHEET (2018), https://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_overview_factsheet_071318_508.pdf [<https://perma.cc/78TZ-3JST>].

98. DOMESTIC VIOLENCE TOOLKIT, *supra* note 95, at 7.

99. “Social service organizations includ[ing] domestic violence programs, local domestic violence shelter programs, tribal domestic violence programs, and other culturally specific community based organizations are an integral part of any coordinated health care and social service response to DV.” FUTURES WITHOUT VIOLENCE, PROJECT CATALYST III: STATE/TERRITORY-WIDE TRANSFORMATION ON HEALTH, IPV AND HUMAN TRAFFICKING 23 (2019), <https://www.futureswithoutviolence.org/wp-content/uploads/Project-Catalyst-III-FOA-Final.pdf> [<https://perma.cc/YA9X-32PR>].

100. *Id.* at 1.

Every U.S. state and territory has a DV Coalition funded by FVPSA.¹⁰¹ These Coalitions are associated with over 2,000 FVPSA-funded DVPs in the U.S.¹⁰² Each Coalition offers social-, legal-, and economic-related services in the form of training and administrative support to promote the health and safety of victims.¹⁰³ Coalitions often partner with various industries in both the public and private sectors to organize productive victim services.

One key action for FQHCs working to prevent and respond to IPV and HT is to first identify their community-based DV or HT advocacy programs and to initiate an MOU indicating a formal partnership. Effective trauma-informed care relies significantly on established partnerships. Across the U.S., DVPs and FQHCs are developing creative and innovative models that have pushed their collaborative efforts even further. Several outcomes were noted through the projects: (1) support of staff wellness and healing—partnership offered the opportunity for staff to address their own personal trauma and health; (2) reliance on the expertise of the partner organization (for advocacy or health care); (3) improvement of health outcomes—for people who are surviving an abusive relationship or living with trauma from previous abuse, the sooner they are connected to health and advocacy support services, the sooner they will be able to address underlying reasons for their health issues; and (4) adoption of trauma-informed care approaches—working with a partner advocacy organization or health center promoted trauma-informed care systems.¹⁰⁴

101. These include the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa. *State & U.S. Territory Coalitions*, NNEDV, <https://nnedv.org/content/state-u-s-territory-coalitions/> [https://perma.cc/MBS3-BBDZ] (last visited Apr. 16, 2020); see also Jeannie L. Chaffin & Lynda Perez, *AFI DCL Family Violence Awareness Month in October*, OFF. COMMUNITY SERVICES (Nov. 20, 2014), <https://www.acf.hhs.gov/ocs/resource/family-violence-awareness-month-in-october> [https://perma.cc/3W2M-BA7J].

102. *Id.*

103. *Id.*

104. FUTURES WITHOUT VIOLENCE, POLICY PRIORITIES TO STRENGTHEN TRAUMA INFORMED CARE FOR CHILDREN IN CALIFORNIA (2017), https://www.futureswithoutviolence.org/wp-content/uploads/Policy_Priorities_TIC.pdf [https://perma.cc/LE7D-ZA2K]; *How to Improve the Health of Survivors of Domestic Violence*, FUTURES WITHOUT VIOLENCE (Oct. 29, 2018), <https://www.futureswithoutviolence.org/health-domestic-violence-survivors/> [https://perma.cc/RL29-NT97].

Key findings from the FUTURES projects between FQHCs and DVPs that could be applicable to medical–legal collaboration, or social services–legal collaboration, delineate the principles of partnership. Exploration of shared goals and vision and determining how the organizations want to build together to support survivor health is crucial. Strategies to accomplish that include the following:

- Hosting cross-trainings where staff visits each other’s locations to learn about services so everyone can be able to describe what the partner agencies can offer patient–clients.
- Developing a procedure for bidirectional warm referrals.
- Developing ways to ensure that survivors referred from the advocacy organization to the health center (or legal services) get access to a “golden ticket” for next day appointments for immediate needs.
- Revisiting or developing MOUs with the advocacy organization leadership and updating it based on determined goals, referral procedures, and any new elements of the partnership.
- Coordinating Care: As referral procedures are refined through experience, it may be helpful to bring each partner agency into certain patient’s care plans.
- Visiting Health Provider and Eligibility Specialist: Can the health center send a health provider or health educator to visit the advocacy organization every two weeks to enroll them as a health center patient and provide basic health care or health education to survivors using their services?
- Advocacy-Based Health Services: Can the advocacy organization work to offer health services on site? What would it take to have advocates specially trained in substance dependency, HIV testing, or sexual health education?

- Mobile Health and Advocacy: Many health centers and advocacy organizations offer mobile services. Can this be coordinated?
- Co-Located Advocates (with medical or legal).
- Tracking Successes: Documentation of referrals from the health center to survivors; tracking utilization of the advocacy services; tracking referrals from the advocacy partner to the health center. This data can be immensely important when demonstrating the use of the partnership, program development, and even state policy.¹⁰⁵

Overall, Project Catalyst highlights the importance of advocates in securing improved health and social outcomes for survivors of DV, sexual assault, and HT by providing crucial support to survivors to navigate health care and other services, including the legal system.

CONCLUSION

Medical–legal collaboration and community partnerships in FQHCs are essential components of a seamless integration of services to prevent HT in communities across the U.S. A critical analysis of HT through a public health prevention framework reveals the importance of addressing the risk factors and social determinants of health by focusing on interrupting the social disadvantages that predispose to violence. Formal MLPs may be a best practice to connect people at risk of or affected by HT with crucial legal services, including immigration legal services, criminal justice legal aid, and civil legal aid, including civil litigation, family law and employment law services, and public benefits eligibility assistance. Other types of medical–legal collaboration can also provide results. Of particular importance in the prevention of and intervention in HT is the effectiveness of advocates and community partnerships to bridge the gaps in the safety net of medical, legal, and social services, which can be illustrated by examining the DV movement. Models of care and

105. *How to Improve the Health of Survivors of Domestic Violence*, *supra* note 104.

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service should emulate the DV movement's approach of partnerships and collaboration with advocates serving a critical function.