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TRAUMA AND TRAUMA-INFORMED CARE: HOW PROSTITUTION DIVERSION PROGRAMS MISS THE MARK

Shelly A. Wiechelt, Ph.D.*

Abstract

This paper is a summary of a panel presentation Trauma and Trauma-Informed Care: Prostitution Diversion Programs, given at the Journal of Health Care Law and Policy's Spring 2023 Symposium, Uneasy Alignments: The Mental Health Turn in the American Legal System. The Article will introduce trauma and other trauma related concepts including PTSD, complex-trauma, and trauma-informed care and consider the challenges inherent in addressing trauma in a trauma-informed manner via prostitution diversion programs.

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Diversion programs and other types of problem-solving or therapeutic courts have been instituted around the United States over the last thirty years. These types of courts and court based programs are intended to reduce the size of court dockets, cut costs, lower incarceration rates, and provide people with assistance for underlying problems to “solve” illegal behavior and offer rehabilitation. Prostitution diversion programs are one type of court based program and are designed to provide individuals facing prostitution charges with an opportunity to avoid incarceration and redress their illegal behavior. Although these remarks focus on prostitution diversion programs, the concepts and issues raised are pertinent to other types of problem-solving courts and court based programs.

Prostitution diversion programs operate on the assumption that individuals engage in prostitution because of underlying problems, particularly substance use disorders and traumatic experiences across their lives. The impact of this trauma on the individual is seen as the root cause of prostitution behavior and a necessary focus of treatment. Prostitution diversion programs typically require participants to engage in trauma and substance use treatment. These well-meaning courts intend to redress trauma related problems and prevent incarceration. However, the structure of a court and mandated treatment pose challenges for addressing trauma in a trauma-informed manner.

UNDERSTANDING KEY CONCEPTS OF TRAUMA

Trauma essentially means experiencing an extremely stressful life event that overwhelms one’s coping capacity. The generally accepted conceptualization of trauma in the United States is delineated in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (“DSM-5-TR”).¹ Criterion A for a Post-Traumatic Stress Disorder (“PTSD”) diagnosis is directly experiencing, witnessing, or learning about a loved one experiencing actual or threatened death, serious injury, or sexual violation, and is considered a traumatic event. Exposure to trauma may also occur via repeated aversive details of a traumatic event, such as might occur in a first responder job setting. Examples of qualifying potentially traumatic events for an individual include combat, torture, terrorist attack, physical assault, sexual assault, natural disasters, serious auto accident, or life threatening illness. Being exposed to such an event does not necessarily result in a trauma reaction. Individual reactions to exposure to a traumatic event vary and are influenced by factors such as the nature of the event, severity of the event, loss of personal power in the event, pre- and post-trauma characteristics, and reactions of others to the event. One could have an initial stress reaction that becomes chronic, a delayed reaction that emerges over

1. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-5-TR (Am. Psych. Assoc.) (5th ed. 2022).

time, recovery from initial symptoms, or demonstrate resilience by maintaining stable healthy levels of functioning.² Individuals who experience traumatic events often feel shame, guilt, and fear. They could develop PTSD, complex-PTSD, substance use disorders (“SUD”), affective disorders, or dissociative disorders, as well as other psychiatric disorders or sub-diagnostic symptoms.

DEFINING POST-TRAUMATIC STRESS DISORDER

PTSD is the most commonly considered disorder when exposure to a traumatic event(s) occurs. Individuals who experience a traumatic event (as described above) meet criterion A for PTSD. There are four clusters of PTSD symptoms: reexperiencing, avoidance, negative cognitions and mood, and arousal and reactivity. Individuals must experience symptoms for more than one month to receive a PTSD diagnosis. The lifetime prevalence rate of PTSD in the general population is 6%. The rate is 4% for adult males and 8% for adult females.³ The comorbidity of PTSD with substance use disorders and other mental health disorders is known to be high.

Complex PTSD is not a separate diagnostic category in DSM-5-TR (despite considerable efforts to have it included as such) because the DSM creators believe its symptoms are incorporated in the existing criteria. This issue is reported on heavily in the clinical literature. Individuals with complex PTSD experience symptoms such as changes in personality, deformations of relatedness and identity, and vulnerability to repeated harm. Negative impacts on affect regulation, attention, cognition, perception, and interpersonal relationships are typical for those with PTSD. Traumatic events that involve prolonged and repeated trauma in relation to others, interpersonal violence, or psychological control and abuse are also thought to contribute to complex trauma syndromes.⁴

PROVIDING TRAUMA-INFORMED CARE

Given the high incidence of trauma and trauma related issues among those who experience mental health and substance use problems, as well as social problems, trauma-informed care should be standard. Social service and healthcare delivery systems and program operations should be sensitive to trauma issues and triggers and avoid retraumatizing individuals or exacerbating problems. According to Moses,⁵ services that are trauma-informed should:

2. George A. Bonanno, *Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events?*, 59 AM. PYSCH. 20, 21 (2004).

3. Paula P. Schnurr, *Epidemiology and Impact of PTSD*, U.S. DEP'T OF VETERANS AFFS., <https://www.ptsd.va.gov/professional/treat/essentials/epidemiology.asp> (last visited Aug. 17, 2023).

4. CHRISTINE A. COURTOIS & JULIAN D. FORD, *TREATING COMPLEX TRAUMATIC STRESS DISORDERS: AN EVIDENCE-BASED GUIDE* (Christine A. Courtois & Julian D. Ford eds., 2009).

5. DAWN JAHN MOSES ET AL., *CREATING TRAUMA SERVICES FOR WOMEN WITH CO-OCCURRING DISORDERS* 20 (2003), <https://www.researchgate.net/publication/252171592>.

- Be infused with knowledge about the roles that violence and victimization play;
- Minimize the possibility of victimization and re-victimization;
- Be hospitable and engaging for individuals who have experienced harm;
- Facilitate recovery;
- Operate on an empowerment model;
- Respect choices and control over recovery;
- Minimize power imbalances;
- Engage in relational collaboration; and
- Emphasize strengths.

The keys to trauma-informed care are:

- *Safety*: Ensuring physical and emotional safety;
- *Trustworthiness and Transparency*: Maximizing trustworthiness, decisions are conducted with transparency, making tasks clear, and maintaining appropriate boundaries;
- *Peer Support*: Facilitating peer support and mutual self-help to establish safety and hope;
- *Collaboration and Mutuality*: Increasing collaboration and meaningful sharing of power in decision making;
- *Empowerment, Voice, and Choice*: Prioritizing client's empowerment and skill building and including their voice and choice in shared decision making towards goals and healing; and
- *Cultural, Historical, and Gender Issues*: Incorporating policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals.⁶

PROSTITUTION DIVERSION PROGRAMS: WELL-MEANING COURTS AND DISAPPOINTING RESULTS

We conducted studies on two court based prostitution diversion programs: the Specialized Prostitution Diversion Program (“SPD”) in Baltimore and Project Dawn Court (“PDC”) in Philadelphia. Both programs operated on the premise that trauma and substance use problems are underlying factors in prostitution behaviors and charges. Existing research supports the idea that trauma is particularly problematic for female sex workers; one meta analysis⁷ shows 29.3% of female sex workers experiencing PTSD, compared to 11.1% of

6. U.S. DEP’T OF HEALTH & HUM. SERVS., SAMSHA’S CONCEPT OF TRAUMA AND GUIDANCE FOR A TRAUMA-INFORMED APPROACH 10–11 (2014).

7. Juan Manuel Millan-Alanis et al., *Prevalence of Suicidality, Depression, Post-Traumatic Stress Disorder, and Anxiety Among Female Sex Workers: A Systematic Review and Meta-Analysis*, 24 ARCHIVES WOMEN’S MENTAL HEALTH 867, 869 (2021).

women in the general population.⁸ Our own research supports the idea that women engaged in street-level sex work have often experienced stressful life events, PTSD symptoms, and other trauma related symptoms. Women at the YANA program (a drop in center for women engaged in sex work in Baltimore) reported experiencing between five and fourteen stressful life events, as well as high levels of PTSD symptoms and trauma related symptoms.⁹ The women in the PDC reported lower numbers of stressful life events, albeit still generally high, ranging from zero to fifteen. They experienced problematic levels of PTSD symptoms and trauma related symptoms.¹⁰ It should be noted that the participants identified other problems that they thought contributed to their legal and social challenges as well: poverty, housing instability, lack of employment opportunities and skills, and social connection.

Court personnel in both programs believed that they could help diversion program participants and get them to stop engaging in prostitution behaviors if they could get the participants to stop using substances, resolve trauma, and engage in recovery. The SPD did not require participants to enter a guilty plea; rather, they were diverted from the court process prior to the plea stage. Participants worked collaboratively with a social worker to develop goals and treatment plans. They were expected to comply with the plans and any mandated treatment. Participants who were noncompliant could be extended in the program or returned to the court to face charges (at the discretion of the judge). Project Dawn required participants to enter a nolo contendere plea that was held in abeyance in order to participate in the program.

The program typically involved mandated trauma and substance use treatment along with plans developed across four phases in the year-long program. Women who were terminated from the program for noncompliance had their nolo contendere pleas entered and were sentenced for their offenses. Both programs included personnel who were trained on the general impacts of trauma but were not necessarily experts on trauma or its intersectionality with substance use disorders or other social and mental health problems. The courts intended to address trauma, with the ultimate goal of preventing illegal behavior and incarceration.

Given that the design of the courts inherently involves power imbalances and coercion, such court based programs cannot fully be trauma-informed. The court determines what is acceptable behavior, what services are needed, the expected level of compliance with court and treatment providers, and the rewards

8. *Id.* at 874.

9. Shelly A. Wiechelt & Corey S. Shdaimah, *Trauma and Substance Abuse Among Women in Prostitution: Implications for a Specialized Diversion Program*, 1 J. FORENSIC SOC. WORK 159, 168, 174 (2011).

10. COREY S. SHDAIMAH, CHRYSANTHI S. LEON & SHELLY A. WIECHELT, *THE COMPASSIONATE COURT?: SUPPORT, SURVEILLANCE, AND SURVIVAL IN PROSTITUTION DIVERSION PROGRAMS* (2023).

and consequences for compliance or noncompliance. For example, the PDC typically mandated care for substance use and trauma related problems at area facilities for program participants. Noncompliance could result in dismissal from the program and incarceration. Choice, empowerment, and collaboration are clearly missing in this court process. The physical structure of the courtroom represented the power that the court held, such as the high judge's bench in the front of the room, attorneys and diversion program personnel at wooden tables beneath the judge, and uniformed officers of the court around the perimeters. The program participant standing before the judge clearly fell into a diminished role. The large wooden door in the center of the wall on the right side of the PDC courtroom that went to a holding cell area seemed especially daunting. We saw the judge instruct the bailiff to escort a noncompliant program participant through that door. While it is true that the judge often expressed compassion and support to participants, she held much greater power and could order a range of consequences at her discretion. The uncertainty of what could happen in the courtroom and at the discretion of the judge surely raised questions regarding safety and trustworthiness.

While the SPD was designed to allow diversion to the program without requiring a plea at its inception, we witnessed a judge require an individual to plead guilty in order to participate in the program. The fickle nature of the court and power of the judge and other court personnel over program participants did not afford them much power or choice.

We acknowledge that the Prostitution Diversion Programs are well-meaning and are intended to help those who are charged with prostitution. It is likely that individuals may benefit from help for potential substance use and trauma related problems. However, involvement in the judicial system and little choice in treatment is not conducive to trauma-informed care and potentially can retraumatize the participant. Decriminalizing sex work and providing individuals with options for therapeutic programs, housing, job training, and healthcare in the community would ultimately support them in an empowering, collaborative, choice-filled manner that would build safety and trust. *The Compassionate Court? Support, Surveillance, and Survival in Prostitution Diversion Programs*, which I co-wrote with Corey S. Shdaimah and Chrysanthi S. Leon, provides a more detailed summary of our research and analysis of prostitution diversion programs.¹¹

11. *See id.*