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The State of Aftercare: A Critical Look at the Response to Victims of Human Sex Trafficking in the United States

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THE STATE OF AFTERCARE: A CRITICAL LOOK AT THE RESPONSE TO VICTIMS OF HUMAN SEX TRAFFICKING IN THE UNITED STATES

by

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Abstract

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This study explored the services available to survivors of sex trafficking in the United States. Thirty organizations completed an online survey addressing the needs of the survivors who accessed their services, and how they addressed survivors' psychological, sexual, substance abuse, legal, educational and vocational, spiritual, and physical needs. The findings provided descriptions of the complex needs of trafficking survivors when they seek help, and the types and forms of services available to address those needs. Results showed how few programs are providing direct services and highlighted the challenge for survivors to get their needs met if they are in an area without any services that are sensitive to their unique needs. The study described service provision for each need category and made recommendations for outcome research and development of trafficking sensitive interventions for each area of need. While the participating programs reported many strengths and successes, they also commented on challenges, including the necessity for more funding and well-trained professionals in various disciplines to provide services to their clients. The field of aftercare services for victims of human sex trafficking in the United States is relatively new, but growing, making this an ideal time to research and strengthen intervention. Findings from the current study can inform future research regarding more effective models of care and encourage professionals across disciplines to become educated in survivors' complex needs.

TABLE OF CONTENTS

LIST OF TABLES

Introduction to Victims of Sex Trafficking

Trafficking in persons, or modern day slavery, is recognized in the global community as a significant problem and an abuse of human rights. United States federal law defines sex trafficking as:

> The recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age. (Victims of Trafficking and Violence Protection Act, 2000 as cited in U.S Department of Health and Human Services, 2011, p. 1)

Human sex trafficking is currently one of the top three largest criminal enterprises in the world and the fastest growing, amassing 32 to 40 billion dollars annually (Bales & Soodalter, 2009; International Labour Organization, 2009; U.S. Department of Health and Human Services, 2011).

According to the newly released Global Slavery Index, there are an estimated 29.8 million people in slavery in the world today (Walk Free Foundation, 2013); however, estimates of victims in the United States are inconsistent, ranging from 57,000 – 63,000 total (Walk Free Foundation, 2013) to 100,000-300,000 prostituted children alone (National Center for Missing and Exploited Children, 2010; Polaris Project, 2010). Unfortunately, it is difficult to accurately estimate the prevalence of trafficking victims because human trafficking goes largely unnoticed on a global scale (U.S. Department of State, 2011). With the information that is available, it is estimated that 70 to 80% of victims are female and approximately 50% are minors (Albanese, 2007; U.S. Department of State, 2008). It is further estimated that 50% of all trafficked individuals are trafficked

for sexual purposes, meaning they are prostituted or victimized through commercial sexual exploitation (Bales & Soodalter, 2009).

The process of a person becoming trafficked begins with being recruited by a pimp or unknowingly becoming involved with complex trafficking networks. International victims are often recruited through the guise of harmless and even beneficial promises of education, work, wealth, or a way out of poverty for themselves and their families (Gjermeni et al., 2008; Hodge, 2008; Mbecke, 2010). Domestically, runaway or abandoned youth are vulnerable and are often befriended by traffickers and pimps at popular teen hangouts. It is estimated that runaway youth will be approached within their first 48 hours on the street for recruitment into some form of sexual exploitation (Spangenberg, 2001). The traffickers offer the necessities of security, and food, as well as gifts in exchange for sex to lure the youth into their service (Albanese, 2007; Estes & Weiner, 2001).

After victims have been recruited, traffickers and pimps maintain complete control over them through violence and by impairing their sense of identity, keeping them too physically and emotionally compromised to escape (Stark & Hodgson, 2003). Victims may also be kept submissive through debt bondage (Chacón, 2010; Hodge, 2008; Hopper, 2004; Pope, 2010), controlling all money and identity documents to isolate victims, restricted access to support services (Albanese, 2007), threats of violence toward the victim or family members (O Briain, van den Borne, & Noten, 2006), and forced drug dependency (Albanese, 2007; O Briain et al., 2006). It is also common for sex trafficking victims to experience severe abuse at the hands of their traffickers including being locked in small spaces, denied access to bathrooms and food, sleep deprivation, beatings, and

physical mutilation (Schwecke, 2011). They also frequently experience abuse by the men who purchase them for sex (Stark & Hodgson, 2003). This form of coercive control closely resembles ritualistic torture (Herman, 2003; O Briain et al., 2006; Schwecke, 2011).

Approximately 1% of all victims are estimated to be successful in escaping their traffickers or being rescued (Bales & Soodalter, 2009). However, escape or rescue does not necessarily lead to freedom for victims who must then face many additional challenges. During their attempts to escape, victims encounter a lack of supportive services, social ignorance, and lack of legal protection. Foreign trafficking victims face additional challenges in that they often end up being held in immigration detention centers without access to medical and psychological care or legal aid (U.S. Department of State, 2010). Also, it is common for victims to be arrested and put in jail on drug or prostitution charges. Because it may be cheaper for a trafficker to acquire a new victim than to pay the bail, victims often remain incarcerated and are not given the help they need (Operation Broken Silence, 2011). Once trafficked individuals are able to escape from their captors, there are few supports in place to provide the necessary help to address their complex needs. In addition, victims commonly feel abused by the social systems that should help them. These experiences perpetuate a common mindset of distrust that continues after victims are in a physically safe environment (Herman, 2003).

Aftercare for trafficking survivors encompasses all of the services survivors may require for rehabilitation and developing the skills they need to successfully reintegrate into society. By the time individuals who have been trafficked find a way out, they have often experienced repetitive physical, psychological, and sexual traumas, the effects of

which can create barriers to accessing the aftercare services they need. One of the first concerns in providing services for victims who have escaped is identifying and addressing the many potential needs a victim could have. The goal of aftercare treatment is to address survivors' complex needs in order to help them recover and reintegrate into society with the skills they need to be financially self sustaining and able to access the resources they need to lead the life they hope for. Even though there is a growing number of people and programs providing some form of aftercare services to victims throughout the United States (Project, 2013), there is a paucity of research assessing the services being offered and the efficacy of those services for survivors of sex trafficking. This study attempted to address this deficit in the research by documenting the range of treatment needs experienced by trafficking survivors and describing the services currently provided across aftercare programs.

Survivors' Needs in Aftercare

Defining the potential needs of survivors of sex trafficking is challenging, and necessitates borrowing from areas of research with individuals whose experiences are similar to aspects of the overall experience of being trafficked (e.g., complex PTSD, torture, child sexual abuse, child neglect, prostitution). There are many organizations dedicated to developing and delivering effective aftercare services, including End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT International; Delaney & Cotterill, 2005). ECPAT International is an international organization dedicated to the fight against the commercial sexual exploitation of children (CSEC). In a rehabilitation training manual ECPAT International published, based on their work with trafficking survivors and the work of other

organizations, they identified the needs of CSEC victims as health, education, psychological services, environment, and social skills with further needs in the vocational and political realms. More specifically, survivors enter programs with immediate physical needs for housing, food, clothing, transportation, safety and security. Healthcare issues resulting from their enslavement also often require immediate response. They include medical and dental assessment and care, and possible addiction treatment, as well as nutrition education and training.

In addition to physical and healthcare needs, it is likely that survivors will have numerous psychological needs. The compounding impact of prolonged traumatic exposure to multiple or constant traumas is best described in the literature on complex posttraumatic stress disorder (CPTSD; Courtois, 2008; Sar, 2011; Schwecke, 2011). The threat to the psychological self and a person's developing identity often leads to problems in individuals' cognitive functioning, in their personality, and in social interactions (Herman, 2003), and may also lead to dissociative disorders (Schwartz, 2000). It is also common for the way survivors make meaning out of their world to become distorted, leading to hopelessness around their ability find someone who can understand them and their belief in their ability to recover (Courtois, 2008). Assessment, counseling, education, a supportive community and emotional safety are all important aspects of beginning to understand and address survivors' psychological needs (Baldwin, 2003; Hedin & Månsson, 2003).

Survivors may also need legal and political support including: human rights education, legal assistance, immigration services, and partners in social and political advocacy (Goodman et al., 2004; Ratts & Hutchins, 2009; Toporek & Williams, 2006).

Because survivors escape from their traffickers without basic resources, it is common for them to qualify for government assistance services through Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF; Baldwin, 2003), but they may need legal counseling regarding their rights and guidance on how to navigate the process to access these services. International survivors qualify for a T-visa through the Trafficking Victims Protection Act (TVPA), giving them legal status, which allows them to remain in the United States for up to four years while their traffickers are being prosecuted (U.S. Department of State, 2010). However, international survivors may not qualify for support services these if they do not help in the prosecution of their captors.

Another difficulty that can emerge from being prostituted is the profound effects it can have on sexuality (Chu & Bowman, 2002). In addition to potentially needing treatment for sexually transmitted infections and physical sexual trauma, survivors may have trouble understanding safe sexual intimacy, and have distorted sexual desire and arousal (Schwartz & Galperin, 2002). It is common for survivors to experience feelings of hypersexuality and exhibit compulsive sexual behaviors, as well as hyposexuality (problems with sexual desire or arousal), or both at different times. They may require counseling to reduce dissociative potential and increase skills for experiencing intimacy and making healthy sexual decisions (Schwartz & Galperin, 2002). Survivors may benefit from sexual health education and addressing physical and emotional sexual healing. Due to their trauma histories, survivors of trafficking may have difficulty trusting or being intimate with others. It is possible that survivors have not developed the skills to trust people or be emotionally vulnerable, therefore, social skills training may also be beneficial in the sexual recovery process (Courtois, 2008).

It is specified in both federal and international definitions of sex trafficking that any prostituted youth is considered a victim of sex trafficking, regardless of the use of force, fraud, or coercion. This is an important distinction since the average age of first victimization in prostitution in the U.S. is 12 to 14 for girls and 11 to 13 for boys and transgender youth (U.S. Department of Justice, 2011). With such young victims, many survivors do not have the chance to complete formal education. Therefore, basic skills like literacy training, and possibly more formal education may be needed depending on the survivors' individual levels of educational and emotional readiness and their motivation for meeting educational goals. The important thing in the educational and vocational aspect of aftercare is to help survivors toward vocational training and career preparedness as a means of generating a sustainable income that will protect them from returning to prostitution (Delaney & Cotterill, 2005).

Finally, because victims are from every race and culture, survivors may also need additional services including language and cultural translation to improve communication and relationships with helping professionals and culturally based models of healing to better approach their unique needs for healing (Williamson, Dutch, & Clawson, 2010). Being sensitive to individuals' cultures may also include providing support for individual spiritual questions and concerns. Although the existence of the aforementioned physical, psychological, sexual, legal, educational, vocational, and cultural needs is highly likely based on other trauma literature, research has not specifically identified the comprehensive needs to be addressed in aftercare or how various aftercare programs are currently addressing these needs. There is some literature on several of these areas separately, like Zimmerman et al.'s (2003, 2006, 2008) work in identifying the physical

health problems of survivors, but none looking at the more holistic picture. The current study addressed this deficit.

Existing Aftercare Programs

Comprehensive aftercare for survivors of sex trafficking that attends to the scope of possible problems requires the involvement of diverse professions and disciplines working at the individual level with survivors. Existing aftercare programs range from organizations that offer multi-focused holistic treatment to survivors, to organizations that occasionally offer care to trafficking victims as well as to clients who were not trafficked, to organizations that are strictly focused on the care of victims through advocacy and awareness. Holistic programs are those that provide a complete range of services such as psychological counseling, physical health services, legal assistance, guidance in addressing educational needs, vocational counseling, and services to help survivors re-integrate into the community. Programs like the Girls Educational and Mentoring Services (GEMS, www.gems-girls.org) in New York and Hope House (www.hopehousenc.com) in North Carolina are good examples of organizations that recognize the complex needs of survivors and share an awareness of the factors that help sustain sexual exploitation such as poverty, racism, and domestic violence.

Some programs (e.g., the Polaris Project, www.polarisproject.org, and Shared Hope International, http://www.sharedhope.org) can connect victims with services, but are focused on the social and legal aspects of aid. Such programs may collaborate with the U.S. Department of State's Office to Monitor and Combat Trafficking in Persons (http://www.state.gov/j/tip/rls/tiprpt), which is primarily concerned with holding nations accountable to combat trafficking in persons through legal and political advances. While

these agencies are very different from the holistic care idea, they are still a very important part of aftercare. Abolition International (www.abolitioninternational.org) is a program that works mainly to help other programs in their approach to aftercare. They are primarily concerned with what happens in aftercare and are working on an accreditation process to align programs with each other under a specific standard of care.

The number of disparate programs working on aftercare for survivors created a need for a formal examination of who is being served in these programs, what needs clients have, and how those needs are being addressed across programs. The findings of this study lay a foundation for improving the types and quality of services available to survivors in the future. This study collected information to increase understanding of what the field of aftercare looks like, and identified commonalities in how programs address the various needs of survivors. Information from this study can be used to highlight areas for continued growth within the field and look for evidence-supported approaches that effectively address the complex needs of survivors.

Research Question

The purpose of this study was to investigate the current state of aftercare programs for survivors of sex trafficking in the United States. It is a descriptive study with three main foci: 1) what different aftercare programs report as the needs of the survivors with whom they work, 2) how programs are addressing reported needs (e.g., evidence based approaches, combinations of physical and mental health treatments), and 3) program perceptions of efficacy and resources seen as necessary to provide effective services.

Chapter 2: Literature Review

The limited information regarding existing aftercare services for victims of sex trafficking makes it difficult to determine their presenting needs and identify which services they should receive. This need for more information provides the justification for examining the current services offered by aftercare organizations. This chapter reviewed the limited existing literature on aftercare for survivors of sex trafficking and the literature on the identified needs of survivors. A vast majority of sex trafficking victims are female, and the limited literature is also focused on women and children. While there are men who are trafficked for sexual purposes, this literature review focused on women and girls due to the absence of information on male victims. Since there is a dearth of scholarly writing specific to trafficking survivors, literature addressing the needs and responses of survivors of other types of trauma was also reviewed. This includes literature on complex trauma, legal assistance, providing physical care and health education, sexual recovery, and working with diverse cultural and international individuals. Emphasis was placed on how each of these literatures could relate to aftercare for trafficking survivors. Finally the information from all of these sources was summarized to aid in explaining the need for professionals across disciplines to understand the three emphases of the current study: victim needs, program response, and perceived efficacy of program responses.

What is Aftercare?

The United States Trafficking Victims Protection Reauthorization Act (TVPRA) of 2003 initiated the collection of data on global law enforcement related to human trafficking. The TVPRA required foreign governments to provide the U.S. department of

State with data on the prosecutions, convictions, sentences, and new or amended legislation in their countries (U.S. Department of State, 2005). The data collected in 2012 showed that of the 7,705 traffickers prosecuted, convictions were obtained for 4,746 cases. That is a 61.6% conviction rate, which is up from the 44% conviction rate nearly a decade ago in 2004. However, it is still low, especially when considering the additional cases that involved arrests and investigations, but were never prosecuted due to poor laws or limited protection for victims who filed complaints (U.S. Department of State, 2013). These convictions represent justice for only some of the 46,570 victims identified in 2012. Unfortunately, no data has been collected on what happens to all of these victims once they are identified. Are they offered services? What kinds of services are they directed toward? Are the services accessible to victims regardless of where they reside? Are victims offered legal protection? Are they informed of their rights? The TVPRA is concerned with collecting information on law enforcement of the cases of identified victims, not the aftercare for the victims.

For the purposes of this study, aftercare refers to the services provided to survivors of human sex trafficking once they have escaped from their traffickers. It can include many different types of services and may look very different among organizations, based on the resources they have available to them. The term is purposefully ambiguous since there is not enough research to construct an operational definition that would clearly capture all the components of aftercare. Once more is known about the services programs are providing to survivors of trafficking, it might be possible to develop a definition.

Aftercare programs range from holistic treatment programs designed specifically for trafficking survivors, to homeless or domestic violence shelters that occasionally work with someone who has been trafficked. They also include programs that are focused on the social and political aspects of trafficking. The current study was primarily concerned with the individual care of survivors. To give an idea of how many aftercare sources there are, Polaris Project claims to have a referral base of over 3,000 professionals and organizations in the U.S. who work with trafficking victims; however, even though they offer referrals in every state, their referral base is not solely in the U.S., and is not restricted to direct aftercare service providers. In addition to service providers, the database includes law enforcement and government officials, as well as those working to combat human trafficking (task forces, coalitions, and collaborative initiatives, etc.). It is unclear how many of the 3,000 provide supportive resources to survivors in need of care. Abolition International's aspiration to accredit programs and open up a collaborative relationship among programs has connected programs around the world to work toward a better model of aftercare. However, even though some programs have joined the care network, there are still many that are not connected to an organizing body, leaving a hole in our understanding of what services are being provided in the whole field.

Based on the current literature and what is known about people who survive the experience of enslavement, aftercare should involve several different components and should be as comprehensive as the complexity of survivors' needs (Herman, 1997). Providing for immediate needs like safety, food, and shelter is important, especially in the early stages of trying to build trust with individuals who cannot trust anyone's "help"

(Herman, 2003). Immediately providing physical assessment and care is also crucial considering the high rates of abuse and illness often endured (Schwecke, 2011; Stark & Hodgson, 2003). Psychological services are essential to help survivors learn to cope with the possible complex trauma and rebuild their sense of who they are. Legal education and assistance are needed to first help survivors establish a legal identity and then to inform them of their rights and empower them with the skills to advocate for those rights. Guiding survivors in identifying assistance programs they may qualify for, such as food stamps or Supplemental Security Income (SSI), could be an important step in their building a sustainable life while recovering (Baldwin, 2003). Sexual recovery is another important component of aftercare to help survivors begin to re-learn the concept of intimacy within the context of a safe and supportive environment (Chu & Bowman, 2002).

The first National Colloquium on Shelter and Services Evaluation for Action was held in November, 2012 as a collaborative effort between Shared Hope International, ECPAT-USA, and The Protection Project at Johns Hopkins University School of Advanced International Studies. The goal of the colloquium was to bring together experts in the field of domestic minor sex trafficking (DMST) services to share their experiences of providing services to DMST victims, and discuss their successes and the challenges they have encountered. Three surveys were administered to providers, survivors, and funders prior to the colloquium to inform discussion and recommendations. Similar to the current study, the goal of the surveys was to get an idea of what current service provision actually looks like.

A report was published following the colloquium including recommendations for the field. Even though their focus was on services for minors, many of their recommendations are applicable to survivors of all ages. The report focused specifically on placement and services, licensing, funding, therapeutic response, and safety and security. While the report does summarize some of the results of the survey they administered, it is primarily focused on the colloquium discussion describing necessary steps in each of the surveyed areas. For example, in the section on placement and services, it outlined the various types of placements (shelter, juvenile detention, long-term care, congregate care, foster care, and community-based care) and presented information to help people make appropriate placement decisions for youth.

One of the most notable things that came out of the colloquium discussion was the caution against applying uniform treatment for all survivors (Shared Hope International, 2013). As we examine available services in this study, and think forward to furthering the research and establishing best practices, it is important to keep in mind that best practice needs to include flexibility. Trafficking survivors have had their choices and control taken from them by their traffickers, so attempting to help them by providing a rigid set of services continues their lack of choice and control. With this population specifically, each approach to treatment does need to be flexible and individualized.

The Experience of Being Trafficked

The literature is clear on the traumatic effect trafficking has on the victim. Being bought and sold as a commodity, often along the same trade routes as guns and illicit drugs, and being abused over a significant period of time can have extremely negative effects on one's sense of self (Courtois, 2008; Farley, 2004; Herman, 2003). Often when

survivors present for services, the clinicians who are there to help them don't have a strong understanding of the terror that prostituted women and children endure, and the process of systematic brainwashing they undergo (Farley, 2003).

Traffickers use several mechanisms of control to keep victims compliant. Debt bondage is a common mechanism of control over foreign victims, where the victim is transported at the expense of the trafficker with an agreement that the cost will be repaid from future earnings. However, traffickers constantly add fees for housing, food, and medical care, making it impossible to ever pay off the debt (Chacón, 2010; Hodge, 2008; Hopper, 2004; Pope, 2010). Traffickers maintain control of identity documents, money, and any other physical means of escape. Similar to what is observed in relationships involving intimate partner violence, victims are kept isolated from anyone who may be able to recognize what is happening or provide assistance (Stark & Hodgson, 2003).

Traffickers will often use more direct mechanisms to insure compliance such as threatening to report victims to the authorities (police, immigration), threatening to tell their families what they have done or threatening to send exploitive photographs or videos to their families, using violence or threats of violence, and threatening violence towards members of their family (O Briain et al., 2006). Human sex trafficking victims often experience a similar level of abuse at the hands of their traffickers as ritual abuse-torture victims, meaning they may be locked in small spaces; denied access to bathrooms; and experience beatings, food or sleep deprivation, and physical mutilation (Herman, 2003; O Briain et al., 2006; Schwecke, 2011). Trafficking victims live in constant terror, and are often mistreated by clients as well as traffickers. "Terror gets the job done; it makes her controllable" (Farley, 2003, p. *xiv*). Even with the level of compliance gained

through torture, traffickers often also force drug dependency on victims so that they are even easier to control and are willing to do more for the trafficker in exchange for more drugs. This further complicates the relationship between traffickers and victims by increasing victim dependence on those who exploit them (Albanese, 2007; O Briain et al., 2006).

It is not uncommon for victims to be arrested for crimes committed as a result of their status as sex trafficking victims, such as prostitution, drug trafficking, and immigration related offenses. Unfortunately, victims are often subject to further abuses while detained (Ugarte, Zarate, & Farley, 2003), and it is common for victims to return to their traffickers and the resulting abuse once they are released. This is a similar phenomenon to Stockholm Syndrome (Graham, Rawlings, & Rigsby, 1994) where individuals held in captivity develop positive feelings toward their imprisoners and negative feelings toward police and other supportive authorities (de Fabrique, Van Hasselt, Vecchi, & Romano, 2007). Additionally, people who have been trafficked often feel a sense of shame in returning home or may experience being unwanted at home. Runaway or throwaway youth may not even feel like they have a home to return to if they wanted to. Returning to their traffickers or a life of prostitution is common when it feels like their traffickers are the only people who will accept them.

Potential Effects of Being Trafficked

With so little published data on survivors of human sex trafficking, it is important to integrate research from various related fields of literature to gain an understanding of how the experience of being trafficked could impact a person. From the little that has been published, we know that being trafficked results in psychological trauma

(Schwecke, 2011), physical and sexual problems (Zimmerman et al., 2003), legal problems (U.S. Department of State, 2010), educational and vocational deficits (Rafferty, 2008) and spiritual problems (Herman, 1997). While there hasn't been research done directly with trafficking survivors in all of these areas, the current research with other traumatized populations can still provide insight into the lives of survivors.

Psychological trauma. "Human-engineered traumatic experiences increase the likelihood, severity, and duration of posttraumatic stress disorder (PTSD) more than do other kinds of traumatic events" (Ein-Dor, Doron, Solomon, Mikulincer, & Shaver, 2010, p. 317). Being trafficked involves multiple levels of human-engineered trauma over a period of time, perpetrated by many different people, and it is expanding our understanding of traumatic disorders (Herman, 2003). A way to conceptualize the common psychological reactions to being a victim of trafficking for sexual purposes is through the literature on what is now being termed complex posttraumatic stress disorder (CPTSD). CPTSD was not listed in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), but the criteria for understanding PTSD can help to define a baseline of symptoms. CPTSD encompasses many of the same symptoms as PTSD, but develops through experiencing prolonged exposure to multiple or constant traumas, where PTSD is thought to better explain the symptoms that can manifest after a single traumatic incident. Although CPTSD was not included in the DSM-5, the literature on the subject is still valid and offers a better means to understand the possible post-trafficking symptoms of survivors (Sar, 2011).

The challenges that survivors of trafficking are faced with are unique and can have a substantial impact on their long term and daily functioning. The three significant problem areas of CPTSD as outlined by Courtois (2008) include an altered sense of self, difficulties in relationships with others, and distorted views of the world and how a survivor makes meaning of information. An altered sense of self includes things like the negative self-perception and lessons of being dehumanized that have been integrated into a survivor's sense of self, leading to a diminished sense of self worth. The problem of difficulties in relationships covers survivors' inability to trust or be intimate with others. Since the average age of first victimization in prostitution is so young, it is possible that survivors did not develop the skills to trust people or be emotionally vulnerable since many of them missed out on a key period in their social development. It is also possible that victims from prior negative home environments were not able to form secure early attachments with their caregivers, further altering their ability to form trusting relationships with safe people. A distorted ability to make meaning of information encompasses survivors' hopelessness around their ability to recover and in finding someone who can understand them (Courtois, 2008).

When working with survivors who have experienced such extreme levels of trauma, having a trauma-informed perspective of care is very important (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Harris & Fallot, 2001). Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one therapeutic model that has strong empirical support for working with trauma survivors across age (especially children and adolescents) and cultural groups. It incorporates elements from cognitive-behavioral, humanistic, empowerment, attachment, and family theories of trauma processing. It involves skill

building, family communication, parenting skills, and establishing safety (Cohen, Mannarino, & Deblinger, 2006). TF-CBT focuses on the whole individual by addressing complex biopsychosocial needs in the context of the supports around the individual. It has been researched and tailored to work with many diverse U.S. populations as well as internationally. Several randomized controlled trials showed positive results that maintained over time for youth who have experienced multiple traumas (Cohen, Deblinger, Mannarino, & Steer, 2004). Even working outside of the specific structure of TF-CBT, having a perspective of looking at the individual while recognizing how their traumatic experiences are impacting them can empower survivors in their recovery process (Zimmerman & Borland, 2009).

In the *Evidence-Based Mental Health Treatment for Victims of Human Trafficking* guidelines published by the U.S. Department of Health and Human Services in 2010 (Williamson et al., 2010), there is an acknowledgement that the psychological needs of trafficking survivors extend beyond PTSD. The report summarizes the literature on mental health challenges for survivors who commonly suffer from other mood and anxiety disorders, dissociative disorders, and substance related disorders. The presence of internalizing problems is clear in the literature (Clawson, Dutch, & Williamson, 2008; Zimmerman et al., 2003; Zimmerman et al., 2006). In fact, Zimmerman et al. (2006) were quoted in a summary of their work outlining the multiple needs of survivors saying, "Women's psychological reactions were multiple and severe, and compare to, or exceed symptoms experienced by torture victims" (p. 15). They found anxiety, depression, hostility, and PTSD to be the most enduring symptoms.

Sexual recovery and health. Zimmerman et al. (2003) noted in their research with trafficking survivors that commonly, "Sexual abuse and non-consensual sex acts included vaginal rape, forced anal or oral sex, forced unprotected sex, gang rape, sex without lubricants, sex during menstruation, and sex accompanied by violent or degrading rituals" (p. 47). Forced sexual encounters such as these are key components of sex trafficking, and addressing their occurrence should be an important aspect of aftercare services. From the early moments a trafficking perpetrator captures a victim, repeated rape is often used to wear the victim down to a point where they "concede" or "consent" to involvement in sex work (Zimmerman et al., 2003). Because of the violence and lack of protection surrounding sexual acts with victims, gynecological problems are some of the most commonly reported health problems of exiting victims (Zimmerman et al., 2003). It is important to note an untrue assumption, that regardless of age, being sexually "experienced," does not mean survivors are necessarily knowledgeable about STI's and pregnancy prevention (Ugarte et al., 2003), nor do they have experience with healthy sexual relationships.

In her book, *Trauma and Recovery*, Herman wrote about the effect of prolonged trauma on all aspects of functioning; physical, emotional, social (Herman, 1997). In the case of victims of severe sexual abuse such as survivors of sex trafficking, there is also an intimacy and sexual component of the trauma (Herman, 2003). One may also assume there may be confusion about sexual identity and sexual preferences. While sexual trauma seems to be an obvious aspect of survivors' experiences, there is not much in the literature that discusses survivors' needs in sexual recovery or intimate relationship problems.

In a study looking mainly at the safe sex practices of prostitutes in their private relationships, Warr and Pyett (1999) explained some of the challenges of maintaining intimate relationships while working as a prostitute, including not wanting to have a relationship at all, partners being upset, or romanticized ideals of relationships characterized by lies and resentment. Additionally, the women in this study were less likely to use safe sex practices in private relationships, putting themselves at a greater risk for STI's.

Herman (1997) noted that in recovery, survivors must recreate their abilities to trust, experience intimacy, gain autonomy and express a true identity, all of which were damaged by their traumatic experiences. All of these abilities are important for healthy, supportive sexual relationships. The experience of being trafficked is disempowering and void of real connections with others; therefore, the recovery process requires empowerment in the context of safe and supportive non-sexual relationships (Herman, 1997). Because sex is such a predominant component of survivors' traumatic experiences, it should also be a focus of comprehensive aftercare.

Legal considerations. Since 2000, combating human trafficking has received the attention of the United Nations (UN) as well as the governments of most countries. The initial considerations of governments were mostly concentrated on prosecuting perpetrators and on preventing further trafficking. In 2000, the United Nations General Assembly adopted the *Protocol to Prevent, Suppress and Punish Trafficking In Persons, Especially Women and Children* (2000a), otherwise known as the Palermo Protocol, as a part of the United Nations Convention against Transnational Organized Crime. The

protocol urges governments to respond to the problem, focusing on prevention, protecting victims, and prosecuting criminals.

That same year, the U.S. passed the Trafficking Victims Protection Act (TVPA) in response to the UN adopting the Palermo Protocol. The Palermo Protocol urged each nation to structure a response including the "3P" paradigm: prosecution, protection, and prevention programs. The TVPA added a fourth "P": Partnership, to draw attention to the need for collaborative efforts from experts associated with many different entities including government and non-government organizations and individuals from different fields. While the Palermo Protocol and the TVPA are concerned with protection, aftercare of identified victims was not an initial consideration. Since the beginning of the TVPA, the U.S. Department of State has published a yearly Trafficking in Persons (TIP) report based on information collected from embassies, government officials, and NGOs. Research trips are done to every region to assess global trafficking and what governments are doing to reduce trafficking in their countries (U.S. Department of State, 2010).

Unfortunately, what seems to have been a more common response by governments as they have been developing a response to human trafficking is what the U.S. Department of State termed the "3D" phenomenon: detention, deportation, and disempowerment. This response to victims is a product of immigration laws overshadowing a victim's potential to be seen as a victim rather than a person without a legal right to be in the country they are in. This makes governments susceptible to criminalizing victims instead of rehabilitating them (Chacón, 2010; Chuang, 2010; U.S. Department of State, 2010). These practices contribute to the fact that 62 countries had not achieved a single trafficking conviction in accordance with the Palermo Protocol by

2011, and the lack of convictions is not due to an absence of trafficking in those countries (U.S. Department of State, 2011).

Survivors in many countries are not often informed about their rights. Instead of being directed toward needed services, they are often detained in shelters or put in jail for violations committed as a result of being trafficked, such as possession or sale of drugs or prostitution (U.S. Department of State, 2010). Not having U.S. citizenship or valid documentation causes additional legal issues for foreign trafficking victims because of discrimination against immigrants in the legal and political systems (Chacón, 2010; Gallagher, 2009). Foreign trafficking victims often end up being locked up in immigration detention centers and denied needed medical or psychological care or legal aid, especially where officers are not trained to identify victims from other detainees (U.S. Department of State, 2010). It can be especially difficult for these victims to communicate the severity of their situations when there is not only a language barrier, but they have also been trained by their traffickers to fear anyone who could potentially help them. To prevent victims from accessing legal services, traffickers often tell stories of the ways that people are abused within the legal or law enforcement systems in the U.S. to make the victim's situation with the trafficker seem like the better option and to reduce the likelihood of escape (Bales & Soodalter, 2009).

A decade after the Palermo Protocol was adopted, the U.S. Department of State's *Trafficking in Persons Report, 2010* described a flaw, saying:

> It is not enough to prosecute traffickers if we do not also provide assistance to the survivors and work to ensure that no one else is victimized. No country has yet attained a truly comprehensive response to this massive, ever increasing, ever changing crime. (p. 6)

The need for aftercare services to provide assistance for victims is finally becoming a consideration in the global response to the bigger picture of human trafficking. Some states now even have laws that enable victims to petition the court to expunge prostitution-related convictions from their record if they resulted from human trafficking (U.S. Department of State, 2013)

Melissa Farley, founder of the organization *Prostitution Research & Education,* recounted the experiences of a U.S. physician she came into contact with who provided medical care to migrant workers in camps in San Diego, CA. The doctor encountered as many as 35 men paying to rape 9- and 10-year-old girls in a single hour, yet when she reported the abuse, she was told by U.S. public health officials that prostitution is not a migrant health concern and she was restricted to working with the pimps and doing what she could to prevent HIV and other STDs (Farley, 2004). This account shows the challenges that aiding victims can pose, and how there are other factors like discrimination and social stigma that can be barriers to providing help, even for children. While victim services are now being considered as a necessary part of the response to human trafficking, it is still a challenge to make services available.

While much of the legal literature is focused on legal protection of victims and the process of prosecuting perpetrators, survivors also have other immediate legal needs that have not been thoroughly discussed in the literature. Since control of documents is one

form of maintaining control, if victims had any identity documents when they were initially victimized, they may not have them when they escape. It is also possible that survivors never had any identity documentation if they were victimized when very young and did not have access to their birth certificate or social security card. An important first step in advocating for survivors and helping them begin a new life is through connecting them with needed support services, but before survivors can be helped through the process of applying for social services (SSI, TANF, etc.), they need assistance in establishing a legal identity.

Legal considerations and delivery of services can be more complex for youth. Of the prostituted youth in the U.S., the average age is 15.5, but the average age of first victimization is younger; 12 to 14 for girls and 11 to 13 for boys and transgender youth (Klain, 1999; U.S Department of Justice, 2011). Many of these children have experienced neglect, run away from difficult home situations, do not possess the skills to survive alone, and may have significant attachment problems already. Turning to sex and prostitution can seem like their only option. The United Nations Children's Fund (UNICEF) added Article 34 to the Convention on the Rights of the Child (United Nations General Assembly, 2000b) in 2000, which pledged, "(to) protect the child from all forms of sexual exploitation and sexual abuse" (p. 10). The international community is attempting to take a stand against the trafficking or commercial sexual exploitation of children, and is enacting laws to increase the protection of children. Evidence of legal protection for minors is seen in the safe-harbor laws passed by some U.S. states to provide prostituted children with the services they need instead of prosecuting them for prostitution (U.S. Department of State, 2013). However, the problem is still increasing

with an estimated 1.2 to 2 million children exploited at any given time (United Nations Children's Fund, 2007; U.S. Department of State, 2010).

This brings up another important legal consideration for aftercare facilities, that un-emancipated minors need parental consent to receive services, but many have left unsafe homes or do not have caretakers. How do these adolescents receive the services they need? Treating youth raises concerns for many social service agencies. Who is responsible for them? Do residential aftercare programs have the proper certifications to take in children? Are local and state policies properly protecting young survivors of trafficking? Should they be put into the foster care system? Are foster care parents equipped to handle the unique needs of trafficked youth? There are numerous questions to answer and work through for aftercare facilities working with youth. The *National Colloquium Report* (Shared Hope International, 2013) shows promise for beginning to answer these and other questions about the unique needs of DMST survivors.

Schooling and vocational needs. Another aspect of survivors' lives affected by being trafficked is the area of life skills development, educational attainment, and vocational readiness. Addressing these aspects of the survivors' lives will increase their chances for obtaining gainful employment and a self-sustaining life with a lower risk of revictimization (Delaney & Cotterill, 2005). This process can be a great challenge, because not only have many survivors been unable to develop career interests and goals, they may not know of their options and skills beyond prostitution (Rafferty, 2008). There has, unfortunately, not been any research published on specific vocational concerns or vocational interventions with trafficking survivors, or how to best prepare them to enter the world of work. Many resources to help inform aftercare services for survivors list

educational and vocational training as an integral part of any comprehensive approach to treatment (Delaney & Cotterill, 2005; Herman, 2003; O Briain et al., 2006; Rafferty, 2008), but none of them offer specific guidelines for how to intervene.

Trafficking survivors face many issues that could be barriers to gainful employment, complicating any possible career related interventions aimed at preparing them to enter the workforce. It is common for survivors to have criminal histories because of the criminal nature of prostitution and the lack of legal protection for victims, as well as the high incidence of forced drug dependence and drug related offenses (Chacón, 2010; Chuang, 2010; U.S. Department of State, 2010). Having either a criminal history or a substance dependence history makes job attainment more of a challenge (Vargese, Hardin, Baur, & Morgan, 2010). Coming from a family background of poverty is another common theme among survivors, both domestic and those who have been trafficked from abroad. One of the most common recruitment tactics used by traffickers is through the promise of financial security and a way out of poverty (Gjermeni et al., 2008; Hodge, 2008; Mbecke, 2010).

Poverty is an issue that impacts job attainment on a personal as well as a societal level and is difficult to overcome for anyone looking for work (Wilson, 1996), let alone someone with other compounding barriers. Individuals living in poverty are often surrounded by many other impoverished people, which can make their outlook on finding work bleaker, their apathy about trying to look for work stronger, and their negative evaluation of their own self-efficacy more prominent (Wilson, 1996). Having a history of these negative thoughts only adds to the already extreme situation that many survivors are in and makes them less likely to explore the opportunities they may have available to

them. There is also a stigma held by employers, where individuals in poverty are seen as lacking work ethic and necessary skills (Wilson, 1996).

Limited education, literacy, and English language skills are also barriers to obtaining a job and are common deficits among survivors, especially those from other countries (Baldwin, 2003; Delaney & Cotterill, 2005; United Nations Office on Drugs and Crime, 2008). Finally, simply having inadequate vocational skills and employable life-skills (e.g., resume building, interviewing, dressing for an interview) contribute to survivors' difficulty in obtaining employment (Delaney & Cotterill, 2005; Herman, 2003; O Briain et al., 2006; Rafferty, 2008). When all of these barriers co-occur, the survivor can feel hopeless about this step in reintegrating into society.

Another significant challenge in vocational rehabilitation is that survivors return to prostitution because of feeling worthless, damaged, and like there is nothing left to lose in doing what they know will make them money (O Briain et al., 2006). This suggests that one of the most challenging barriers to equipping survivors for new employment possibilities is their own negative thoughts and fatalistic beliefs about their futures, a trend also seen in female victims of intimate partner violence (Chronister & McWhirter, 2006; Davidson, Nitzel, Duke, Baker, & Boviard, 2012).

Because trafficking victims are targeted at a young age, their ability to complete formal education is diminished (Courtois, 2008), and they have limited access to future educational opportunities that could afford them a chance of economically stable job choices. Offering GED or literacy programs may be a good place to start this aspect of a survivors' recovery, but their ability to engage depends on their level of educational and emotional readiness and motivation. Some survivors may not be ready to take on an

educational program and may benefit more from trade or technical training (Delaney & Cotterill, 2005; O Briain et al., 2006; United Nations Office on Drugs and Crime, 2008).

Another problem caused by the young age of entry into the trafficking industry is that it may complicate the career development process by inhibiting youth from meeting career development milestones. Specifically, being trafficked could result in reduced freedom to be vocationally curious, to develop their orientation to an internal unique self, and to engage in the types of career exploration that other youth have access to (Sharf, 2010). Because they have been denied the support to go through the traditional growth stages, survivors may also lack career adaptability, which is important for conceptualizing themselves in a future career and planning the steps needed to get there. Adaptability is also important to career decision-making (Savickas et al., 2009).

Spiritual needs. The experience of being trafficked takes great toll on all of the areas discussed thus far, however, Herman (1997) adds to our understanding of the impact of trauma by including the additional reality of a spiritual crisis when faced with such violations.

> Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis. (p. 51)

When the trauma involves the inhumane treatment of a person by another human being, not only do the long-term traumatic reactions seem to be much worse (Ein-Dor et al.,

2010), but there is also a greater likelihood that the survivor may develop a loss of faith in humanity as Herman alludes to.

Spiritual beliefs understandably come into question following any traumatic experience, but there is also research that shows positive outcomes related to spiritually supporting beliefs and practices. Involvement in spiritual or religious practices has been linked to reduced symptoms of PTSD (Elliott, 1994) and an increase in posttraumatic growth (Schultz, Tallman, & Altmaier, 2010), a trend that shows up even in childhood (Bryant-Davis et al., 2012). The benefits seen from religious or spiritual involvement often involve a shift in religion, or a greater need to make meaning from spiritual beliefs that are not connected to an organized religion (Walker, Reid, O'Neill, & Brown, 2009). A person's post-trauma spiritual journey can be a very important factor in improving outcomes, but it may require an exploration of other ways to define or understand spirituality than they were accustomed to before the trauma.

It seems that in offering a comprehensive approach to post-trafficking care, spirituality cannot be left out, however, there are some major challenges to meeting the spiritual needs of traumatized clients. Spirituality is a broad and often individually defined construct. Religion is also difficult to define and encompasses many different possibilities for programs to be sensitive to. In addition to the challenge of understanding spirituality and religion, there are not many resources available specifically addressing the spiritual aspects of traumatic experiences, especially when focusing exclusively on survivors of sex trafficking.

While therapeutic settings should be places where a person feels safe to address any challenge, concern or problem, including spirituality and religion, addressing

spiritual or religious concerns might be more of a necessity than an option. The assault on trafficking survivors' pre-existing beliefs about themselves, the world, and any spiritual being adds an additional challenge of existential crisis to the complexity of their presenting problems. Since trauma is disempowering and disconnecting from others, it must be repaired in the context of relationship, and the relationships in the aftercare environment are ideally suited to do so. Unfortunately, even thought it may be therapeutically indicated to discuss the intersection of trauma and spirituality, there seems to be a reticence among counseling professionals to confront the range of possible needs in the area of spiritual or religious development (Zinnbauer & Pargament, 2000).

There are several theories as to how the spiritual healing process can occur; these include attachment therapy and integrated trauma-focused cognitive behavior therapy (TF-CBT). There are also recommendations in the literature for interventions targeting specific components of recovery like forgiveness focused treatment (Schultz et al., 2010) and methods of reconstructing God (Horak, 2006). Thinking in the context of overall trauma recovery, spiritual needs can be addressed through developing a healing relationship and then working through the necessary stages of recovery: (1) establishing a sense of safety, (2) remembering the intricate pieces of the trauma and mourning the many associated losses, and (3) re-establishing connections (Herman, 1997). Through each of these stages, the focus remains on empowering the survivor while he/she approaches the task of re-defining a sense of self, re-learning how to relate with others, and creating a new system for making meaning (Courtois, 2008). From the spiritual perspective, survivors work through these steps to define their understanding of their

personal spirituality, learning to relate to a spiritual or religious community and/or power, and determine how to make meaning of the spiritual aspects of their lives.

For many trauma survivors, especially those who have endured long-term abuses at the hands of others, the first challenge in the trauma/spirit recovery process is to begin to trust people (counselors, family, friends, and other helping professionals) who might be able to help create the sense of safety and hope necessary for further recovery (Boehnlein, 2007; Herman, 1997). In aftercare programs, staff, counselors, and survivor mentors can serve as attachment figures, recreating the role of the secure base needed in early childhood to promote exploration and the development of self-identity. After a trauma has broken down the sense of self, these individuals can provide a safe place while the survivor reconstructs the connections and meaning that were damaged through the trauma (Boehnlein, 2007; Maltby & Hall, 2012). This theory of a reparative attachment relationship can also be used to approach the potentially disorganized attachment with spiritual beings or a higher power, or to one's spiritual beliefs. As the survivor learns how to securely attach, the possibility of forming a more secure attachment with a higher power or spiritual system is much greater (Maltby & Hall, 2012).

Forgiveness, or releasing negative feelings toward a person who has wronged you, is a challenging concept in the recovery process, especially with such horrific interpersonal trauma as being trafficked. However, forgiveness may relate closely with a person's spiritual or religious beliefs and has been associated with other positive outcomes (Schultz et al., 2010). An especially important aspect of forgiveness when working with this population may be self-forgiveness. Self-forgiveness can be beneficial

to address with survivors who have self-condemnation related to their experience of being trafficked. Self-condemnation has been associated with several negative outcomes; so working through a survivor's thoughts on self-forgiveness could be a benefit not only to their spiritual health, but also to their overall wellness (Worthington & Langberg 2012).

It is clear that spirituality is intricately interwoven into the fabric of traumatic reactions. This crisis of faith is just one area of need for trafficking survivors, but it has the ability to influence positive and negative outcomes in other areas of need. Even if the extent of the spiritual crisis is looking for an answer to a question like, "why do bad things happen to good people?" there is no simple approach to addressing the conflict.

Physical health and related issues. Women often escape trafficking with significant physical and medical problems. Several studies of women and adolescent trafficking survivors highlighting the physical consequences of trafficking show direct and indirect physical issues resulting from their experiences. Direct results include: broken bones, contusions, head and neck trauma, and loss of consciousness as a direct result of abuse or escape injury (Zimmerman et al., 2003). Zimmerman et al. (2008) reported that 95% of surveyed women and girls experienced abuse while being trafficked. Other direct physical implications include dermatological problems like rashes, scabies, and lice resulting from deplorable living conditions, and other diseases with higher prevalence in impoverished areas such as tuberculosis (Ugarte et al., 2003).

Young women are often paid more for not using a condom, or are not given a choice to do so, which increases the prevalence of sexually transmitted infections (STIs) and unwanted pregnancies (Ugarte et al., 2003). Women also frequently must endure the

pain of complications associated with abortions, which are often forced on them and paid for by traffickers who then add the cost of the procedure to the woman's debt (Hyland, 2001). The most commonly reported physical symptoms associated with being trafficked include: headaches, tiring easily, having dizzy spells, back pain, memory difficulty, stomach pain and pelvic pain, as well as STI's (Zimmerman et al., 2008). Because of high rates of substance use associated with being trafficked, victims also often require drug and alcohol detox or rehabilitation and must suffer the physical pains of dependence and withdrawal and cope with the cognitive deficits that often accompany prolonged substance dependence (Ugarte et al., 2003).

Some indirect implications of being trafficked have been identified as well. These include headaches, high fevers, unhealthy weight loss, and gastro-intestinal problems that are assumed to be the result of the stresses associated with being trafficked and resulting compromises to the immune system. The indirect problems are further compounded by the possibility that abuse, neglect, and extreme physical stress precede trafficking experiences, increasing the probability of negative physical reactions. One study reported that 59% of surveyed survivors had pre-trafficking abuse experiences (Zimmerman et al., 2008).

Proper health care is not always available to victims and they are often denied healthcare while under the control of traffickers. They also may not have knowledge of where to get needed healthcare or have the means to pay for it. Due to the cognitive control factors that traffickers use to increase fear of the outside world and decrease the likelihood of escape, there is a strong potential for victims to be fearful of another "system" like medical personnel. Since many health care facilities are not well trained at

identifying possible trafficking cases, it is common for them to be treated similarly to other individuals who also experience discrimination within the healthcare system (e.g., people who are homeless or substance dependent, racial minorities, immigrants, and people with limited English language skills). Victims may have experienced mistreatment in a healthcare setting and be wary of seeking needed services (United Nations Office on Drugs and Crime; 2008, Zimmerman & Borland, 2009).

Summary

The complexity of developing as a person under such traumatic and disempowering circumstances leads to equally complex problems in many aspects of a person's life. Survivors of human sex trafficking have needs to be addressed through comprehensive aftercare in the areas of complex psychological trauma, physical health and well being, substance use, sexuality, legal problems, spirituality, and schooling and vocational deficiencies. Although the literature on other populations experiencing trauma provides suggestions for likely trafficking survivors' needs, there have not been any previous evaluations confirming the existence of all of these needs appearing together in survivors of human sex trafficking. Nor has there been documentation of how organizations are addressing these needs in the survivors with whom they work.

Chapter 3: Method

The purpose of this study was to develop a comprehensive understanding of how organizations working with survivors of sex trafficking identify and respond to survivors' needs, and to identify areas of strength and needed growth within the field of aftercare. A link to a web-based survey was sent out to organizations identified as providing some form of aftercare treatment to survivors of human sex trafficking in the United States. The only requirement for participation in the study was direct contact with sex trafficking survivors. There was no requirement for the number of services offered specifically to trafficking survivors, or for the means of delivery of services. Prior to data collection, the University's Institutional Review Board approved the study.

Participating Programs

Organizations providing aftercare services to women and girls who have been trafficked or exploited in the commercial sex trade were identified through contacts the primary investigator made in the aftercare field, trafficking resource websites (Freedom Connect, 2008; Polaris Project, 2013), and general web searches as well as recommendations from other programs. Because of the continued growth in the field during data collection, and the limited information available to the public on some organizations, creating an exhaustive list of all organizations in the U.S. was not possible.

Organizations were contacted if they were thought to have any direct contact with survivors. A list of 121 organizations was compiled. Of the 121 programs, nine declined to participate for various reasons including not working directly with survivors, organizational policy prohibiting participation in research, and not having the time to complete the survey. An additional 16 were excluded because they were no longer active or were purely advocacy

based (they did not provide direct service to survivors). Of the remaining 96 programs, 30 completed the full survey and 16 completed partial data. The 46 programs that completed at least partial data were from 19 States, 48% of which were in the western United States (AZ, CA, OR, UT, WA).

Measures

All contacted organizations were asked to complete the Human Sex Trafficking Aftercare Survey (Appendix A), an Internet based survey constructed for the purpose of the study. The survey was designed by the primary investigator and was validated per recommendations of Goodwin and Leech (2003) by sending it to three professionals with expertise in the field to review. The survey was then revised based on feedback received to elicit the most accurate and thorough responses from participating programs. The survey consisted of nine sections including details about the organization, specific information on the seven needs categories (psychological, sexual, substance abuse, legal, education and vocation, spiritual, and physical), and a final optional section for additional comments. Participants could also provide contact information if they so desired.

Prior to requesting information on the specifics of how organizations address survivors' needs, participants were presented with questions about their program or organization including: general services offered, what the program did best in working with trafficking survivors, program goals, location of program (state, type of area), type of program (residential, non-residential, government, or non-government run, non-profit, faith-based), funding sources, types of evaluation/assessment conducted, general demographic information on clients served (age, gender, ethnicity, etc.), admission procedures, and safety/security measures. Questions were also asked concerning staff composition including:

number of staff (full-time, part-time, and volunteer), qualifications necessary for employment, and training of staff (required prior to work and any ongoing training).

To assess responses to survivors' needs, participants were presented with the categories of needs one at a time and asked if they frequently encountered the listed need in the survivors they worked with, and if so, how the need presented. For example, participants were asked "Do you commonly see trafficking victims who have psychological/mental/emotional health problems?" If they responded in the affirmative, they were then asked to check all of the problems they saw (e.g., PTSD, depression, anxiety, suicidal ideation, distrust, eating disorders.). After indicating the concerns that were common in their programs, participants were asked to indicate whether or not the care for that need was a part of their model of care. If participants responded that they did treat the specific need in their program, they were presented with further questions about their approach to treating the need including a rating of how effective they perceived their approach to be. This rating of perceived effectiveness was measured by a 5-point scale, where 1 was "not very effective," 3 was "somewhat effective " and 5 was "highly effective." If participants responded that they did not have a response to the specific need in their model of care, they skipped the detailed questions and were asked if they planned to offer services in the future to treat the need. This process was repeated for each of the seven needs.

Because respondents were not required to complete the survey in one sitting, it is impossible to determine how long the survey actually took to complete. However, the majority of participants completed the survey in under an hour, with a number in the 20 to 45 minute range.

Procedure

After the survey was validated and converted into the interactive web-based format, it was tested for errors and completion times. An initial list of 72 programs was compiled prior to data collection, however through the process of contacting programs and searching their websites, an additional 49 programs were identified. To increase participation, each organization was contacted individually via email and/or phone and asked to complete the internet-based assessment. Organizations reached by phone were sent a follow up email explaining the purpose and importance of the study, formally requesting participation and supplying the link to the survey. For organizations that were not able to be reached by phone, an email was sent either through their website, the general organization email address, or to an individual identified on the program website as the director or a key staff member. Organizations were not able to be reached by phone for several reasons including, no listed number, there was no answer, or it was stated on the program website that email contact was preferred.

Data collection was ongoing from March-June of 2013. After initial contact, programs were sent follow-up or reminder emails every 3-4 weeks. When participants clicked on the link embedded in the email, they were taken directly to the introduction page of the survey on the SurveyGizmo host site. Programs that began, but did not complete the survey, were sent individual edit links to the survey they had already begun. Participants also had the option to stop the survey at any point and have a link emailed to them to complete it later. A statement of thanks followed the formal survey and researcher contact information was provided in case participants had study related questions. Participants had an option to enter their contact information at the conclusion of the survey and to indicate if

they would like to receive the results after the study and formal write up of the results were complete. After participants finished the survey, their responses were stored on the SurveyGizmo server.

There were no direct incentives to participants for filling out the survey other than helping to better understand the state of aftercare for human sex trafficking, and the potential to learn from the experiences of other programs within the field. However, for each completed survey a $2 donation was made to the Polaris Project to fund trafficking rescue efforts for a total of $60. Participants who requested results of the study at the end of the survey or through direct email to the primary investigator, were sent a copy of the final report to use for grant applications and in program materials.

Chapter 4: Results

The goal of this research was to describe the current state of aftercare services available to survivors of human sex trafficking. Descriptive statistics are presented for the programs as well as each area of need that participants were asked to address. Frequencies are presented on how many programs addressed each need and the approaches that programs used to address those areas. Finally, information is presented that describes the individuals who are providing services, and what programs identify as barriers to addressing the needs of their clients. Since this is an area that has not been thoroughly researched in the literature, descriptive analysis is the ideal technique to describe what is currently happening. This information provides a foundation for future inquiry and program expansion within the field.

Responding Programs and Program Availability

A necessary component of understanding how different organizations work with survivors is understanding how survivors learn about and access the organizations and services. An examination of the websites of the 121 sites identified and contacted for the current study indicated that 105 provided direct victim services. Looking at organizations by state revealed that there were 25 states that did not have any direct service organizations contacted by the investigator. To investigate the availability of services in each state, the Polaris Project website's list of organizations and service providers (www.polarisproject.org) was consulted. The Polaris Project had expanded their state organization lists by the close of data collection. There were 231 organizations across the U.S. listed on the site, and New Jersey was the only state without any organizations listed. Taking a closer look at each organization however, revealed that the Polaris

Project site included ‘advocacy only’ organizations and other organizations that did not specifically provide trafficking aftercare, but where victims could possibly access supportive services. Narrowing the list down to providers offering direct services for trafficking survivors reduced it to 106 sites, across 37 states (14 states did not have any direct service options). It would be a great challenge for survivors in the 14 states without services to find the help they need, as it would be for those in states that may only have one or two programs in one city. These numbers make it clear that the response to the problem does not meet the need. Figure 1 shows direct service organizations contacted for this study by state, Figure 2 shows participating programs by state.

Figure 1

Direct Service Organizations Contacted by State

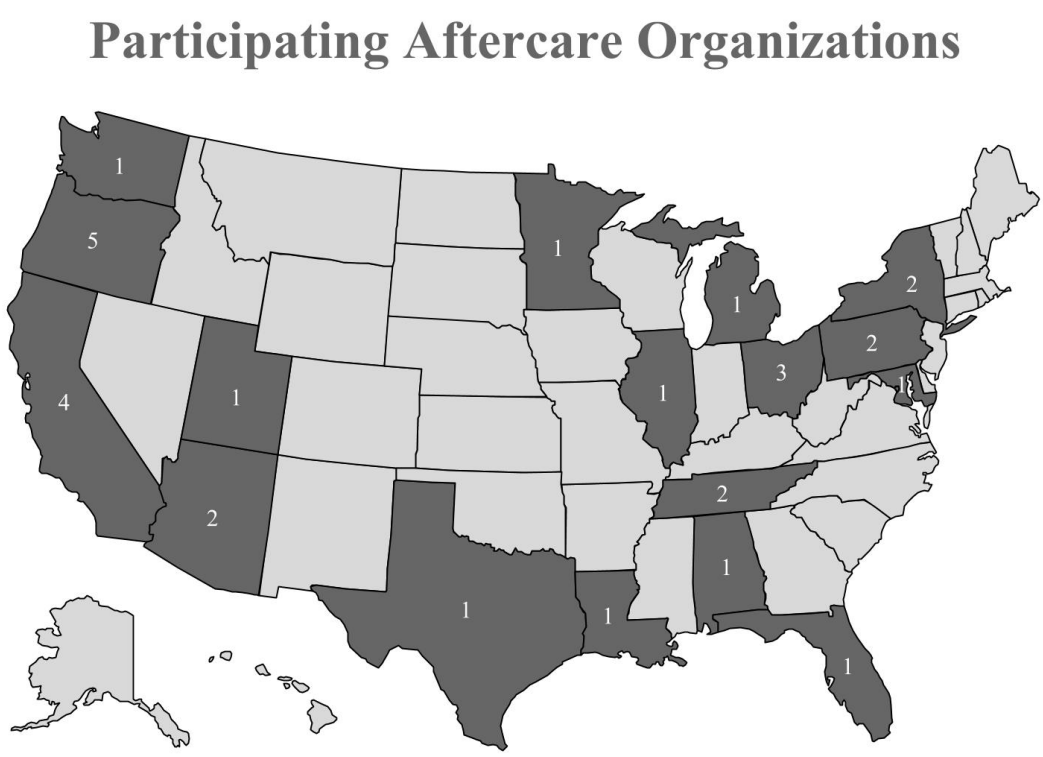

Figure 2

Participating Aftercare Organizations by State

Descriptive Information on Programs, Staff, and Survivors

Program information. Program questions addressed structural and organizational information, like location, type of organization, funding, method of service delivery, services offered, and safety precautions. Because of the newly emerging awareness of the global problem of human sex trafficking, there are many different types of programs that work with survivors. Some programs are non-profit organizations solely dedicated to trafficking survivors, while others are small programs in a larger social service organization, or a part of the federal response to survivor care. This emerging attention to trafficking was evident in the relative newness of the participating programs, as only one third existed prior

to 2009. Since many of the programs (36.7%) only recently began working with survivors, this affected the information on the average length of survivor participation and the number of survivors different programs had worked with.

Of the programs included in this study, 40% classified themselves as faith-based, or having a spiritual focus, and two programs classified themselves as government organizations. All but one program reported being a non-profit organization. Of the various possible sources of funding, two thirds reported receiving grants, 80% received private donations, 20% received some sort of government support, 53% received funds from local partnerships, and 23% received funds from corporate partnerships. One program reported that their trafficking survivor services were funded through discretionary funds from their organization's budget, and five programs reported that their organizations did not receive financial support to specifically fund their work with trafficking survivors.

There are many different ways that programs approach their work with trafficking survivors. Some programs may engage only in outreach to people still being victimized by raising their awareness of resources to help them escape their current situation, while others may offer residential care with an array of services offered in-house or through community partnerships. Nearly 47% of the programs involved in the current study offered residential care, and 43.3% of programs offered some sort of day-treatment program. Outreach services were offered by 43.3% of participating programs, and 53.3% of programs provided community-based services in conjunction with relationships they had developed with trusted community partners.

It is important to know how survivors actually access services, especially because they are scarce. According to the surveyed programs, their referrals for treatment come from a variety of sources. The most common referral sources reported by responders included: community partnerships (anti-trafficking advocacy organizations, and other professionals in the community; 80%), law enforcement (73.3%), other survivors (66.7%), outreach to current victims (56.7%), court mandate (46.7%), or the State Department of Children's Services (30%). Only six programs reported accepting involuntary admits into their programs.

The immediate needs of trafficking victims when they first escape are different than their long-term recovery needs. While the long-term focus may include various interventions across needs areas, immediate needs are things like a change of clothes, a place to sleep, medical assistance, and a safe person to help them through the initial process. Nearly half of all responders reported that their staff is involved in the victim rescue process, 47.4% provide access to a forensic exam at a licensed sexual assault crisis center, and 53.3% have emergency housing available.

In terms of specific services provided, Table 1 shows a list of services and how prevalent they are among the surveyed programs. All 46 programs that completed at least some of the survey indicated all of the services they offered. The most commonly offered services included: independent living skills, mental health services, food and clothing, housing, and safety planning. Other services may only be needed by a select group of survivors, such as repatriation assistance and language interpretation. These services are more necessary for programs that reported working with foreign-born survivors. Of the 23 programs that reported working with foreign born survivors, 39.1% offer English

language lessons, 26.1% offer language interpretation services, and 13% offer assistance for survivors who wish to return home to their country. These percentages are slightly higher than in the full sample, but still seem low when thinking of the importance of these services to individuals with a language barrier.

Table 1

Types of Services Provided to Trafficking Victims

Service	%	Service	%
Independent living skills	69.6	Human rights education	28.3
Food and clothing	65.2	Reunification (for survivors who wish to be reunited with their families)	26.1
Mental health services	65.2		
Housing	60.9		
Safety Planning	60.9	English language lessons	23.9
Educational opportunities	58.7	Protection by the criminal system	19.6
Physical Safety	54.3		
Health education	45.7	Language interpretation services	15.2
Transportation	45.7	Repatriation (for foreign survivors who wish to return to their home country)	6.5
Economic assistance	45.7		
Medical care	43.5		
Dental care	39.1	Help taking care of family in home country (for foreign survivors)	4.3
Vocational training	39.1		
Legal and immigration services	32.6		
Job placement	30.4		

Another important component of survivor care is maintaining their physical safety. Programs were asked to indicate the specific physical safety measures used to protect survivors and staff. Maintaining an undisclosed location and having restricted entry were both endorsed by 53.3% of the programs, half of the programs had an alarm system, 36.7% were periodically patrolled by local law enforcement, 30% had security cameras, and five programs had a security guard. While five programs did not endorse

any of the specific security measures, 50% reported using three or more different measures to protect survivors and staff.

Programs were also asked about evaluation or assessments conducted to improve services or used with the survivors they work with. Nearly half of the programs reported conducting pre-treatment and post-treatment assessments, and 73.3% reported that they conduct periodic assessments of needs and symptoms. Over half of the programs include evaluation of staff effectiveness into their program, and two thirds of the programs reported enlisting survivor feedback to improve their services.

Staff. Respondents provided information about staff characteristics, such as numbers, professions represented, and training. The treatment of the array of needs that survivors have requires a team of professionals and volunteers coming together. Participating programs had a mean of 8.53 full and part-time staff, and a mean of 13 volunteers. In terms of medical care, nine programs reported having nurses as staff or volunteers and six programs reported having physicians on staff or as volunteers. In the area of mental health, 12 programs reported having social workers as staff or volunteers, 18 reported having professional counselors and 11 reported that they had psychologists either on staff or as volunteers with their organization. All programs reported having some connection to a mental health professional, but not all of them had one on staff. In addition, nine programs reported spiritual leaders, and eight programs reported legal professionals were a part of their staff and volunteers. Thirteen of the surveyed programs reported enlisting the help of survivor mentors as staff (survivors of sex trafficking who are further along in their recovery and have successfully re-integrated into society) to help others through the difficult process of recovery.

Survivors. Programs were asked to provide basic demographic information about the group of survivors with whom they work to help inform the understanding of who is accessing the available services. A majority of the programs reported commonly working with adults (n = 22, 83.3%). As for minors, over half of the programs reported having worked with them, but only one third reported minors as clients they commonly work with. Similarly, while most programs primarily see United States citizens and acknowledge having worked with foreign-born survivors, only 20% reported foreign citizens as a common demographic. It also seems that females are the primary consumer across programs, with 91% reporting mainly working with female, whereas males and transgender individuals are more rarely served in the programs surveyed. Less than 10% of programs reported males as a common demographic and nearly 12% reported working with transgender individuals.

When it comes to ethnic background, a majority of programs worked with African or African American, European American, and Latino survivors. Four programs listed Native American or Alaskan Native as a commonly served group, five programs reported commonly working with Asian or Asian American survivors, and even though no one reported Hawaiian or Pacific Islander as a common ethnic group, eleven programs did report having worked with them.

The Needs of Human Trafficking Survivors

For each of the identified needs trafficking survivors are likely have, participants were asked if they perceived the survivors they worked with as having that need, what the need looked like in their clients (specific problems or concerns), whether or not care for that need was a part of their treatment model, and if so, how effective they perceived their approach to be. Of the 30 programs that completed the survey, 100% reported that the

survivors they worked with had a need for both psychological services and education and vocational services; 96.7% reported seeing a need for legal services, spiritual services, and physical health services; and 93.3% reported a need for sexual recovery services, and for drug/alcohol abuse services. Eighty percent of the programs acknowledged the presence of all seven needs categories, and another 16.7% reported commonly seeing at least six of the seven need categories, confirming the complexity of survivor needs.

Even though 20% of the programs did not respond that they *commonly* saw all seven areas of need, 100% of the programs marked at least one issue in each list of examples given for each category. For example, One program responded "no" to the question "Do you commonly see trafficking victims who have sexual problems or concerns?" but also reported seeing survivors who lacked sexual desire, and had histories of sexually transmitted infections (STIs), and previous abortions (forced or not). While this specific program acknowledged that sexual challenges existed for the survivors they worked with, they did not indicate that it was something they commonly saw as a need to be addressed. Endorsing specific concerns, but not reporting commonly seeing a specific need, implies that some programs may have interpreted the question differently. Because of that, programs that responded "no" to whether or not they commonly saw a specific problem, but who marked several examples and integrated the need into their model of care, were counted in the "yes" group for noticing that need as a concern for survivors.

In terms of addressing survivors' needs, whether they were commonly seen or not, 14 of the programs responded that they had integrated the care for all seven needs into their work with survivors. Of the remaining 16 programs, seven of the programs integrated six needs, four programs provided care for five needs, three programs had

services to address two needs, and the remaining two programs only offered services for one need.

The care of psychological needs was the most commonly included service, with 27 programs reporting that it was a part of their treatment model. Both physical health needs and education/vocational needs were included in the treatment models of 26 programs. Spiritual needs and legal needs were included in 23 programs, sexual concerns were addressed in 22 programs, and drug or alcohol abuse/dependence was addressed in 21 programs.

For each need integrated into a program's care model, they were asked to rate how effective they thought their program's response to that need was on a scale where 1 was "not very effective," and 5 was "highly effective." For the response to psychological needs, 26 programs rated their perceived effectiveness with a mean rating of 4 (*SD* = 0.80). Perceived effectiveness of response to sexual problems was the lowest, only 20 programs rated themselves, yielding a mean rating of 3.65 (*SD* = 0.75). Twenty-two programs rated themselves for their response to drug/alcohol problems with a mean response of 3.9 (*SD* = 0.94). For legal services, 22 programs yielded a mean rating of 4 (*SD* = 0.93). Education/vocational services had 24 responses and a mean rating of 3.79 (*SD* = 0.88). Interestingly, more people rated themselves at a 3 in this area whereas in the other categories, the modal response was a 4 or 5. Finally, the two highest mean responses were for spiritual services (*n* = 22, mean = 4.23, *SD* = 0.81) and physical health services (*n* = 24, mean = 4.17, *SD* = 0.96). The number of programs that rated their effectiveness was lower than the total programs because not all programs addressed all of the needs, and some programs did not respond to the effectiveness items.

Psychological/mental/emotional health problems. Psychological, mental, and emotional health problems were the most commonly reported concerns that participants observed in the survivors they worked with. From the list of 20 possible psychological concerns, the mean number endorsed was 10.43 (*SD* = 4.25). Table 2 shows the prevalence of each psychological concern listed. The most prevalent psychological problems were similar to what is seen in the literature (Zimmerman et al., 2006), depression, anxiety, and PTSD. Also consistent with the literature, over 80% of programs noted distrust as a significant challenge for survivors. The risk of suicidal ideation was acknowledged by nearly three-quarters of programs.

In addition to the common psychological issues previously identified in the literature, respondents in the current study also indicated high rates of additional problems experienced by the survivors they treated. Although it is not clear what respondents based their answers on (e.g., knowledge of diagnoses, professional opinion, or more casual assumptions about the survivors with whom they worked), nearly every item was endorsed by at least a quarter of participants. Neurodevelopmental Disorders have not been previously assessed among survivors, yet learning disabilities, Attention-Deficit/Hyperactivity Disorder, and Intellectual Disability were highly endorsed by study participants. Personality disorders, especially Borderline Personality Disorder were common, and Dissociative identity Disorder was reported by more than a quarter of participants. Eating disorders were seen in a quarter to a third of programs, Obsessive Compulsive Disorder was thought to be present among survivors in half of the programs, and even more severe mental illness like Schizophrenia was seen in a quarter of participating programs.

Table 2

Psychological/Mental/Emotional Health Problems

Observed problem	%	Observed problem	%
Depression	96.7	Obsessive Compulsive Disorder (OCD)	50.0
Anxiety	96.7	ADHD	43.3
Post-traumatic Stress Disorder (PTSD)	93.3	Intellectual Disability	36.7
Distrust	83.3	Anorexia	33.3
Suicidal Ideation	73.3	Dissociative Identity Disorder (DID)	28.3
Learning Disabilities	66.7	Bulimia	26.7
Complex PTSD	63.3	Schizophrenia	26.7
Bi-Polar Disorder	63.3	Narcissistic Personality Disorder	26.7
Panic Disorder	60.0	Histrionic Personality Disorder	10.0
Borderline Personality Disorder	56.7	Homicidal Ideation	3.3

Programs that integrated mental health services into their model of care (n = 27) were asked about their access to mental health professionals. Seventy-eight percent reported having a mental health professional on staff. Programs were also asked if they conducted any assessments of survivors' psychological distress symptoms. Six programs reported that they did not do any assessment for psychological symptoms, but over half of the remaining programs checked that they used three or more instruments from a list of possible assessments. Over half of the programs reported using at least one trauma symptom assessment or screener. Seven of the programs reported using a structured interview for psychological problems, and the Beck Depression and Anxiety Inventories were also endorsed by a quarter of respondents. Several programs also wrote in other assessments that they commonly used, including spiritual and substance use scales.

A very important aspect of the psychological care of survivors is how interventions are actually administered. All programs except for one reported that individual counseling services were available to the survivors, and 73% of those

programs offer on-site counseling. Programs were asked if they used a specific manual or method for individual counseling services, and many reported using Trauma Focused Cognitive Behavioral Therapy or other forms of trauma informed therapy or CBT. Other treatments that were listed included Dialectical Behavior Therapy, Integrative Treatment of Complex Trauma for Adolescents (ITCT-A), and Seeking Safety. Ninety-two percent of programs offered group counseling, and 82.6% of those programs reported having on-site counseling groups.

Programs offered a mean of 5.65 (*SD* = 3.22) therapeutic activities per week. These activities included life skills training, family therapy, physical activity or fitness training, survivor mentoring, community mentoring, art or music therapy, equine or other animal assisted therapy, psychoeducation, gardening, and community service. Three quarters of the programs offered life skills training, half offered some form of physical activity, and two thirds offered survivor mentoring. Art therapy was also a commonly offered therapeutic activity (51.9%), and gardening was an option for survivors in 40.7% of the programs. Participants reported 12-step groups, parenting classes, game nights, and opportunities to pursue individual interests as other therapeutic activities they supported.

Of the three programs that did not integrate psychological care into their programs, two reported that they planned to do it in the future, and the other reported they did not have a plan to include mental health services directly but said they did refer survivors to others for services. Of all of the programs that responded, 46.2% reported having a goal to incorporate more mental health services in the future. Answers given for what programs would need to be able to better address survivors' psychological needs included: money, more staff, more space, and pro-bono services. The most salient remark

seemed to be about the necessity of well-trained mental health professionals who can deliver services in languages other than English, and who have experience with human trafficking related problems. One program wrote "A proper understanding in mental health professionals of the specific trauma that is undergone by trafficking survivors would assist in each survivor's progress. Furthermore, mental health professionals that specialize in working with trafficking survivors would be a wonderful addition to our city." Another program added "The biggest problem is (not) having trained individuals in prostitution victimization and the understanding of human trafficking bondage etc."

Sexual problems and concerns. Participants commonly reported the presence of sexual concerns among the survivors they worked with. From the list of 10 possible sexual concerns, the mean number endorsed was 5.17 (*SD* = 2.23). Table 3 shows the prevalence of each of the listed sexual concerns. The most prevalent sexual concern reported was having a history of STI's. The next most common problems speak to the juxtaposed experience of survivors who often experience an intense fear of intimacy while also exhibiting compulsive sexual behaviors. Lacking sexual desire was only reported by one third of programs. Over half of the programs endorsed that the women they work with have had previous abortions and other sexual or gynecological problems, and many endorsed a lack of accurate sexual knowledge and knowledge on how to prevent pregnancy and STI's to be a problem for their clients. Nearly half of the programs also endorsed that they commonly saw survivors questioning sexual identity.

Table 3

Sexual Problems and Concerns

Observed problem	%	Observed problem	%
History of Sexually Transmitted Infections (STIs)	83.3	Limited accurate sexual knowledge	46.7
		Sexual identity questions	46.7
Compulsive sexual behaviors	70.0	Limited knowledge of pregnancy/STI prevention	36.7
Fear of Intimacy	70.0		
Previous abortions	63.3	Desire disorders	33.3
Other sexual/gynecological problems or concerns	56.7	Other (lack of boundaries, pregnancy)	10.0

Programs that integrated sexual health services into their model of care (n = 22) were asked about their approach to addressing sexual concerns. A majority of the programs (90.9%) reported that counseling is available to survivors to address sexual concerns, some even reported sexuality as a key focus of their care model. One program stated "Our entire program has been developed for adolescent sex trafficking survivors so our focus is holistic care in this regard." Nearly two thirds of the programs reported offering counseling for sexual concerns on-site and integrating sexuality into their groups.

Only two of the programs reported working with a certified sex therapist to help survivors toward sexual recovery, 27.3% reported that psychologists addressed sexual concerns with survivors and 54.5% reported professional counselors were responsible for it. Based on qualitative responses, several programs indicated that survivors attended prostitution or trafficking groups that focused on sexuality as a component of the curriculum, and that they had group leaders and peers who addressed their concerns.

Of the eight programs that did not integrate sexual care into their programs, three reported having a goal to do so in the future, three stated they did not have a goal to

include care for sexual problems, and two did not respond. Of all of the programs that responded, 64.7% reported having a goal to incorporate more sexual recovery services in the future. Answers given for what programs would need to be able to better address survivors' sexual health needs were similar to those reported for psychological needs: money, more staff, more space, and specific resources to address sexuality. The lack of professionals with an understanding of human trafficking was also noted as a barrier to better services by many of the programs. One program noted a desire for professionals in their area who could provide services with an "…understanding of the trauma that is undergone by trafficking survivors, specifically that their value has been reduced to a profit margin and their worth in their eyes is based on sexual/labor/organ output…"

Drug or alcohol abuse/dependence. The presence of drug and alcohol problems among trafficking survivors was reported by 93.3% of participants. From a list of eight substances presented to participants, the mean number endorsed was 5.30 (*SD* = 2.59). Table 4 shows the prevalence of various substance use problems that participating programs reported for the survivors they served. The most commonly observed problem was with alcohol. The next most common problems included marijuana and cocaine, followed by methamphetamine, heroine, and prescription pills, each of which was endorsed by two-thirds of the programs. Ecstasy was also seen as a problem by many programs, and several programs wrote in additional substance problems they encountered, including crack, hallucinogens, and methadone.

Table 4

Drug or Alcohol Abuse/Dependence

Observed problem	%	Observed problem	%
Alcohol	86.7	Heroin	66.7
Marijuana	80.0	Prescription pills	66.7
Cocaine	76.7	Ecstasy	56.7
Methamphetamine	66.7	Other (crack, hallucinogens, methadone)	33.3

Programs who integrated substance abuse treatment services into their model of care (n = 21) described how they approached the challenge of treating survivors' substance disorders. Participants were provided a list of six resources for substance recovery and asked to indicate which were available to individuals in their program. A majority of the programs (85.7%) reported that drug and alcohol counseling was an option in their program, 76.2% indicated that they provided access to a detox program and 76.2% reported connecting with 12-Step AA or NA programs. For survivors in need of more intensive treatment, 61.9% provided access to drug rehabilitation day-treatment, and 57.1% either provided or connected survivors with a residential rehabilitation program. Finally, 47.6% reported other substance related support groups as a resource, and one program reported using acupuncture and Chinese medicine as recovery resources.

Several programs indicated that they get survivors into an outside detox program before they become engaged with the trafficking recovery services, which included continued support for sobriety. One respondent noted, "We refer to area rehab programs. We also find that after rehab, having a structured program to enter, with job skills training, budgeting, parenting classes and the like, helps with the success of transition."

Looking at who provides substance treatment, 71.4% reported working with a substance abuse counselor. Nearly half of the programs indicated that "other mental health professionals" deliver substance abuse treatment, and 52.4% indicated that support group leaders are involved in their substance abuse response. Only five programs listed sponsors from recovery organizations (AA, NA, etc.) as being formally involved in their approach to substance problems.

Nine programs indicated that the treatment of drug or alcohol abuse and dependence was not a part of their treatment model. Four of them reported a goal to include substance treatment in the future, and five stated they did not have a goal to include care for substance problems. Of all of the programs that responded, 64.7% reported having a goal to incorporate more substance abuse services in the future. Similar answers were given for current barriers to providing additional services, such as lack of funding, not having a substance abuse counselor, and a dearth of needed local community resources. One program also pointed out the additional challenge of finding acceptable community partners because of the stigma associated with involvement in prostitution. They wrote, "The survivors in our program have complex addiction issues and it can be difficult to find programs who will accept the mix of type of addiction as well as the sex work background. We are continually working to develop community partnerships so that we have better options for this population."

Legal aid needs. Legal problems were acknowledged as a common area of concern by all but one program. A list of five legal needs from the literature was presented to participants, but additional information in this area comes from the "other" options that participants filled out themselves. The mean number of legal needs endorsed,

including the needs that participants wrote in, was 3.10 (*SD* = 1.61). Table 5 shows the prevalence of the different legal problems. The most common legal need endorsed was having survivors enter programs with a criminal record. Sixty percent of programs reported working with survivors who were actively prosecuting their traffickers, and nearly half reported immigration needs, which included issues of needing to apply for a T-Visa, and involvement with Immigration and Customs Enforcement. Only a quarter of the programs reported working with un-emancipated minors who would need consent and special consideration because of their age and unique status. The least endorsed option was a need for human rights education.

Around one-third of programs added additional legal needs. Respondents reported additional needs of gaining custody of children, or child support issues, civil cases against traffickers for back wages, divorce, open domestic violence cases, obtaining orders of protection, establishing a legal identity (social security card, birth certificate), legally changing one's name for security reasons, and issues with being on probation.

Table 5

Legal Aid Needs

Observed problem	%	Observed problem	%
Criminal record	86.7	Other	36.7
Actively prosecuting traffickers	60.0	Un-emancipated minors	26.7
Immigration needs	46.7	Need for human rights education	23.3

Programs who integrated assistance with legal needs into their model of care (*n* = 23) were asked about how they provided legal help. Participants were provided a list of five resources for legal support and asked to indicate which were available to individuals

in their program. The most commonly available assistance was help with applying for government assistance (69.6%). Two thirds of responding programs reported offering legal advice and resources offered in roughly half of the programs included legal counsel or representation (52.2%) and assistance applying for a T-Visa (47.8%). Human rights education was less commonly endorsed, and was only seen in 39.1% of responding programs. Some programs also wrote in additional resources that included giving referrals for legal services, helping with probation issues, and helping with credit debt issues. Only 39.1% of programs reported having legal services available on-site. When asked about the specifics of who provided legal services, 65.2% reported working with a lawyer, 30.4% reported having a paralegal professional help them, and 39.1% reported having volunteer advocates offer help with legal matters.

There were seven programs that indicated that legal aid was not a part of their treatment model. Two of them noted they might include legal services in the future, four indicated it was not a goal of theirs, and one did not respond. Of all of the programs, 37.5% reported having a goal to incorporate more legal services in the future. Barriers to providing additional services again included lack of funding, need for pro-bono services, and a need for local lawyers with experience in the area. One program noted that in addition to attorneys with knowledge of trafficking, they need attorneys who are skilled in civil legal matters, because they recognize civil problems as "a newer area that we should explore in assisting our clients."

Education and vocational needs. All of the programs recognized that educational and vocational needs were evident in the clients they worked with. Participants were again given a list of problems and space to add any additional concerns

they commonly encountered. Of the list of four concerns, plus an additional "other" section, the mean number of needs endorsed, was 3.10 (*SD* = 1.27). Table 6 shows the prevalence of the educational and vocational needs as seen among the programs. Interestingly, all four proposed needs were endorsed by at least half of the programs. In accord with the literature, nearly all programs reported seeing clients with limited educational attainment, and most reported commonly working with clients who have limited job skills and work experience outside of being prostituted. What is also notable is that over half reported illiteracy as a problem among the survivors they worked with. Half of responding programs reported having worked with clients who were not native English speakers. As noted earlier, only 23.9% of programs provided English language lessons. Of the 15 programs that reported working with clients who were not native English speakers, only eight offered English classes, and seven offered language interpretation.

Table 6

Education and Vocational Needs

Observed problem	%	Observed problem	%
Limited educational attainment	93.3	Illiteracy	63.3
Limited job skills/experience	86.7	English as a second language	50.0

Even though it was unanimously recognized as a significant need, not all programs integrated educational and vocational services into their model of care (*n* = 26). Participants were asked specifically about providing schooling for minors. Several programs reported providing some form of formal education (42.3%), the most common of which was through enrollment in public school, however, 73.1% of programs reported

providing formal schooling options (not just for minors). Over three quarters of the programs helped clients finish high school or get a GED, and 61.5% helped with college.

Many programs also offered vocational services either alongside education or subsequent to accomplishing educational goals. Services to help survivors figure out what they can do (other than prostitution), and how to be successful were common (e.g., vocational counseling (61.5%) and trade skill training (50.0%)). The most common trade skills clients had access to were: computer skills (42.3%), culinary arts (30.8%), and cosmetology (26.9%). Other options listed by programs included training in sales, hospitality, or as nursing assistants. When asked about the intended outcome of trade skill training was, many programs listed things like job placement, a means of financial stability, building self confidence, learning to communicate with others and responsibility. One program stated, "…most importantly is financial stability to prevent a resident from going back to [the] streets as a means to survive."

After helping clients gain the necessary education and skills, the next step is preparing them to get a job. Many programs offered help at this level; 84.6% provided assistance with completing applications and developing interview skills. One program even reported providing job placement opportunities. Nearly three-quarters of participating programs who provide education and vocational support had on-site services.

There were four programs that indicated that assistance with educational and vocational needs was not a part of their treatment model. Only one of them noted they might include educational and vocational services in the future, two indicated it was not a goal of theirs, and one did not respond. Of all of the programs, only five reported having

a goal to incorporate more educational and vocational services in the future. Barriers to providing additional services included lacking partnerships with local community colleges and vocational schools, lack of funding and scholarships, overcoming clients' criminal records, and needing more volunteers to help with tutoring and training. One program noted a challenge in this area, that "Many professionals may not be able to properly address a survivor's perceived lack of progress," speaking of the difficulty of working with individuals who do not accurately view their personal educational and vocational development. Another program spoke of two of the greatest challenges survivors face when working toward their goals:

> Our women primarily have a prostitution charge on their records, and this stereotypically makes finding employment difficult. Some of our women have served a lot of jail time and have other charges on their records. Also, some of our women have been out of school since entering the life in their early teens, so it has been a very long time since they have used school and learning skills.

Spiritual needs. All of the programs except one reported seeing spiritual needs in the survivors they worked with. Five of the six spiritual concerns listed were endorsed by over half of the programs. The most commonly endorsed programs were: a desire for spiritual support, a loss of faith in humanity, and a desire to practice a specific religion. In the space for additional commonly encountered spiritual concerns, programs added a desire for help from a higher power, and distorted ideas about their spirituality. The mean number of spiritual needs endorsed was 4.20 (SD = 1.77). Table 7 shows the prevalence of spiritual needs as seen by the responding programs.

Table 7

Spiritual Needs

Observed problem	%	Observed problem	%
Desire for spiritual support	86.7	Questioning spirituality or the meaning of life	70.0
Loss of faith in humanity	76.7	Anger directed toward spirituality	53.3
Desire to practice a specific religion	73.3	Fear of spiritual retribution	36.7

As mentioned earlier, 40% of the participating programs classified themselves as being "faith-based," yet 76.6% integrated spiritual services into their model of care (n = 23). Even programs that did not have spirituality already ingrained into their program viewed clients' spiritual issues as needing to be addressed. Participants were asked to explain how survivors' spiritual needs were addressed in their programs. One program said their approach was, "Through relationship. Many survivors have been wounded in the name of religion even by well meaning people wanting to help. We love them unconditionally. When they are ready and start asking questions or bringing the topic up, we answer questions truthfully and respectfully."

Specific services offered on-site include bible studies (43.5%), other spiritual book studies (34.8%), visits by a spiritual leader (34.8%), meditation time (34.8%), and religious services (26.1%); however, 95.2% of programs reported that they offer opportunities for survivors to attend religious services of their choice. Other services that were added by programs include addressing spiritual concerns in counseling, talking with religiously oriented staff, referring to outside spiritual leaders, spirituality groups, and encouraging the focus of Alcoholics Anonymous on a higher power.

There were seven programs that indicated that spiritual support was not a part of their treatment model. Two of them noted they might include spiritual services in the

future, three indicated it was not a goal of theirs, and two did not respond. Of all of the programs that responded (n = 11), five reported having a goal to incorporate more spiritual support services in the future. Barriers to providing additional services included lack of funding and lack of referral sources. One program added a consideration of the possible stigma that may impact survivors in religious settings by recognizing a lack of "A proper understanding amongst church leaders and attendees of the specific trauma that is undergone by trafficking survivors…"

Physical health problems. All of the programs except one reported seeing physical health problems among the survivors they worked with. Participants responded to a list of 18 physical health needs identified in the literature as commonly endorsed by survivors. The most commonly endorsed problem was sexually transmitted infections. Other diseases were reported less commonly and included hepatitis, HIV/AIDS, scabies and lice, and tuberculosis. Headaches and memory difficulties were the second most commonly reported concerns, and there were several visible physical concerns that were highly endorsed including bruises, pregnancy, head or neck trauma, malnutrition, broken bones, and rashes. More subjective concerns that were frequently endorsed were things like tiring easily, stomach and pelvic pain, and back pain. Additional concerns that participants mentioned included dental problems, eating disorders, sleep disorders, and sensory issues like vision and hearing problems. The mean number of physical health needs endorsed was 8.90 (SD = 4.83). Table 8 shows the prevalence of the physical health problems as endorsed by responding programs.

Table 8

Physical Health Problems

Observed problem	%	Observed problem	%
Sexually transmitted infections (STIs)	76.7	Back pain	46.7
Headaches	73.3	Broken bones	40.0
Memory difficulty	70.0	Rashes and other skin problems	40.0
Bruising	60.0	Hepatitis	40.0
Tiring easily	60.0	HIV/AIDS	36.7
Stomach and pelvic pain	60.0	Scabies and lice	33.3
Pregnancy	53.3	Dizzy spells	20.0
Head and neck trauma	46.7	Occasional loss of consciousness	10.0
Malnutrition	46.7	Tuberculosis	10.0

Many of the participating programs (n = 26) integrated physical health services into their model of care. Participants were asked what they did if a client had a physical injury or illness when she/he accessed their services. Responses ranged from programs that provided immediate medical assessment and care by on-site staff or a promise to provide care within 24 hours, to programs that professed a case-by-case response plan, but did not have a specific protocol for how to respond. All programs expressed a dedication to provide clients with the care they needed but varied in their access to the necessary resources to effectively do so.

Over half of the programs reported working with clients who were pregnant. Many reported offering resources such as referring for proper prenatal care, counseling and support for decisions about what to do with the pregnancy, and parenting classes. A few responders alluded to the possible challenges that having a child while in a program might create. One program reported "Our facility is not licensed to receive minors. So, women are not able to join the program if they have custody of a child under 18," and

another stated “she's allowed to stay up to birth and beyond, until the child is ambulatory, then she has to find other accommodations.” Only one quarter of the programs allowed survivors to have their children with them in the program.

Because unprotected sex is a common occurrence for trafficked women, programs were asked if they had a policy on giving Plan-B or the “morning after pill” to prevent pregnancy for survivors who wanted to take it within the first 72 hours after rescue. Only six reported having a policy. Of the programs that commented on this question, a few reported recommending the pill or taking clients to a place that offers it, others reported that it would be available if clients asked, and several mentioned religious or pro-life beliefs as reasons not to offer it to the women they work with.

Because of the potentially invasive nature of physical treatment of survivors, it is important to be aware of the personnel who deliver the services. Two programs reported having a medical professional on staff, and seven reported having someone on-call. Other programs access medical services by appointment. Even though several programs may have greater access to medical professionals, 92% of programs provided medical care off-site. Many programs mentioned in a free response section having specific community partners that they worked with to get medical services for their clients.

Four programs that indicated that the care of physical problems was not a part of their treatment model, and only one of those said they will include physical health services in the future. Of all of the programs that responded (n = 13), six reported having a goal to incorporate more physical health services in the future. Barriers to providing additional physical health services included lack of financial resources, limited referral resources for local specialists (e.g., gynecology), lack of professionals to provide other

health services to clients (nutrition education, physical fitness, etc.) and again, a lack of awareness in the field of the specific needs of trafficking survivors. One program explained the last barrier by expressing a desire for "A proper understanding and sensitivity in health professionals of the specific trauma that is undergone by trafficking survivors," and added a similar desire to other areas of need, for local healthcare professionals with a specialty in working with this vulnerable population.

Chapter 5: Discussion

Human trafficking is a significant global problem that creates challenges for societies and governments as well as the diverse organizations and professionals interacting in various capacities with victims, perpetrators, and consumers. There is no denying that sex trafficking happens all across the U.S., and thankfully the number of individuals and organizations fighting against the problem is continually growing. While governments are busy trying to address the problem from a socio-political perspective and lending support where possible to promising organizations, the main burden for raising awareness, training professionals in various fields, addressing social stigma, and caring for individuals falls onto various organizations. Some of these organizations were developed with the purpose of advocating and caring for trafficking survivors, while others ended up working with survivors because they were already serving a similar population (domestic violence, homeless, abused children, etc.). This study describes what those organizations are doing and identifies areas for growth within the field to help existing and developing organizations strengthen their capacities for helping survivors.

There are many organizations and individuals already working to address the needs of those who suffer most from the global demand for commercial sex: the women, men, and children who live through the de-humanizing experience. They suffer a form of trauma that has ramifications for many aspects of their lives. The results of this study contribute to the extant literature regarding the needs that survivors of sex trafficking have: needs that include everything from the basics of food, clothing, and safe shelter; to medical and mental health care, education, and legal aid; to more long-term personal

needs, like the freedom to re-develop a sense of self in a safe and supportive environment.

The list of things that survivors might need in their process of rebuilding their lives can seem overwhelming for those working to design and implement programs and services to meet all of those needs. Even though participating programs all recognized the extent of survivor needs, most of them lacked the resources to respond to all of them, or to respond in a way that they felt was fully effective. First of all, programs that worked directly with survivors were scarce, with only a small number listed in the whole country, and several states without even a single one. Adding that programs have varied abilities to respond comprehensively to survivor needs, this raises questions about how survivors access the services they need and find support for needs that may not be addressed in the organization that they are able to connect with. Across the areas of need addressed in this study, one of the most common barriers to improving services was a lack of professionals who were sensitive to the needs of trafficking survivors. This may in part be due to the relative novelty of social awareness surrounding human trafficking. However, the lack of awareness within a range of professions means that for the time being, survivors are unlikely to find professionals in their cities who have training in working with their unique needs.

This need for additional professionals should not be seen as an indictment of those already providing services. It would be wrong to discount the hard work and dedication of the organizations that responded to the survey. They do what they can with varied resources and with the limited information that is currently available in the field. They are pioneers in working with this population and are very familiar with the daily

challenges of this work. The responders differed in their ideas of which needs should be addressed within their programs, and their perceived ability to address certain needs with the resources they have, but still recognized unaddressed needs as deficits. The organizations included in this study specifically shared a need for more funding, among other things, to be able to offer all of the services they believed their clients require in order to fully recover and reintegrate in to society, and live a self sustaining life.

The goal of this research is not to point out what programs are not doing, but to report what they are doing and begin to think about what could be done if programs had additional resources to develop programs for their clients. All programs were able to indicate at least one need in each category (psychological/emotional, sexual, substance abuse, legal, educational/vocational, spiritual and physical) that was prevalent among the clients they work with, and nearly half reported integrating the care for all seven needs into their model of care. Some programs did not address some needs and it was not a given that programs without a response to that need intended to address the need in the future. This suggests that even though programs recognize something as a problem, they do not always see it as their responsibility – or as feasible - to respond to it. Some programs intentionally chose a smaller number of needs to respond to, others omit certain needs from their treatment model because they don't have the means to address them, and some programs offer only the services to trafficking survivors that they offer to the other populations they work with (i.e., domestic violence or refugee services who work with trafficking survivors only because their program provides services to a similar population).

It is clear that even though all seven needs categories were highly endorsed by participants, survivors do not all have exactly the same needs. Foreign-born survivors have unique needs in addition to what is common to domestic clients. This is an important area for further identification of needs and development of services. Services specific to foreign survivors were not highly endorsed among all of the responding programs, even though over 75% of respondents reported working with survivors who came from another country. While the percentage of services specifically for foreign-born survivors was higher when examining only programs that reported working with them, a majority of programs do not offer language interpretation (73.9%) or English language lessons (60.9%). Ideally, programs working with foreign survivors would have the resources to assist the survivors in communicating in the most comfortable way for them, especially when they have to communicate such sensitive and possibly traumatic information.

Another area of unique need is in working with minors. Over half of the programs reported working with minors, yet there was little discussion of the unique challenges of working with un-emancipated youth. Because the survey was broadly worded to encompass all possible survivors, there were not questions that specifically addressed the unique organizational challenge of working with youth, such as getting the proper licenses from the state to house minors and working collaboratively with state social service agencies to meet children's needs. The National Colloquium Report (Shared Hope International, 2013) partially addresses this gap in the study, as it focused on services for domestic minor sex trafficking victims. The authors of that report noted several challenges to the proper placement and treatment of minors including trouble with

licensing requirements for working with youth, placement restrictions for specific youth (history of running away, altercations with other residents, lack of vital records, unavailable guardian, low IQ, pregnancy, etc.), and the legal challenges to transferring youth to another state to receive services if none exist where they are.

Response to Specific Needs

Response to psychological/mental/emotional needs. There were some noteworthy findings in the area of psychological needs. Nearly three-quarters of respondents reported suicidal ideation as a concern among the survivors they worked with. While this is not an unexpected response to the level of complex traumatic experiences survivors have had, it is important to acknowledge the risk faced by aftercare programs and the need for effective assessment and monitoring for safety. Not all programs reported having a mental health professional on staff, and it is unknown how easy it is for programs to access one who is familiar with their clients in the event of a crisis. Increased risk assessments and check-ins with clients to monitor self-harm and suicidal thoughts may help programs to avoid crisis situations. Another recommendation is to teach clients several positive coping skills like deep breathing, relaxation, and meditation that the non-mental health staff can be trained to practice with them. These exercises can be one option to help prevent clients from escalating to a crisis, and can also benefit clients who have not indicated an elevated risk of suicidality.

A majority of respondents noted that PTSD was a common problem for survivors, and over half reported seeing complex-PTSD (CPTSD) in the survivors they work with. It is not known whether the difference between PTSD and CPTSD was clear to respondents, as the literature on CPTSD is limited and it has not been recognized as a

distinct diagnosis. While the distinction between types of traumatic reactions may be unclear, a majority of participants reported distrust as a significant problem; a symptom that is consistent with the literature on CPTSD. Knowing this can help inform more effective intervention by including aspects of CPTSD treatment, like working slowly to rebuild trust with clients.

Also notable in the area of psychological needs was the high rate of endorsement for Neurodevelopmental Disorders (learning disabilities, Attention-Deficit/Hyperactivity Disorder, and Intellectual Disability). These have not been previously indicated in the literature as common problems and raise the question of etiology. Are these concerns primarily attributable to low educational attainment, underlying neurocognitive problems stemming from pre-trafficking developmental delays, or the result of the common occurrence of traumatic brain injury among victims. Regardless of the underlying factors, a treatment approach that is sensitive to neurodevelopmental disorders is necessary to facilitate survivors' educational and occupational attainment.

Because the research is sparse on applying interventions to treating the specific psychological, mental, and emotional health problems of trafficking survivors, it is difficult to say what interventions are best suited to their needs, or how current evidence supported treatments for trauma will work with this population. We are also lacking outcome data on the specific approaches that different programs take to addressing these problems. Even though several programs reported using evidence supported interventions such as TF-CBT, Integrative Treatment of Complex Trauma for Adolescents (ITCT-A), or Seeking Safety, there is not any research specifically supporting their effectiveness with trafficking survivors. There is an opportunity for researchers in psychology to pair

with some of these programs and providers of psychological services to collect outcome data on different approaches. Such research would be an invaluable contribution to the future development of an effective model of mental health care to address such complex psychological concerns.

Response to sexual concerns. In the area of survivors' sexual recovery, the most highly endorsed problem was the presence or history of sexually transmitted infections (STI's). While this problem is medical, it is important to consider the diagnosis in terms of how survivors view themselves, and how they see the possibility for intimacy in the future. Because of the lack of control victims have over their sexual safety and their ability to protect themselves, it would be important to assess feelings and thoughts associated with how STI's were contracted, when they knew they were infected, what kind of care they received for it, and how others interacted with them as a result of having an STI.

Additionally, programs indicated both the presence of difficulties with intimacy and compulsive sexual behaviors. It is not clear from the data if the intense fear of intimacy and compulsive sexual behaviors were present in the same individuals, or were both just highly prevalent among the diverse clientele, but these issues speak to the possible inner challenge of having had no control over their sexuality while being trafficked and trying to regain their sense of who they are in their sexuality. It was also not clear from the survey how different programs view sexual empowerment or whether they see growth in survivors through the development of non-sexual intimacy with others, as was suggested in the sexual trauma literature (Herman, 1997).

It is also notable that two-thirds of the organizations reported that it was common for the survivors to have had abortions. From the literature, we know that victims who become pregnant are often forced to have an abortion regardless of their personal beliefs about abortion (Hyland, 2001). The information from the present study is consistent with the literature, but the beliefs among the programs differed about offering things like Plan-B, or pregnancy counseling, and allowing women to remain with them if they have a baby. The pro-life beliefs of some of the programs may make it more challenging for some survivors to make current decisions and process past experiences related to pregnancy, abortion, and birth. The betrayal these women may have experienced by doctors who performed the forced abortions on them may further complicate this aspect of their recovery because of the distrust they could have toward any support or medical treatment that they are offered.

Respondents' ratings of their perceived efficacy of the services they provided ranged from "somewhat effective" to "highly effective." Interestingly, more programs rated their efficacy in responding to sexual concerns lower than any other area. One possible explanation is that there is not adequate training among professional training programs in discussing sexual concerns. The fact that 40% of the programs classified themselves as faith-based, raised an additional question about discomfort in addressing complex sexual concerns within faith-based communities. A few programs noted their spiritual beliefs as a reason for not addressing some sexual concerns.

Response to substance use recovery needs. Participants almost unanimously endorsed drugs and alcohol as problems for the clients they worked with. Many of the programs involved outside services like detox programs, rehabilitation programs, and

community-based AA meetings, yet a common barrier was the challenge of finding outside resources that are sensitive to (and accepting of) the complex issues that complicate the substance use problems of survivors. Even though programs endorsed a willingness to help clients get the resources they need, they also expressed needing more abundant, more sensitive, or just stronger substance recovery services. More research is needed to assess the adequacy of traditional recovery programs for survivors or to develop substance abuse services for survivors that are sensitive to their unique co-occurring problems. Research on triggers and challenges specific to addiction among trafficking survivors and outcome research on different treatment methods that integrate trafficking specific needs into addiction treatment would be a benefit to the field.

Response to legal needs. The list of legal needs included in the survey captured only a fraction of the legal issues and challenges for people providing services to trafficking survivors. In addition to what seems obvious (criminal records, giving testimony against traffickers, immigration, and special considerations for minors), it was also common to have to help survivors do things like establish a legal identity and regain custody of children in foster care. Because traffickers often maintain possession of any formal documentation victims have, clients commonly escape without identification, birth certificates, passports, or other documentation. It is possible that domestic survivors have never had a social security number, and it is likely that they no longer use their birth name.

It seems common for clients to be involved with many professionals in the legal system like district attorneys, probation officers, and state appointed counsel before even thinking of needing help from a lawyer to do things like applying for government

assistance, suing for back wages, getting orders of protection, or filing for divorce. While several programs reported working with legal professionals who had experience in trafficking needs, there was a general recognition of need for other legal professionals who were also knowledgeable about the experiences of their clients, especially professionals willing to offer pro-bono services. More research is needed to expand the current assessment of the extent of survivor legal needs and to create resources for legal professionals on effective approaches for meeting the varied needs of trafficking survivors.

Response to educational and vocational needs. Though participants unanimously reported that the survivors they worked with had a need for educational and vocational services, they also were more likely to rate their program's response in this area as only "somewhat effective" than any other area. This area of need is also strongly influenced by other needs. In an economy where jobs are hard to come by, especially for individuals with criminal backgrounds and possible physical or psychological limitations, the barriers to gainful employment may seem daunting. This stands out as an area for specific research and training on how to most effectively intervene to prepare survivors for alternative jobs outside of prostitution; helping them become financially stable, create meaning in their lives, and develop a stronger sense of dignity.

It can be disheartening to consider what is needed to support survivors in obtaining employment and becoming financially self-supporting. Programs are faced with the challenge of helping survivors who have a wide range of previous educational experiences - from grown women who never learned how to read because they were first prostituted at a very young age to women who have taken college level classes. Clearly,

this area requires very individualized services because of the range of ages and experiences of clients. This is also a crucial area to address because effective intervention in this area can create tangible means of achieving success in other areas. This is why many programs help clients finish high school or get their GED, develop job skills, and learn how to interview and obtain work. Based on the literature on educational and career interventions with victim of intimate partner violence (Adams, Bybee, Tolman, Sullivan, & Kennedy, 2013; Rothman, Hathaway, Stidsen, & de Vries, 2007), we know that success in these areas could go a long way in building survivors' self-efficacy and belief in their opportunities to have a life outside of prostitution.

The literature on intimate partner violence also confirms many of the challenges for women who may have substance abuse problems, suicidal thoughts, mental health challenges (depression, anxiety, PTSD, etc.), and life experiences that set them apart from co-workers. Though having a job and being financially self-supporting have been related to positive outcomes for victims of intimate partner violence (Rothman et al., 2007), there are numerous obstacles to job success (Adams et al., 2013). Because of the many other factors complicating survivor's daily lives, trying to finish school, get a GED, or obtain and maintain a job could become an additional area of frustration for clients if they are not successful, or if they expect themselves to be able to do things that they never had the chance to learn. It was interesting that one program noted a challenge in finding professionals who were able to effectively address that frustration with clients who felt that they were not making the progress they wanted. Not only is educational and vocational intervention an area for continued research and development, but also it is important that mental health workers and vocational counselors be aware of the unique

challenges survivors face in this area. Any educational or vocational intervention should integrate this awareness of the numerous barriers so success, both the external and personal.

Some respondents conceptualized the educational/vocational area of need as being more than tangible skill training or meeting goals that would lead to financial independence. They were aware that being successful in a job takes more than education and skills. Write-in responses showed an understanding of this area as a confidence builder, a way to work on communicating appropriately and effectively with others, and a way to learn responsibility. A few of the programs viewed having a job as a way to teach things like communication and professional behavior, but teaching these soft skills early in the work exploration process could help survivors to be more successful in obtaining and maintaining a job. The United States Department of Labor's Office of Disability and Employment Policy has a curriculum titled *Soft Skills to Pay the Bills — Mastering Soft Skills for Workplace Success* (2012). It was designed to teach communication, enthusiasm and attitude, teamwork, networking, problem solving and critical thinking, and professionalism to youth. Considering the level of career development of many survivors, using a similar skill based curriculum that teaches these additional skills for success in the workplace could be beneficial. More research on the personal barriers to having success in job related areas, as well as how to strengthen the personal and interpersonal functioning that lead to vocational success will be an asset in developing comprehensive approaches to help clients strive toward success at their own unique pace.

Response to spiritual needs. In terms of spirituality, responders saw clients as wanting spiritual support and wanting to practice a religion while also processing the

existential issues of losing faith in humanity, questioning their spirituality or religious beliefs, and experiencing anger directed toward spirituality (higher power, churches, religious people they feel judged by). Participants showed an understanding of the complexity of this area and felt effective in addressing that complexity and creating environments that were safe to process all of their clients' conflicting feelings. Many programs identified as faith-based and incorporated a strong Christian component into their approach to providing services, including giving spiritual needs assessments, having Christian staff available to discuss spiritual matters or answer questions, and offering in-house bible studies. It seems that faith-based programs highly value spiritual support and development as a means of helping survivors recover. Further research should be conducted on the potential benefits of a strong focus on spiritual development and possible protective factors it may create. It would also be interesting to research outcome factors and program specific differences in programs with a stronger focus on spirituality, especially in the realm of survivors' perceptions of their own spiritual needs being met.

Some programs reported using approaches like mindfulness and meditation to improve spiritual health, but it is unclear if or how survivors' pre-trauma spiritual beliefs and understanding are addressed, and how they are exposed to different ways of thinking about or understanding spirituality post-trauma. It is also unclear how survivors respond to interventions for existential concerns like having a loss of faith in humanity, which was endorsed as a concern in three quarters of responding programs. Such concerns may require other sorts of intervention, such as volunteer work, which was noted by a few programs. While volunteer work may begin to repair some faith in humanity, there are no

outcome studies on such alternate interventions and how they may improve the lives of survivors.

Another potential aspect of addressing the spiritual needs of survivors is difficulties connecting with the larger spiritual community. One program pointed out that people they have encountered in church, including spiritual leaders, were not always welcoming to individuals who have been involved in the sex industry and were not well educated on the experiences that survivors have lived through. Another possible area for intervention is with churches and religious communities who may interact with survivors. Interventions of this type could advocate for survivors by breaking down stereotypes and addressing the stigma associated with prostitution. One participant noted that many survivors have been hurt by religion or by religious people. Working with local spiritual communities to create safe places to address those hurts could be very helpful to survivors struggling with spiritual issues.

Response to physical health problems. It is no surprise that programs endorsed seeing so many physical problems among the survivors they work with. While the programs expressed a desire to provide for survivors' medical needs, there was not a consistent response to these concerns among the programs. It is unclear from this study what kinds of community partnerships were in place for medical services, and whether or not programs have specific professionals that regularly provide medical care. It is also unknown if the medical professionals who work with the programs have specific knowledge of the needs of people who have been trafficked. Respondents did, however, rate themselves as highly effective in meeting survivors' physical health needs.

The lack of a structured medical response and organized models of healthcare reported in this study have also been identified as serious concerns by numerous health care professionals working with trafficking survivors. The Coalition to Abolish Slavery and Trafficking, a California based anti-trafficking organization, initiated a professional network called HEAL Trafficking (http://www.castla.org/heal-trafficking) in October of 2013. The goal of HEAL Trafficking is to create a forum for professionals to share resources and ideas for meeting the health needs of survivors. They recognize the many barriers to providing quality care to this population and believe that opening up communication among professionals may help to reduce barriers. Such an organized, collaborative forum opens up opportunities for research. One possible area for research is in trafficking-specific knowledge gaps among professionals, which could inform more specialized trainings to better meet the needs of the audience. The forum also increases the collaborative power of professionals to collect outcome data and disseminate information on effective treatments.

Findings Across Need Areas

There were several important findings that were consistent across all need categories. The first is that financial support and the need for more resources was an identified barrier to providing or improving services in every category of need. Other, previously mentioned barriers that workers in this field face include stigma and ignorance and lack of community partners. However, even if some of these other barriers are overcome, most programs don't have the financial resources to provide the level of service that survivors need. This not only hinders organizations from being able to provide ideal services, but it also contributes to the challenge of conducting outcome

research to inform best-practice models of care for trafficking survivors. Most programs do not have available staff to develop rigorous outcome research protocols or the financial means to carry them out. This is unfortunate because programs may have the means to provide highly effective services for a few areas of need, but it is important to see how different interventions can work together to address the more complex problems that survivors experience across needs areas.

The second significant finding is that many programs listed psychologists and other mental health professionals as individuals who deliver the services under multiple needs categories (psychological, sexual, substance addiction, educational/vocational, spiritual), yet programs also listed a lack of knowledgeable professionals as a barrier to effective intervention. Mental health professionals are often trained to address a variety of concerns, and while they must practice within the scope of their training, it is possible for mental health professionals to address many of the survivors' areas of need. However, there appears to be a lack of mental health professionals with an understanding of the complex needs and experiences of trafficking survivors. This lack of knowledgeable professionals could compromise the strength of psychological care available as well as impact the delivery of services in other areas of need. There needs to be a way for psychologists and other mental health professionals to obtain training in working with human trafficking survivors that includes training in working with issues of sexuality, addiction, vocation, and spirituality. An easily accessible specialty certificate or specific coursework to prepare professionals who want to enter this field would be a benefit to the field as well as the individuals who most need the services.

One of the main recommendations of the National Colloquium Report (Shared Hope International, 2013) is applicable for all survivors, not just minors. It cautions service providers from developing services that are not adaptable to the specific needs of the clients they work with, and recommends the development of stronger, evidence based services to treat the complex needs of survivors while also allowing enough flexibility to meet individual needs. There are evidence-supported treatments for different areas of need, like TF-CBT or the ITCT-A to treat psychological trauma, or AA and NA for substance abuse. These have been shown to be effective, and can be adapted to meet the individual needs of trafficking survivors. One concern however, is that there is a dearth of research to support the use of specific treatments with trafficking survivors, and a lack of research looking at the use of multiple treatments together to target the cluster of needs survivors may have. One way to begin to do this is to focus on programs (like the 14 programs in this study) that report integrating services for all seven categories of need into their model of care. Beginning to collect outcome data with programs that offer comprehensive services will give us a clearer understanding of effective approaches and the interplay of a broader set of services to treat survivors, and will inform a stronger definition of necessary aftercare services. This study and the National Colloquium Report support aftercare services that are flexible enough to empower survivors with individualized care, while attending to each need (psychological, sexual, substance abuse, legal, education and vocation, spiritual, and physical) and their complex interaction with each other.

Summary of Recommendations for Future Research

There is a clear lack of empirical data to inform services provided to survivors of human sex trafficking. While some helpful information has been gleaned from research done with survivors of other forms of trauma, there is a need for more research conducted with trafficking survivors. Any research in this area would be a great benefit; however, outcome studies looking at the effectiveness of treatments for the complex interaction of needs seen in trafficking survivors would be especially useful to programs developing their models of care and to survivors. Other needed areas of future research include the extent and effect of neurodevelopmental disorders on survivors recovery processes, how survivors sexual trauma experiences have impacted their thoughts about intimacy and sexuality, and the knowledge of and comfort with working with trafficking survivors among service providers.

Summary of Practice Recommendations

The gap between awareness of survivors' needs and ability to effectively respond was clear in the results of this study. A few things emerged from the responses that stood out as lacking among programs, which may help as programs think forward to improving their services. One clear area of need is in assisting programs to meet the needs of foreign survivors, especially those who may not speak English or for whom English is their second language. Connecting with translators or translation services to help survivors communicate in the easiest way for them could go a long way in empowering them in their recovery. Training stood out in several areas as a need both within programs and among professionals in the various fields working with survivors. Training program staff on crisis management and safety planning for survivors who are potentially suicidal

seems to be a huge need for the safety and security of survivors. Participants noted ignorance and bias, especially in churches and addiction treatment as barriers to building strong communities of support for the survivors they work with. Integrating training for community partners and for professionals across fields to be able to understand and appropriately respond to the needs of survivors may help to improve overall community response.

Limitations

There are several limitations in conducting research focused on human sex trafficking, beginning with lacking an established base of literature to guide the design of the research project and the development of the measure. Because such little research has been conducted in the field of aftercare for victims of human sex trafficking, many expectations that informed the creation of the survey were based on work with other types of trauma survivors.

Another complicating factor was that there are various types of organizations that offer services to survivors, and the degree to which they focus specifically on victims of trafficking also varies. There are likely many other organizations working with trafficking survivors whose direct focus is on something other than trafficking, meaning there were possibly many other organizations that could not be identified for this study.

Another limitation was in surveying individuals who work in non-profit agencies. It is likely that their time was limited due to the high demands of their jobs. This made it challenging to recruit programs to participate and complete a lengthy survey. Two of the programs declined to participate because they did not have the time to complete the

survey, and there is no way to know how many of the 50 programs that did not respond were also restricted by time constraints.

Tied to the limitation of surveying non-profit agencies is the requirement that an individual with significant knowledge of the program's functioning and services complete the survey. It is likely that the individuals with the strongest knowledge of the different aftercare programs had other important responsibilities and may not have had the time to complete the online survey. Also, because of the kind of work they do, even individuals who were willing to participate had crises come up during the time they had allotted to complete the survey. This had the effect of limiting the sample size. There were 30 programs (out of 96 identified organizations) that responded to the whole survey. While this is only a percentage of programs that were asked to participate, it is comparable to the number of participants in the National Colloquium Report (n = 41; Shared Hope International, 2013). It should still be noted that the generalizability of the findings could be compromised by the sample size.

Even though professionals viewed the survey and provided feedback in its development, there are several alterations that could improve the usability of the survey and the clarity of results. These include adding clarifying questions such as asking whether their reports of survivor problems were based on knowledge of diagnoses and survey information, or professional opinion based on interactions with survivors. There are also items that could be added to symptom lists based on common write-in responses, such as adding, "obtaining identity documents," and "divorce or custody cases" to the list of common legal aid needs. It is likely that these did not significantly influence the findings, but would be areas to consider improving if the survey is used again.

Conclusion

The purpose of this study was to explore the services available to individuals who have been victims of human sex trafficking in the United States. The findings provide descriptions of the complex needs of trafficking survivors when they seek help, and the types and forms of services available to address those needs. The few programs in existence highlight the need for more programs and more well trained professionals in various areas of expertise to enter the field. There are many people working to advocate for and support survivors in their recovery, but the field of aftercare, like many social services areas, is underfunded. This research, in spite of its limitations can inform future research to further develop the field of aftercare and encourage professionals to become educated in the complex world of survivors.

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Appendix 1: Human Sex Trafficking Aftercare Survey

Thank you for your willingness to participate.

As an individual working with survivors of human sex trafficking, your knowledge and experience are very valuable. Aftercare for trafficking survivors encompasses all of the services survivors may require for rehabilitation and reintegration into society, and there are many programs and individuals providing such services to survivors throughout the United States. There is, however, very little research looking at what services being offered and how well those services are meeting the needs of survivors of sex trafficking. This study will attempt to address a component of this gap in the research by identifying the range of treatment needs of trafficking survivors and describing the services currently provided across a range of aftercare service programs. Knowledge about how your aftercare services program works with survivors will help paint a clearer picture of the overall response to trafficking survivors' needs and where the areas for growth and strengths are within the field.

1. What is the name of your Organization? _____

2. What is your current position in the organization? _____

- _____ Program Director
- _____ Program Founder
- _____ Program Coordinator
- _____ Administrative Assistant
- _____ Physician
- _____ Nurse
- _____ Psychologist
- _____ Professional Counselor
- _____ Other Counselor
- _____ Social Worker
- _____ Case Manager
- _____ Chaplin/Pastor/Rabbi/Minister
- _____ Survivor Mentor
- _____ Security Guard/Police
- _____ Legal professional
- _____ Volunteer
- _____ Other: _____

3. What aftercare services do you provide for victims of sex trafficking?

- _____ Housing
- _____ Food and clothing
- _____ Medical care
- _____ Health education
- _____ Dental care
- _____ Legal and/or immigration services
- _____ English language lessons
- _____ Language interpretation services
- _____ Independent living skills
- _____ Educational opportunities
- _____ Vocational training
- _____ Job placement
- _____ Transportation
- _____ Economic assistance
- _____ Protection by the criminal system
- _____ Physical Safety
- _____ Safety planning
- _____ Repatriation (for foreign survivors who wish to return to their home country)
- _____ Help taking care of family in home country (for foreign survivors)
- _____ Reunification (for survivors who wish to be reunited with their families)
- _____ Mental health services
- _____ Other: _____

_____ Human rights education

4. What do you feel like your aftercare services program does the best?

Program Information

The following questions will ask specific information about your organization, and the way your aftercare services program functions. In an effort to gain a clearer picture of what aftercare service programs are doing in their work with victims of sex trafficking, it is important to gain information about the services themselves. Feel free to skip any questions that do not pertain.

1. What are the goals of your aftercare services when working with trafficking victims? (feel free to copy and paste a description from your materials)

2. In what city/state are your aftercare services provided? (List all if there are multiple sites)

Will have several city/state dropdown menus

3. What type of organization are your aftercare services a part of? (Mark all that apply)

Government Non-profit Faith-based
Private For-profit Other: _____

4. What method of service do your aftercare services use to treat survivors? Check all that apply.

_____ Residential
_____ Day treatment
_____ Home based care
_____ Outreach
_____ Shelter
_____ Community-based program
_____ Other: _____

5. What are the sources of your funding to work with trafficking survivors? Please check all that apply.

_____ Grants
_____ Private donations
_____ Government support
_____ DCS funding
_____ Discretionary funds from the general organization budget
_____ We don't receive support specific to trafficking victims
_____ Local partnerships
_____ Corporate sponsorships
_____ Other: _____

6. Are formal evaluation of effectiveness a part of your aftercare services?

_____ Pre-treatment assessments only
_____ Post-treatment assessments only
_____ Pre and post treatment assessments
_____ Periodic assessments of needs and symptoms
_____ Evaluation of staff effectiveness
_____ Evaluation of survivor feedback
_____ Other: _____

7. What do you do with the information from evaluations if collected? _____

Who Works in the Aftercare Services?

1. How many staff do you have working with sex trafficking victims?
Please indicate what positions and how many of each you have.

Position:	# Full time	# Part time	# Volunteer
_____ Program Director			
_____ Administrative Assistant			
_____ Physician			
_____ Nurse			
_____ Psychologist			
_____ Counselor			
_____ Social Worker			
_____ Case Manager			
_____ Survivor Mentor			
_____ Chaplin/Pastor/Rabbi			
_____ Security Guard/Police			
_____ Legal professional			
_____ Volunteer			
_____ Other: _____			
_____			
_____			
_____			
_____			
_____			
_____			

2. Do staff members and volunteers receive training in working with human trafficking survivors?
□ Yes □ No

What types of trafficking specific training do you require? _____

How many hours of training? _____

If you require continuing education for your staff, what do you require? _____

About Your Aftercare Services

1. When did you begin to offer aftercare services? (Year)

2. When did the program begin consistently working with victims of trafficking? _____

3. What is the shortest time of survivor participation in your aftercare services? _____

4. What is the longest time of survivor participation in your aftercare services? _____

5. What is the average length of survivor participation? _____

6. How many residents/participants are currently involved in your aftercare services? _____

7. How many residents/participants have been involved in your aftercare services since they were first offered? (skip if unknown) _____

8. For Residential programs, how many beds do you have? _____

9. How many survivors can your aftercare services work with at one time (residential and non-residential)? _____

10. Which of these survivors do you work with? Please check all that apply.

_____ Minor
_____ Adult
_____ US. Citizen
_____ Foreign born
_____ Female
_____ Male
_____ Transgender

11. Who do you **most commonly** work with? Please check all that apply.

_____ Minor
_____ Adult
_____ US. Citizen
_____ Foreign born
_____ Female
_____ Male
_____ Transgender

12. What are the ethnicities of the survivors that you work with?

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Hispanic or Latino
_____ Native Hawaiian or Other Pacific Islander
_____ White/Caucasian
_____ Two or more ethnicities
_____ Other: _____

12. What ethnicities do you **most commonly** work with? Please check all that apply.

_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Hispanic or Latino
_____ Native Hawaiian or Other Pacific Islander
_____ White/Caucasian
_____ Two or more ethnicities
_____ Other: _____

12. How are survivors referred to you? Please check all that apply.

_____ Department of Children's Services
_____ Law enforcement
_____ Community partnerships
_____ Outreach

_____ Court mandate
_____ Survivor referral
_____ Referral (other)

_____ Other: _____

13. How do you admit potential participants? _____

14. Are involuntary admits treated by your trafficking services? □ Yes □ No

15. Is your staff involved in the rescue process? □ Yes □ No □ Sometimes

16. When a sex trafficking victim is rescued, do you have them go through a forensic exam for evidence recovery at a licensed sexual assault center? □ Yes □ No

17. Do you have 24-72 hour emergency housing available to rescued victims? □ Yes □ No

18. What types of self-harm behavior, if any, do you see? _____

19. What precautions, if any, do you take to protect survivors from self-harm? _____

20. What safety/security measures, if any, have you taken to protect clients and staff at your facility?

_____ Undisclosed location
_____ Gates
_____ Restricted entry
_____ Security cameras
_____ Patrol by local law enforcement
_____ Alarm System
_____ Security Guard
_____ Other: _____

How do survivors present to your aftercare services?

The following questions will ask specific information about what needs you see in victims when you first begin working with them. For each of the endorsed needs categories, there are further questions about how your organization addresses them. In an effort to understand how aftercare services are working with victims of sex trafficking, it is important to describe who is seeking or using services and how different programs approach working with survivors.

For each of the following categories of needs, please indicate whether it is a need you commonly see in victims. If it is a common need, check each specific condition with which clients present. For the remaining questions, please answer with as much information as you can provide. Feel free to copy and paste from program materials.

Psychological/mental/emotional health problems □ Yes □ No

If Yes, check all that you have observed:

_____ Depression
_____ Borderline Personality Disorder

_____ Anxiety
_____ Suicidal Ideation
_____ Homicidal Ideation
_____ Post-traumatic Stress Disorder (PTSD)
_____ Complex PTSD
_____ Panic Disorder
_____ Distrust
_____ Bi-Polar Disorder
_____ Anorexia
_____ Bulimia
_____ Schizophrenia
_____ Dissociative Identity Disorder (DID)
_____ Obsessive Compulsive Disorder (OCD)
_____ Narcissistic Personality Disorder
_____ Histrionic Personality Disorder
_____ ADHD
_____ Learning Disabilities
_____ Intellectual Disability
Other: _____

Is the care of psychological/mental/emotional health problems a part of your treatment model? □ Yes □ No
(If no, survey will skip to the next major section)

1. What resources are available to a survivor with psychological/mental/emotional health needs? _____

2. Do you have a mental health professional(s): □ On staff □ On call □ By appointment
What are their professions and degrees held? Please check all that apply.
_____ Psychologist
_____ Social Worker
_____ Counselor
_____ Marriage & Family Therapist
_____ Bachelors (in a mental health related field)
_____ Masters (in a mental health related field)
_____ Doctorate (Ph.D.)
_____ Other: _____

3. What, if any, licenses or certifications do you require of mental health staff?
_____ Bachelors (in a mental health related field)
_____ Masters (in a mental health related field)
_____ Doctorate (Ph.D.)
_____ Licensed
_____ Certified
_____ In the process of becoming licensed or certified
_____ In training (supervised off site)
_____ Completed site specific training
_____ Other: _____

4. Do you do any assessments of survivors' psychological distress?
_____ Structured Clinical Interview for DSM Disorders (SCID-4)
_____ Beck Depression Inventory (BDI)
_____ Beck Anxiety Inventory (BAI)
_____ Child Sexual Behavior Inventory (CSBI)
_____ Child PTSD Symptom Scale (CPSS)
_____ Trauma Symptom Checklist for Children (TSCC)
_____ Trauma Symptom Inventory (TSI)
_____ UCLA PTSD Index for DSM-IV
_____ Violence Exposure Scale for Children-Revised (VEX-R)
_____ Clinician-Administered PTSD Scale (CAPS)
_____ Life Events Checklist (LEC)
_____ Trauma Screening Questionnaire (TSQ)
_____ PTSD Checklist (PCL)
Other: _____

5. Is individual counseling available to survivors? □ Yes □ No

6. If yes, do you have a specific manualized or evidence supported treatment method that you use for individual counseling? □ Yes □ No

If so, what treatments are commonly used? _____

7. Is individual counseling offered at the center or off site?

8. Is group counseling available to survivors? □ Yes □ No

9. If yes, do you have a specific manualized or evidence supported treatment method that you use for group counseling? □ Yes □ No

If so, what treatments are commonly used? _____

10. Is group counseling offered at the center or off site? _____

11. How often (either weekly or monthly) are these therapeutic activities are available to survivors? Feel free to skip any that do not pertain.

		# of times per week	or	# of times per month
_____	Individual counseling	_____		_____
_____	Group counseling	_____		_____
_____	Life skills training	_____		_____
_____	Family therapy	_____		_____
_____	Physical activity or fitness training	_____		_____
_____	Survivor mentoring	_____		_____
_____	Community mentoring	_____		_____
_____	Art therapy	_____		_____
_____	Music therapy	_____		_____
_____	Equine therapy	_____		_____
_____	Other animal assisted therapy	_____		_____
_____	Psychoeducation	_____		_____
_____	Gardening	_____		_____
_____	Community service	_____		_____
_____	Other: _____	_____		_____
	_____	_____		_____
	_____	_____		_____
	_____	_____		_____

13. How effective do you think your program's overall psychological response is?

Not Very Effective		Somewhat Effective		Highly Effective
1	2	3	4	5

14. If your aftercare services do not have the resources to handle psychological needs, do you have a goal to incorporate this in the future? □ Yes □ No □ Planning □ Maybe

15. What would you need to be able to better address survivors' psychological needs?_____

Sexual problems and concerns □ Yes □ No

If Yes, check all that you have observed:

_____ Compulsive sexual behaviors
_____ Desire disorders
_____ History of Sexually Transmitted Infections (STIs)
_____ Limited knowledge of pregnancy/STI prevention
_____ Limited accurate sexual knowledge
_____ Other sexual/gynecological problems or concerns
_____ Sexual identity questions
_____ Fear of Intimacy
_____ Previous abortions
_____ Other: _____

Is the care of sexual problems and concerns a part of your treatment model? □ Yes □ No
(If no, survey will skip to the next major section)

1. What resources are available to survivors with sexual health needs (psychological/emotional)?_____

2. Is counseling available to survivors for sexual concerns? □ Yes □ No

3. If yes, do you have a specific manualized or evidence supported treatment method that you commonly use for counseling concerning sexual concerns? □ Yes □ No

If so, what is the most prevalent approach used?_____

Are there any other commonly used treatments?_____

4. Who administers counseling for sexual concerns?

_____ Certified sex therapist
_____ Counselor
_____ Social worker
_____ Psychologist
_____ Volunteer
_____ Other: _____

5. What are their qualifications?

_____ Licensed
_____ Certified
_____ In the process of becoming licensed or certified
_____ Completed site specific training
_____ In training (supervised off site)
_____ Other: _____

6. Are sexual counseling services offered at the center or off site?

7. How effective do you think your sexual recovery services are?

Not Very Effective		Somewhat Effective		Highly Effective
1	2	3	4	5

8. If your aftercare services do not have the resources to handle counseling for survivors sexual concerns, do you have a goal to incorporate this in the future? □ Yes □ No □ Planning □ Maybe

9. What would you need to be able to better address survivors' sexual recovery needs?

Drug or alcohol abuse/dependence □ Yes □ No

If Yes, check all that you have observed:

_____ Alcohol
_____ Marijuana
_____ Ecstasy
_____ Cocaine
_____ Methamphetamine
_____ Heroin
_____ Prescription pills
Other: _____

Is the care of drug or alcohol abuse/dependence a part of your treatment model? □ Yes □ No
(If no, survey will skip to the next major section)

1. What, if any, resources are available if a survivor has drug or alcohol abuse/dependence problems? Please check all that apply.

_____ Detox program
_____ Rehabilitation program- residential
_____ Rehabilitation program- day treatment
_____ Drug/alcohol counseling
_____ AA or NA group
_____ Other support group
Other: _____

2. Do you have a specific treatment method that you use for drug or alcohol abuse/dependence?
□ Yes □ No

If so, is it manualized? Yes No

What method do you use?

3. Who administers the treatment?

_____ Substance abuse counselor
_____ Other mental health professional
_____ Support group leader
_____ Sponsor
_____ Other: _____

4. What are their qualifications?

_____ Licensed
_____ Certified
_____ In-recovery sponsor
___ In the process of becoming licensed or certified
___ In training (supervised off site)
___ Other: _____

_____ Completed site specific training

5. Is treatment for drug or alcohol abuse/dependence offered at the center or off site?

8. How is ongoing substance use treatment delivered?

9. How effective do you think your response to drug or alcohol abuse/dependence is?

Not Very Effective		Somewhat Effective		Highly Effective
1	2	3	4	5

10. If your aftercare services do not have the resources to handle substance use needs, do you have a goal to incorporate this in the future? □ Yes □ No □ In planning □ Maybe

11. What would you need to be able to better address survivors' substance use needs?

Legal aid needs □ Yes □ No

If Yes, check all that you have observed:

_____ Criminal record
_____ Immigration needs
_____ Actively prosecuting traffickers
_____ Un-emancipated minors
_____ Need for human rights education
_____ Other: _____

Is assisting with legal aid needs a part of your treatment model? □ Yes □ No
(If no, survey will skip to the next major section)

1. What resources are available if a survivor has legal problems or needs?

_____ Assistance applying for a T-Visa
_____ Assistance applying for government assistance
_____ Legal advice
_____ Legal counsel or representation
_____ Human rights education
Other: _____

2. Who provides legal assistance?

_____ A lawyer
_____ A paralegal professional
_____ A volunteer or advocate
_____ Other: _____

3. What are their qualifications?

_____ Licensed
_____ Certified
_____ In the process of becoming licensed or
_____ Completed site specific training
_____ In training (supervised off site)
_____ Other: _____

_____ certified

4. Is legal assistance given at the center or off site? □ On-site □ Off-site □ both

5. How effective do you think your legal assistance program is?

Not Very Effective		Somewhat Effective		Highly Effective
1	2	3	4	5

6. If your aftercare services do not have the resources to handle legal assistance, do you have a goal to incorporate this in the future? □ Yes □ No □ In planning □ Maybe

7. What would you need to be able to better address survivors' needs for legal assistance?

Education and vocational needs □ Yes □ No

If Yes, check all that you have observed:

_____ Limited educational attainment
_____ English as a second language
_____ Illiteracy
_____ Limited job skills/experience
_____ Other: _____

Is assisting with education and vocational needs a part of your treatment model? □ Yes □ No
(If no, survey will skip to the next major section)

1. What resources are available if a survivor has education or vocational needs?

_____ Vocational counseling
_____ Formal education options
_____ GED preparation
_____ Trade skill training
_____ Assistance with application and interview skills
_____ Other: _____

2. Who provides education or vocational assistance?

_____ Psychologist
_____ Masters level professional counselor
_____ Licensed teacher
_____ Social Worker
Staff member
A volunteer
_____ Other: _____

3. What are their qualifications?

_____ Licensed
_____ Certified
_____ In the process of becoming licensed or certified
_____ Completed site specific training
_____ In training (supervised off site)
_____ Other: _____

4. Is schooling offered for minors? □ Yes □ No

_____ Students attend a local public school
_____ Students attend a local private school
_____ Students are home-schooled at the facility
___ Tutoring services are offered on site
___ The program does not coordinate student schooling
___

_____ A school is run at the facility _____ Other: _____

5. Is education or vocational counseling given at the center or off site? □ On-site □ Off-site

6. Are survivors trained in trade skills? □ Yes □ No

If so, which ones?

Vocational:

_____ Vocational counseling
_____ Cosmetology
_____ Culinary
_____ Computer skills
_____ Sewing
_____ Mechanical
_____ Other: _____

Educational:

_____ Elementary School
_____ Middle School
_____ High School/GED
_____ College
_____
_____ Other: _____

8. What is the intended outcome of trade skill training (i.e., building self confidence, job placement, financial stability, etc.)? _____

9. How effective do you think your education and vocational assistance program is?

Not Very Effective		Somewhat Effective		Highly Effectiv
1	2	3	4	5

10. If your aftercare services do not have the resources to handle education or vocational assistance, do you have a goal to incorporate this in the future? □ Yes □ No □ In planning □ Maybe

11. What would you need to be able to better address survivors' needs for education or vocational assistance?

Spiritual needs □ Yes □ No

If Yes, check all that you have observed:

_____ Loss of faith in humanity
_____ Questioning spirituality or the meaning of life
_____ Desire to practice a specific religion
_____ Anger directed toward spirituality
_____ Desire for spiritual support
_____ Fear of spiritual retribution
_____ Other: _____

Is care for spiritual needs a part of your treatment model? □ Yes □ No

(If no, survey will skip to the next major section)

1. How are survivors' spiritual needs addressed? _____

2. Do you provide opportunities for individual spiritual pursuits?

If so, what opportunities are available?

3. Do you offer any spiritual support onsite?

_____ Bible study
_____ Other spiritual book study
_____ Prayer meetings
_____ Religious services
_____ Meditation time
_____ Visit by a spiritual leader
_____ Other:

4. Do you offer survivors opportunities to attend a religious service of their choice? _____

5. How effective do you think your approach to survivors' spiritual needs is?

Not Very Effective		Somewhat Effective		Highly Effectiv
1	2	3	4	5

6. If your aftercare services do not have the resources to support survivors' spiritual needs, do you have a goal to incorporate this in the future? □ Yes □ No □ In planning □ Maybe

7. What would you need to be able to better address survivors' spiritual needs?

Physical health problems □ Yes □ No

If Yes, check all that you have observed:

_____ Broken bones
_____ Bruising
_____ Head and neck trauma
_____ Memory difficulty
_____ Occasional loss of consciousness
_____ Dizzy spells
_____ Rashes and other skin problems
_____ Scabies and lice
_____ Headaches
_____ Tiring easily
_____ Back pain
_____ Stomach and pelvic pain
_____ Tuberculosis
_____ Hepatitis
_____ Sexually transmitted infections (STIs)
_____ HIV/AIDS
_____ Other:

_____ Pregnancy
_____ Malnutrition

Is the care of physical health problems a part of your treatment model? □ Yes □ No
(If no, survey will skip to the next major section)

1. What protocol is followed if a client has a physical injury/illness when she/he accesses services?

2. What services are available if a client is pregnant when she accesses services?

3. Do you allow survivors' children in the program?

4. Do you have a policy on giving Plan-B (pregnancy prevention used after unprotected sex) to survivors within the first 72 hours after rescue? □ Yes □ No
If Yes, what is the policy?

5. Do you have a policy on offering prophylaxis to survivors after rescue? □ Yes □ No
If Yes, what is the policy?

6. Do you have a medical professional on staff or on call? □ On-staff □ On-call □ By appointment

What degree do they hold? Please check all that apply.

_____ MD
_____ DO
_____ Nurse Practitioner
_____ BSN
_____ RN
_____ LPN
_____ Certified Nurse's Assistant
_____ In the process of becoming licensed or certified
_____ In training (supervised off site)
_____ Other:

7. Is medical treatment given at the center or off site?

8. How is treatment delivered for ongoing medical problems?

9. How effective do you think your overall medical response is?

Not Very Effective		Somewhat Effective		Highly Effectiv
1	2	3	4	5

10. If your aftercare services do not currently have the resources to handle medical needs, do you have a goal to incorporate this in the future? □ Yes □ No □ Planning □ Maybe

11. What would you need to be able to better address survivors' medical needs?

Additional Information

Is there anything specifically you do to help prepare survivors for re-integration into the community?

Is there anything else you would like to share about your aftercare services? Please include it here.

The following questions are here in case you would be willing to be contacted for further information, or if you would like to see the completed results of the study.

1. What is your name?

2. Would you be willing to be contacted by phone or email in order to furnish additional information?
□ Yes □ No

If by phone:
What is the best phone number to reach you?
What is the best day and time to reach you?
What time Zone are you in?

If by email:
Email address:

3. Would you be willing to share your program website if you have one?
What is the web address?

4. Would you like to be placed on a list to receive the results upon completion of this study?

□ Yes □ No

E-mail or mail address to send results: _____

_____

_____

Thank you for taking the time to fill out this survey and share information about the services you offer to victims. The work you are doing is of immeasurable value, and I truly appreciate your willingness to share your experience.

If you have any questions or would like to follow up for any reason, feel free to contact Richelle McGhee, the principle investigator, at ramcghee@memphis.edu.

http://edu.surveygizmo.com/s3/1037287/The-State-Of-Aftercare-A-Critical-Look-At-The-Response-To-Victims-Of-Human-Sex-Trafficking-In-America