INSTITUTE for SHELTER CARE

National Practices Survey Report 2017

A survey of residential service providers for victims of domestic human trafficking

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The Samaritan Women

The Samaritan Women

Section A. Background

In 2016, our organization, The Samaritan Women, was gifted with the funds to host a national conference for service providers that offer residential care to victims of domestic sex trafficking. The gathering was held over a four-day period at Wheaton College in Chicago, Illinois in July of that year. Twenty-two agencies were present, and a host of individuals who aspired to get involved in survivor care. From that event, three observations emerged:

1. The majority of those in attendance were the founders of their organizations, many of whom left other occupations to pursue what they felt to be a calling on their lives. All of us had weathered long seasons of feeling alone, crazy, full of doubt, despair, and isolation...and yet we pressed on. It was poignantly clear that this group of pioneers needed the collegiality of this unique gathering.

2. Many of us were having similar experiences and making comparable decisions, but had no baseline against which to measure if we were doing things correctly. To this day there remains no credible, authoritative entity offering guidance (or dare we say, "best practices") for how this work should be done.

3. The other group of people who attended the 2016 conference were those who were in some stage of envisioning a similar work, or having trouble getting started. Some had started and abruptly stopped. Some were still dreaming. But these attendees were looking to those who had gone before, to help them. In spite of how much we, ourselves, still needed help, we also realized that we owed a debt for the honor we'd been given. We needed to pay it forward.

This study was conceived by a small group of colleagues to (1) unite us in collegial sharing, (2) establish a baseline of practice, and (3) equip the next generation of service providers with our experience. This effort does not endeavor to present itself as academic or scientific; however, the information contained herein may prove instructive to either.

It's also important to note that this is not the first effort of its kind. In 2012 Shared Hope International issued its National Colloquium report on residential programs for domestic minor sex trafficking victims. In 2013 the Illinois Criminal Justice Information Authority produced its National Survey of Residential Programs for Victims of Sex Trafficking. Both are thoughtful, important efforts, worthy of your consideration.

This survey and publication was conceived of and created intentionally for service providers and those who dare to enter into this work. On behalf my colleagues and me, we hope you are blessed by our efforts.

Acknowledgements

First and foremost, we offer humble **thanksgiving to God** for calling us to this work. We pray that this study will help all of us grow in our commitment and excellence, to the good of those we serve, and to His glory.

We are grateful to all the **residential service providers** who gave of their time to complete this survey and offer their experiences so that others might benefit. This is an incredibly generous field of pioneers. As Dr. Bruce D. Perry is quoted as saying:

> *"Surprisingly, it is often when wandering through the emotional carnage left by the worst of humankind that we find the best of humanity as well."*[1]

This work is grateful to you—some of the best of humanity, working to pull people out of the darkest deeds of humankind.

The Samaritan Women specifically acknowledges the contributions of **Jeff Barrows** (GraceHaven, OH), **Karen Kutzner** (The Well, PA) and **Louise Allison** (PATH, AR) for their input on the survey instrument.

Thanks to The Samaritan Women staff who had a hand in this work: **Allison Deitz** for her efforts in background research, **Melissa Yao** for stoking participation and working directly with respondents, **John DeMichael**[2] for his creation of the report logo, and **Julie Haltom, Susan Schneider,** and **Calvin Fanning** for their editorial input.

I would personally like to thank the **NorthStar Initiative** of Pennsylvania, for gifting me with the bed and breakfast retreat in tranquil Lancaster County. It was the ideal setting for immersing myself in the writing of this report.

Founder and Executive Director
The Samaritan Women

1 Perry, B. D. (2017). The Boy Who was Raised as a Dog and Other Stories from a Child Psychiatrist's Notebook: What *Traumatized Children Can Teach us about Loss, Love, and Healing*. New York, NY: Basic Books.

[2] www.hirejd.com

A Word About Language

There is not, at the present time, a clear and standardized lexicon among service providers for victims of human trafficking. For the purpose of this report, we have adopted a set of terms in an effort to be the most inclusive to those in this field.

Agency	this is the general term we'll use to refer to the organization/nonprofit/ entity that is represented by these survey results. Agency should not presume any governmental affiliation, but merely serve to define an organized effort, most often under the legal classification of a 501c3 nonprofit entity.
Client	we'll use this age- and gender-neutral term to refer to the individual who is placed within a residential program and taking advantage of those services. Other terms are used by agencies within their programs, such as "Resident," "Guest," "Survivor," "Sparrow," etc. While "client" lacks the warmth and affection with which these agencies regard them, it affords us a neutrality in reporting that is important.
LEA	refers to Law Enforcement Agency, either federal or state
Program	the set of policies, curricula and activities that are being offered within an agency and in specific response to the population needs.
Supervisory Staff	refers specifically to those persons who work within the residential setting and have direct contact with the client population.
Victim	we use this term because of its legal relevance and to refer to an individual prior to acceptance into a program (after such point, the individual will be referred to as "client").

NOTE: Respondents' write-in comments are reported as-written, including any grammatical or typographical errors. Only in such case as identifying information was provided, have those comments been edited.

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The Study

Section B. Purpose

This endeavor is--first and foremost--intended to serve those who are fearlessly and tirelessly providing services to survivors of domestic human trafficking. This is meant to be a display of honest sharing and encouragement to one another, a statement of "I understand where you are, because I am there as well."

Secondarily, this work is offered to those who aspire to be a part of restorative care for trafficking victims, those of you who are yet on the outside of this work, but desire to look within. We cannot possibly prepare you for this work, but we hope this proves helpful in your journey.

Thirdly, this effort seeks to educate and offer opportunities for deeper collaboration with those on whom we depend:

> *To Law Enforcement, the Courts, Child Protective Services, and other Victim-Referring Agencies* – we hope this gives you some insight into how we see the needs of trafficking victims and how we're trying to help. Let this work further the dialogue between us so that we can work more effectively together.
>
> *To the Philanthropic Community and Donors* – we hope you're inspired by the commitment and sacrifice of these agencies and will make investments to further this work based on both head and heart.
>
> *To the Academic Sector* – we hope you'll use this foundation upon which to establish useful research, and to prepare the next generation of abolitionists and care providers.
>
> *To Advocates, Elected Officials, and other Public Servants* – we give you a glimpse into our reality so that you can be a voice, not only for these agencies, but also for the individuals we serve.
>
> *To the Church* – we hope this work informs and helps to target the ways you can engage your prayers, service, and support. The work is plentiful, but the laborers are few[3].

We believe that the issue of domestic human trafficking bears down on all of society, most keenly on governance, social order, economics, and moral health. These are issues that impact all of us; therefore, we believe that all of society must engage in combatting this scourge, and attending to those who have been so heinously affected by it.

[3] The Bible. Book of Luke 10:2

Section C. Methodology

The survey was issued in early April 2017 and closed at the end of August 2017, for a five-month response window. The Samaritan Women identified 171 agencies across the United States that are serving victims of domestic trafficking. We were specifically targeting programs that identify as short- or long-term residential (those with "beds"), as opposed to all forms of direct service.

We initiated contact with each of those agencies by phone and email to first verify that they were open and actively serving this population, then sent out the survey invitation. Follow-up phone calls and emails encouraged response.

All data reported herein is based on self-disclosure of personal experience. There are no objective, standard metrics by which this form of work is measured; therefore, we assume all responses to be true, as reported. In no way did this effort seek to evaluate the quality of the work being done, but merely to establish a baseline of what is being done.

Section D. Respondents

Fifty-eight agencies (34% of our initial invitation list) from twenty different states responded to the survey. The states with the most number of unique agency responses were: Texas (7), Pennsylvania (6), and Florida (5). A complete list of respondents and their corresponding locations is listed in Appendix A.

We encouraged those agencies with at least a year of operating experience to complete the survey; however, we did garner a few responses from agencies who are "open but not yet serving clients" (6.90%) and "temporarily closed" (3.45%). The majority, however, (89.66%) reported being open and serving clients. The agencies who reported not yet serving clients were omitted from most of the results.

It's worth noting that several agencies were reluctant to respond citing apprehension about how the information would be reported. We believe that this is an important indicator of how this field currently lacks a unified identity and how these individual agencies are under a great deal of pressure to appear credible. There was a notable absence of a collegial, "we're-all-in-this together" spirit among some agencies, and some lamented at already having endured significant external criticism. This hypothesis was later confirmed in some of the responses.

Respondents were reassured that individual responses would not be cited in this report and no entity outside of The Samaritan Women would have access to individual response data. In a few cases, however, The Samarian Women has offered some specific illustrations from our work or those who granted permission--not to be construed as "best practice"- but merely to offer a point or example.

Type of Agency

There is not, at this point in time, a standard categorization scheme for these types of agencies. We asked respondents to identify with one or more of the following types based on a schema we had devised. They self-identified as:

22.41%	**Emergency Shelter** – usually a 24-72 hour holding, often in coordination with law enforcement
15.51%	**Assessment Center**- average of 30- 90 days of residential care with minimal services, goal is to determine long-term course of action
82.76%	**Restorative Home** – long-term care, often 12 months in duration, with specific program activities and a goal of social re-entry
13.79	**Graduated Housing** – independent supportive housing with accountability

Responses to this question exceed 100%, reflecting that some agencies operate more than one type of facility. The few "Other" responses identified as a secondary school treatment center, resource center, or advocacy group. Most individuals who provided responses (81%) represented leaders within these organizations (Board member, Founder, Executive Director and/or Program Director). Only one person identified as Clinical Director and two as Residential Staff. The "Other" options (14%) reflected titles we could not discern as leadership or line staff, because at the present time there are no field-specific standards in job titles or descriptions for this type of work.

Year of Incorporation

To gauge the maturity of these agencies, we asked about their year of incorporation versus years of direct service to survivors of trafficking. The oldest organization responding was incorporated in 1976; the youngest in 2017. Distribution of these agencies by years of incorporation showed:

13 years or more	8-12 years	3 – 7 years	2 years or fewer
11 respondents 19%	11 respondents 19%	30 respondents 52%	6 respondents 10%

This wide distribution of histories can be explained if we understand that some agencies have prior histories of serving victims of abuse, violence, sexual assault, or agencies with traction in residential care, and that have expanded over the years to include victims of domestic human trafficking. Many of the younger agencies were founded with serving victims of trafficking as their initial charter. It's worth stating, that all should be considered welcome around the table of collegial sharing and support.

Years of Direct Client Service

5.28

Average number of years these agencies have been in direct service to trafficking survivors

Across these agencies, the average number of years providing direct service to survivors was 6; however, if we omit the two agencies that reported over 20 years' experience (given that their services predate the TVPA and TVPRA[4] definition of human trafficking), then the average number of years in direct service to human trafficking survivors across these agencies is 5.28. This is a critical lens through which these findings should be read. Ours is a very young field, with many agencies still in their founding years, and still in a season of experimentation.

Sixty-nine percent of these organizations operate as Independent/Private nonprofit agencies, and 22.41% as part of a small-medium sized nonprofit. Only four agencies are part of a large national nonprofit, or part of a network of residential homes. One respondent identified as part of a regional task force or coalition. We should not miss the point that most of these agencies are independent (and as we'll note, the only or one of very few in their state), so we must read into this picture a fair amount of isolation and lack of support. This will resound in later data points and respondent comments.

Licensing

The requirement for these agencies to be licensed varies from state to state. For many states, there is a keen distinction between group homes serving minors versus adults. The former often must be licensed and in compliance with state regulations. A search conducted of the Child Welfare Information Gateway's state guides and manuals portal[5] yielded licensure manuals for all states (and the District of Columbia) except:

Arizona	New Hampshire	Tennessee
Minnesota	Pennsylvania	West Virginia
Missouri	South Dakota	Wyoming

In Missouri, child care facilities may request exemption from meeting some of the state's licensure requirements, and the state's denial of the request may be appealed once.[6]

One-quarter of these respondents reported that they are licensed due to state requirement and 6% are in the process of licensure. For 69% of respondents, licensing is either not required or the agency has chosen not to pursue it. It's important to note that most all agencies serving minors are required to be licensed. Some of those licenses held include:

Residential treatment facility	Residential childcare facility
Children's residential facility	Specialized foster group home
Therapeutic foster group home	

[4] TVPA – Trafficking Victims Protection Act of 2000 and TVPRA – Trafficking Victims Protection Reauthorization Act of 2005
[5] https://www.childwelfare.gov/topics/systemwide/sgm/?CWIGFunctionsaction=stateguidesmanuals:main (search selections: All States, Licensing, All Audiences)
[6] https://s1.sos.mo.gov/cmsimages/adrules/csr/current/19csr/19c30-60.pdf

We inquired as to the advantages of licensure. Four respondents noted that licensing offered them "credibility." Two noted that being licensed brought in state funding. The remaining responses spoke to not being able to operate in their state without it. As for the disadvantages of licensing, write-in responses included:

- *An unbelievable amount of red tape*
- *No advantages at all*
- *Mandatory reporting*
- *Delayed our opening*
- *Lots of policies*
- *Over zealous analysts*
- *No carve outs for the special needs of trafficked children*
- *Hoops to jump through that were not necessarily beneficial*

Accreditation

Given the fledgling nature of this field, there is not a specific accreditation (or accrediting body) for residential service providers for victims of human trafficking. Nonetheless, we asked if these agencies were accredited by any other body. Two agencies reported having earned accreditation with ECFA - the Evangelical Council on Financial Accountability. One reported COA - Council on Accreditation, and one reported being in the process of CARF - Commission on Accreditation of Rehabilitation Facilities.

We asked, "If there were a national accreditation for residential service providers for victims of trafficking, would your agency pursue that accreditation?" and the responses were:

37.74%	Absolutely, yes
13.21%	Yes, if it came with the potential for funding
28.30%	It depends: not if it was too time consuming or costly
30.19%	It depends: not if it meant we had to change our way of doing things
13.21%	I'm not sure I understand what accreditation would do for us
1.89%	Absolutely, no

Among those who were receptive to accreditation, we asked what benefits would they would want to realize from that accreditation. The largest population of responses (34%) said that they would hope earning accreditation would lead to increased funding/donor confidence. Twenty-two percent spoke to the desire for national standards, and 20% to heightened credibility. A small number of responses (11%) suggested that accreditation would lead to accountability and/or an increase in client referrals.

Section E. Financials

Annual Budget

$476,267
Average annual budget of these agencies in 2017.

Forty-two agencies reported their annual operating budgets for 2017 which tallies to over $20 million in victim care. Their cumulative budgets average to an annual operating budget of $476,267 per agency for 2017. Four agencies reported budgets in excess of $1million each, with the smallest budget reported at $75,000.

The Samaritan Women conducted a Funding Landscape study of residential service providers in 2016[7] specifically to examine their funding and financials. In that September 2016 study, we reported that of the 12 agencies responding, the highest budget for 2016 was $1,474,144, the average was $520,000, and the lowest was $10,800.

Cost of Care

Several agencies in this study are either too early in their years of service or have not yet calculated Cost-of-Care. We obtained 38 responses to the question of annual cost of care per client. From that dataset, the overall average (across all client ages and needs) is $40,426/year. We must move cautiously with that figure, however, because we did not assert what expenses factor into that number. There is a wide disparity across these agencies in terms of their expenses (housing, staffing, licensure, direct services, etc.). Refer to Sections I and J for details on the services most commonly offered by these agencies to assess Expense-to-Value ratio.

Compared to 2016

In our 2016 Funding Landscape study, we presented the following findings:

2016	High	Average	Low
All Respondents	$103,080/year	$43,848/year	$12,000/year
Adult-Serving Agencies (9)	$5,127/month $61,624/year	$2695/month $32,340/year	$1,000/month $12,000/year
Minor-Serving Agencies (3)	$8,590/month $103,080/year	$6,530/month $78,360/year	$3,500/month $42,000/year

From the 2017 sample there were 16 agencies serving Minors and only 11 that reported cost of care. The average across these responses was $65,784/year/child, but the responses ranged from $118,625/year to $13,000/year. It's important to note that some of the per diems for minor care are dictated by state government agencies, and not based a calculation of actual services-to-client. In short, the range appears to too wide to be predictive and the variables are many.

[7] To obtain a copy of the 2016 Funding Landscape report, email jallert@thesamaritanwomen.org

Sample Comparisons: Minor

What should it cost to care for a minor child who is a victim of trauma and trafficking? It's difficult to come up with a clean comparison because of the diverse and specialized needs of a traumatized minor. The Adoption Council offers us a comparative for cost-of-care for minors in foster care, as follows:[8]

Daily: $70-$71 Monthly: $2,148.50 Annually: $25,782

We pulled from the Economic Policy Institute for the cost-of-care for a minor in four regions of the United States.[9] In the area of Baltimore, Maryland, one child necessitates an increase in the family's annual budget by $25,140; in Houston, Texas, by $17,525; in Green Bay, Wisconsin by $21,645 and; in San Francisco, California by $35,908.

	Baltimore, MD		Houston, TX		Green Bay, WI		San Francisco, CA	
Monthly Costs for…	1 Adult, 0 Children	1 Adult, 1 Child	1 Adult, 0 Children	1 Adult, 1 Child	1 Adult, 0 Children	1 Adult, 1 Child	1 Adult, 0 Children	1 Adult, 1 Child
Housing	$847	$1,252	$623	$926	$422	$681	$1,191	$1,956
Food	$271	$399	$271	$399	$271	$399	$271	$399
Child Care	$0	$808	$0	$565	$0	$792	$0	$689
Transportation	$475	$480	$450	$454	$480	$484	$475	$480
Health Care	$206	$314	$228	$347	$268	$421	$345	$519
Other Necessities	$540	$798	$432	$640	$335	$522	$706	$1,138
Taxes	$494	$878	$314	$446	$310	$590	$644	$1,443
Total	$2,833	$4,928	$2,317	$3,777	$2,085	$3,889	$3,632	$6,624
Annual Total	*$33,994*	*$59,134*	*$27,803*	*$45,328*	*$25,024*	*$46,669*	*$43,581*	*$79,489*

Clearly, there is a wide variance in the cost of care between a "typical child in a family setting" versus a trafficked minor placed in a therapeutic residential setting. Explanation of that variance may be found in the range of services and personnel needed to meet the trafficked minor's unique needs.

Sample Comparisons: Adult

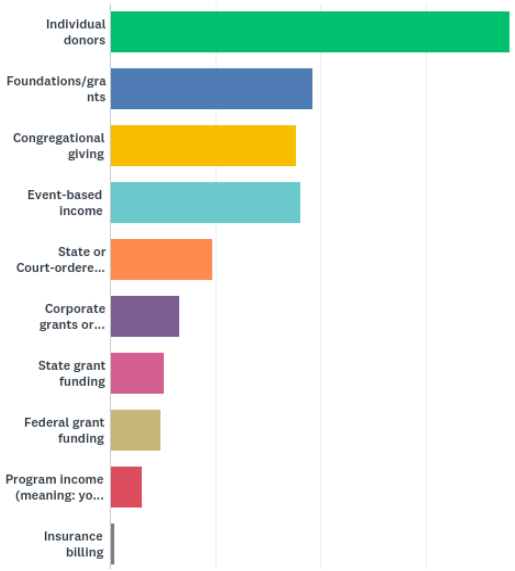
Our 2017 survey asserts that the average cost of care across 31 adult-serving agencies is $28,253/year, a modest increase from our 2016 study. For further comparison, we looked at the U.S. Housing and Urban Development Agency (HUD) report on the average cost per person for adults experiencing homelessness. Below is a sample from three geographically-dispersed areas.

[8] https://www.adoptioncouncil.org/images/stories/NCFA_ADOPTION_ADVOCATE_NO35.pdf (p. 3)
[9] http://www.epi.org/resources/budget

	Cost per Day	Cost per Month	Cost per Year
Des Moines, IA			
Transitional housing, shared rooms	$34	$1,020	$12,240
Permanent supportive housing, shelter + care	$18	$540	$6,480
Houston, TX			
Transitional housing	$55	$1,650	$19,800
Permanent supportive housing	$22	$660	$7,920
Jacksonville, FL			
Transitional housing	$29	$870	$10,440
Permanent supportive housing	$29	$870	$10,440

As with minors, there is sufficient variance for us to ask the next question: How does a trafficked adult's needs differ from those of an "average" adult? We hold these questions as we progress to later sections of this report.

Sources of Funding



By significant margin, these agencies are funded through acts of charity by individual donors. Only two agencies reported not receiving individual donations in support of their work. Eighty-six percent of these agencies reported financial support from faith-based congregations, but the amount of income derived from foundations/grants or fund-raising events was reported as slightly higher than congregational giving.

This chart may be unintentionally misleading, as some congregations and corporations offer grant programs. Respondents may have reported corporate or congregational giving under foundations/grants. Also, given that many of these agencies are faith-based, we would assume that attendees to their fund-raising events would likely include a faith-based population. It is not possible to distinguish clearly these sources of income.

What is clear from this dataset is that very few of these agencies are realizing any federal or state funding. According to the ACF's Office of Legislative Affairs and Budget[10] Fiscal Year (FY) 2017 Operating Plan, the allocations budgeted for 2016 ($13 million for foreign-national victims and $5.755 million for domestic victims) remained constant for this year. Anti-trafficking funds are categorized as one of the ACF's discretionary, as opposed to mandatory (i.e., programs that, by law, must receive funding), programs. The ACF's total budget for FY 2017 was $63.005 billion dollars,[11] meaning that anti-trafficking funds for that same time period comprised less than 0.03% of the total budget.

[10] https://www.acf.hhs.gov/olab/fy-2017-acf-operating-plan
[11] https://www.hhs.gov/about/budget/fy2017/budget-in-brief/acf/discretionary/index.html

These agencies have little-to-no sources of sustainable income; meaning, they must work to raise their funding. Funding is not coming in automatically from government appropriations, insurance billing or program income. The agencies with the most sustainable income streams are those serving minor victims, for whom their state provides a per diem. Those serving victims over age 18 are largely fending for themselves.

It would appear that individual donors and foundation grants can be quite generous. We invited these agencies to share news of the single largest financial gift (or grant) each organization had ever received and 41 agencies responded. Minus the one agency that reported a $2.1million gift over two years, the average of largest gift received was $234,080. Three agencies footnoted that their largest gift was specifically to purchase the shelter home property.

Capital campaigns are generally conducted to raise one-time funds for large expenditures, such as property. Over 35% of these agencies have held a capital campaign and considered it successful. Just under 30% report that they have not conducted such a campaign but have plans to in the future. There was no reporting on the amount of funds raised through capital campaigns.

Payment for Services

To put a finer point on the absence of sustainable income, we inquired as to how many of these agencies charge for their services. As predicted, the clear majority of agencies are not working under a fee-for-service model.

87%
Of these agencies do not charge clients for their services.

0%	We only take clients with insurance
2%	We only take clients who are funded by our state
2%	We only take clients who can pay our program fee
9%	We accept multiple forms of payment
87%	We don't have a fee for our services

For a few of these agencies, clients are required to pay a nominal program fee or rent as the client obtains employment and remains in the program. Of those fees reported, they range from a low of $5/day (or $1,800/year) to a high of $345/day (or $125,925/year). It is worth noting that for the agency requiring a $345/day per diem, that agency reports its per diem rate was set by the state as part of their licensing. This should not, then, be interpreted as actual cost of care. Similarly, the agency reporting $5/day program fee notes that this fee requirement is less to off-set operational costs, and more to teach clients the discipline of basic money management. Again, $1,800/year should not be read as reflecting actual cost of care.

Expenses

In our 2016 Funding Landscape report, we noted that 77% of respondents said that their Executive Director/CEO had gone uncompensated for at least one year, or at the most, seven years. The average was three years without compensation. Our 2017 dataset offers a similar finding with 65% of agencies reporting that their Chief Executive Officer has gone at least one full year without compensation, with the average of 3.5 years sans compensation. Half of these agencies also reported that other staff positions have worked uncompensated.

Also in the 2017 survey, 31 agencies reported the annual salary of those Executive Directors. The average compensation is $51,025/year with a high of $115,000/year and a low of $14,000/year. We looked to see if there was an appreciable difference in compensation for those who direct minor-serving facilities. The average annual salary of Executive Directors for those agencies was $62,545, which is notable. A calculation that should be performed relative to executive salaries would also be cost of living in their area of service, and baseline of credentials.

Section F. Referrals

3,023
Number of victim referrals made to 39 agencies in 2016

This section is intended to help us understand how client referrals come to these agencies and the criterion by which these agencies accept or deny a victim referral. Only 39 of the 58 agencies responded to the question of "How many referrals were made to your agency last year?" Several wrote in comments that suggest this is a data point that those agencies simply do not track. Of those 39 responses, there was a total of 3,023 referrals made to these agencies in 2016. That figure equates to an average of 77 referrals per agency. However, if we subtract the two outlying agencies that reported over 400 referrals in that year, the average number of the remaining 37 agencies is 55. It is worth noting that 8 agencies reported having fewer than 8 referrals last year.

Most of these agencies (70%) do not maintain a formal wait list for referrals, but may put a referral on hold until a bed becomes available. Sixteen percent of these agencies maintain a wait list. The remaining do not. As will be noted later, only a few of these agencies use a digital system for tracking client information, including referrals.

Referral Sources

There are two ways of looking at entities that source victim referral: the sources that are making referrals with the *most number of agencies*, versus the sources that are making the *most number of referrals*. We asked about both. Contrast the following two tables to see how these 39 agencies are obtaining victim referrals:

Number of agencies getting referrals from this source		Total number of client referrals from this source	
34	Family members of victims or Self-referral	1,129	Other anti-trafficking or human trafficking victim service agencies
29	Other anti-trafficking or human trafficking victim service agencies	687	Family members of victims or Self-referral
29	Courts (judge, attorney, victim advocate)	493	Courts (judge, attorney, victim advocate)
27	State or local law enforcement	477	Federal law enforcement (HSI, FBI, USMS)
24	Federal law enforcement (HSI, FBI, USMS)	460	Child Protective Services
17	Drug & Alcohol rehab program	384	State or local law enforcement
15	Human Trafficking Task Force	321	Agency's own outreach efforts
14	Domestic violence agency	203	Human Trafficking Task Force
14	Hospital/Medical provider	170	Drug & Alcohol rehab program
14	Agency's own outreach efforts	140	Domestic violence agency
2	Child Protective Services[12]	99	Hospital/Medical provider
8	Polaris Project/ Nat'l Human Trafficking hotline	37	Polaris Project/ Nat'l Human Trafficking hotline

[12] Consider that only 16 out of 58 respondents report serving Minors, therefore the agencies providing services to Adults only would have little or no need for contact with Child Protective Services.

General public awareness, interpersonal contacts, and professional networking are vital to victims securing placement

This data is helpful to both the national anti-trafficking movement at large, and individual agency efforts. From this comparison of referral sources, we see that individuals (victims, family members, and agency staff) are responsible for the greatest number of referrals. This suggests that public awareness, interpersonal contacts, and professional networking are vital to victims securing placements. Also ranking high in both metrics are court-affiliated professionals and law enforcement. These two tables also suggest that more work needs to be done to provide frontline professionals with education and screening tools, as well as a credible list of service providers, so they can also better identify and make referrals.

Intakes

We asked these agencies to report the total number of intakes into their residential program(s) in 2016. There were 42 agencies that responded to this question for a total of 778 intakes. That equates to an average of 18.5 intakes per agency last year.

18.5
Average number of intakes per agency in 2016

For the referrals that these agencies could not accept (for whatever reason), 87% endeavor to put the referrer in touch with alternative programs, either by providing a list of other agencies to contact, or by making a personal contact with another agency in a collaborative effort to place the client. Herein, we see where ensuring that these agencies know of one another and can make peer-to-peer introductions is vital to effective victim response.

6 beds
Average number of client beds per agency

The average bed count for most of these agencies is 6, which may suggest that these smaller agencies must be narrower in their acceptance criteria. One respondent painted a clear picture of how she endeavors to maintain a delicate balance about filling beds:

We found on-boarding a single child was always tumultuous and took 90 days for house to settle down. We were working toward on-boarding 2 at a time to create bond of newcomers versus 1 against several tenured residents

Assuming a fit, we asked, "What is the average turnaround time between receiving a referral and being able to take the client?" and learned that these agencies are quite swift, particularly if we consider that these agencies may be taking referrals from anywhere in the country.

15%	We average a few hours from referral to intake
28%	We average 1-3 days from referral to intake
19%	We average 5-7 days from referral to intake
21%	We average 7-10 days from referral to intake
4%	We average two weeks or more from referral to intake
13%	It varies too widely for us to have an average

Capacity

over 52%
of these agencies indicated that their programs were not typically filled

If we work simply from the averages offered in this report, each agency receives 55 referrals per year and accepts only about one-third of those referrals, or 18.5 candidates (see next Section on Declines). With an average bed count of 6, one might assume, then, that these beds are continuously filled. However, this survey offers us a surprising finding: over 52% of these agencies indicated that their beds were not typically filled. Twelve agencies reported that their beds remain 100% filled, and four agencies reported that they had at least 3 months of the year where they had 100% vacancy. Clearly there's a gap between the touted statistics on how many victims there are in the United States and how housing is the #1 need for survivors if these agencies are open and available, but not operating at capacity. What is impeding the connection between the need and the supply?

We invited the respondents to tell us measures they take to stoke referrals. Once again, we see that networking among agencies and with referral sources within the community (and beyond) has been vital to connecting victims with services. Some agencies are very intentional about stimulating referrals by sending out email alerts whenever there is an opening, or doing outreaches to community partners to make them aware of the service. Still, we might infer that much more needs to be done to make citizens and referral sources aware of the agencies offering these unique services.

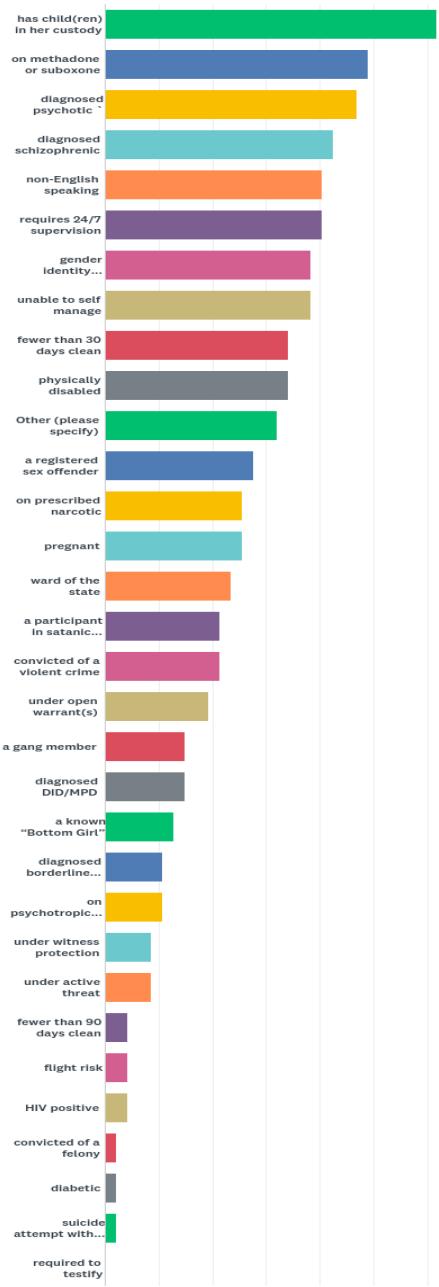
Declines

As introduced above, the averages for referral and intake suggest that upwards of two-thirds of the referrals made to these agencies are not accepted into the program. It's important for us to understand what might be the limitations of these agencies and why these placements may not be fulfilled. We asked these agencies to indicate the conditions under which they would most likely decline a referral. Not surprisingly, the #1 condition was "has children in her custody." Serving women with children often requires specialized licensing, personnel, and facility accommodations that these agencies may not have in place, and therefore the decision to decline is immediate.

> *Probably one-third of all our intake calls are for survivors with a child. We just can't take them into our facility, but it's so hard knowing that there's very few options for them.*

The following table rank orders the reasons for a referral decline.

Reasons for Declines



has child(ren) in her custody	61.70%
on methadone or suboxone	48.94%
diagnosed psychotic `	46.81%
diagnosed schizophrenic	42.55%
non-English speaking	40.43%
requires 24/7 supervision	40.43%
gender identity different from biological gender	38.30%
unable to self-manage	38.30%
fewer than 30 days clean	34.04%
physically disabled	34.04%
Other (please specify)	31.91%
a registered sex offender	27.66%
on prescribed narcotic	25.53%
pregnant	25.53%
ward of the state	23.40%
a participant in satanic rituals	21.28%
convicted of a violent crime	21.28%
under open warrant(s)	19.15%
a gang member	14.89%
diagnosed DID/MPD	14.89%
a known “Bottom Girl”	12.77%
diagnosed borderline personality disorder	10.64%
on psychotropic medication	10.64%
under witness protection	8.51%
under active threat	8.51%
fewer than 90 days clean	4.26%
flight risk	4.26%
HIV positive	4.26%
convicted of a felony	2.13%
diabetic	2.13%
suicide attempt within past 12 months	2.13%
required to testify	0.00%

It’s reasonable to assume that some agencies may have to balance facility and staffing limitations against referrals with physical disabilities or particular medical disorders.

We noted that being on a methadone or suboxone regiment, ranked higher than severe mental illness. One respondent explained:

> *She's a zombie on that stuff! You can't do any therapeutic work because she's so doped up. We'd rather be helping her with behavioral strategies for staying clean than just swapping one high for another.*

It was surprising how "flight risk," "felony convictions" or "suicide attempt or ideation" were not factors for decline. As one respondent offered, "*That's just our normal around here*."

At this juncture, it's worth reiterating that 87% of these agencies report that if they are unable to accept a referral, they make concerted effort to work with the referrer to facilitate placement in another agency.

Section G. Client Profile

Not all agencies serve all types of human trafficking victims. In fact, it's rare that an agency has the internal infrastructure, resources, and expertise to adequately care for all types of survivors. It will be important to read all subsequent areas of inquiry through the lens of the population these agencies generally serve—and *not* serve. Many of the following questions were framed to help us better understand the referral characteristics that these agencies can –and cannot—accept.

Type of Trafficking

Only one agency in this sample claimed "labor trafficking" as their service population and 10% selected "any form of trafficking," whereas 11% percent selected "Sex trafficking – only if verified as a trafficking situation." The majority (77.36%) claimed "Sex trafficking/prostitution/sexual exploitation in any form" as their service set. What this suggests is that most of these agencies are accepting client referrals outside of the narrow, legal definition of sex trafficking victim and are considering many forms of sexual exploitation within their service set.

Gender

All the agencies in this study reported that they serve female clients. There is legitimate national concern over the fact that men/boy victims are under-served. Of this survey population, only five agencies reported offering services to male victims, and nine agencies offering services to transgendered victims. The *National Survey of Residential Programs for Victims of Sex Trafficking* published in October 2013[13] interviewed 37 residential programs across the U.S. Of those 37 programs, two (Children of the Night in California and Grounds of Grace in Illinois) reported that they would accept male and female sex trafficking survivors.

Age Range

The Federal definition of the crime of human trafficking draws a line of demarcation between Adult and Minor at age 18. There is no state where the line between adult and minor victims of human trafficking is not 18 years old, as states' human trafficking legislation base themselves on the Trafficking Victims Protection Act[14] and its definitions (section 103(8): "The term ''severe forms of trafficking in persons'' means – (A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age").

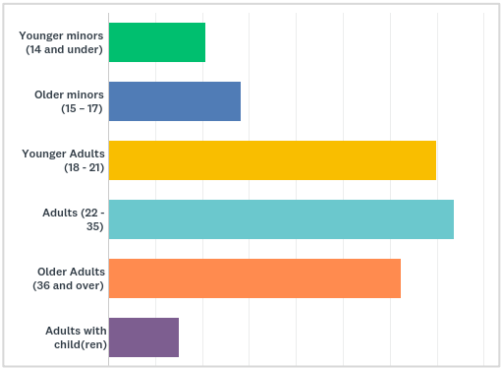
However, there remains an on-going debate in this country as to what constitutes an adult. Take, for example, emancipation. In some states that can happen as early as age 14. A child can drive at age 16. She can vote at age 18. She can purchase alcohol at 21, but she cannot rent a car until age 26. This is a larger social confusion, but where it pertains to restorative care for victims of trafficking, is that many agencies are limited in the age range they can serve based on legal or regulatory factors, not the maturity level or needs of the client. One agency explained how age can be a grey area:

[13] http://www.icjia.state.il.us/assets/pdf/ResearchReports/NSRHVST_101813.pdf
[14] https://www.state.gov/documents/organization/10492.pdf

We're classified as an adult program, but we have, on occasion, taken older minors when the parent grants us temporary custody of the child. Most of the time, the child is within a few months of turning 18 and the parent wants to get her settled into a program she can commit to long-term. I have to say, this arrangement seems to work very well. Usually the victim has such grown-up behaviors that she probably wouldn't do well in a minors' program.

For the purposes of this survey, we offered more than just the Adult vs. Minor segmentation, because some agencies limit the age of intake on the upper end as well. The responding agencies in this survey serve:

20.75%	Younger minors (14 and under)
28.30%	Older minors (15 to 17)
69.81%	Younger Adults (18 to 21)
73.58%	Adults (22 to 35)
62.26%	Older Adults (36 and over)
15.09%	Adults with child(ren)



Sixteen agencies responded to the survey indicating that they serve either Older (15-17) or Younger (14 and under) Minors, and 45 agencies reported serving Adults (over age 18). There were also eight agencies that reported serving Adults with Children.

Citizenship

Almost half of these agencies (49%) reported that in terms of Citizenship, their service population is "Domestic (U.S.) only." Forty-seven percent indicated "Domestic and Foreign National" and the remaining 4% reported "Illegal Alien/Asylee/Refugee."

Geographic Reach

In contrast to some of the anti-trafficking campaigns that territorially claim, "Not in My State!" we were pleased to learn that among this sampling of agencies, there is a much more national perspective. A mere 6% of agencies reported that they only serve survivors from their home state, with the vast majority (94%) claiming that they will serve survivors from *any* state. This certainly shows an acknowledgment of the fact that the crime of domestic human trafficking disrespects geography and judicial boundaries, as victims are often relocated within their period of exploitation. But this also begs the question: do sources that are in the position to refer survivors also know that these agencies are willing and able to receive interstate referrals? How are these referring sources able to identify possible placement agencies? As the Section on Referrals suggests, most of these agencies are seeking to increase their referral base and increase their bed capacity levels.

Languages

The majority of these programs (98.11%) deliver services in English, 30.19% in Spanish, and 8% in either Korean or Mandarin. Seventeen percent reported that they make use of translation services (up to 55 different languages). While translation services are certainly beneficial, they should not be considered the same as being able to fully deliver the program in the client's native language. This study did not ask agencies to report the ethnicities of their clients; however, in a 2016 report from the Polaris Project[15], victims were identified in these ethnic categories:

Latino/Latina: 33.4%
White: 18.5%
Multi-ethnic/racial: 4.5%
Asian: 22.9%
African/African-American: 17.7%

The Office for Victims of Crime's 2013 report noted the following racial/ethnic background breakdown for sex trafficking survivors in 2011[16]:

Black: 40.4%*
White: 25.6%*
Hispanic: 23.9%
Other: 5.8%
Asian: 4.3%

*These numbers are corroborated in a 2011 Bureau of Justice Statistics report[17].

Sobriety

The prevalence of drugs and alcohol in/around prostitution and trafficking is well established. It's also common that victims will present with co-occurring disorders, typically of PSTD and Substance Abuse. What is the position of these agencies on substance abuse/addiction, as a condition for program acceptance?

6%	We only accept clients who have more than 120 days clean
6%	We only accept clients who have at least 60 days clean
30%	We only accept clients who have at least 30 days clean
9%	We only accept clients who have at least 14 days clean
49%	We take clients regardless of clean time

It is worth considering this data point juxtaposed against later findings that suggest while many of these agencies are accepting clients *regardless* of sobriety, these same agencies report needing more training in dealing with addictions and addictive behaviors.

[15] http://polarisproject.org/sites/default/files/2016-Statistics.pdf
[16] http://victimsofcrime.org/docs/ncvrw2013/2013ncvrw_stats_humantrafficking.pdf?sfvrsn=0
[17] https://www.bjs.gov/content/pub/press/cshti0810pr.cfm

Diagnosis

Along the same line, what restrictions might these agencies have on other forms of mental illness or diagnosed disorders?

32%	We will take clients with any (or no) mental health diagnosis
53%	We are not equipped to serve clients with severe mental illness/psychosis
13%	We don't trust their diagnoses, so we accept them and then have our clinicians re-diagnose
2%	We are not equipped to serve clients with any mental health diagnosis

This question elicited several write-in comments, most of which suggested that these agencies are making intake determinations on a case-by-case basis and are actually less reliant on the diagnoses reported during the client referral process. For example:

> *We don't serve women with some mental challenges but it depends on the diagnosis*
>
> *Each case is looked at independently and evaluated based on several criteria and current milieu*
>
> *We're going to consider not only her diagnosis, but who else we have in the house at the time. We've learned we can really only have one or two Borderlines in the house at the same time or it'll be chaos!*
>
> *We don't start with their diagnosis. If they are trafficking victims, we take them. We then have them reassessed.*

Medications

Only a few agencies reported having a medical professional on staff, and many outsource their medication management protocol. So, what might be their limits on client medications?

56%	We allow all forms of physical or mental health medications
9%	We do not allow psychotropic medications
26%	We do not allow narcotic medications
26%	We only allow certain medications
0%	We do not allow any medications

In retrospect, this question was poorly worded. We should have distinguished between pharmacology for physical ailments versus mental health medications. One respondent made this error clear:

> *We're less likely to question meds for her bodily health issues, but we've developed a real skepticism about mental health "meds." Our girls are so over-prescribed and most of them have no idea what they are on or why. It's a real mess!*

Section H. Facilities and Operations

Housing Type

This group of agencies had a near-even split between single-family homes-rural (40 units) versus single-family homes-urban (48 units), with homes in an urban setting being slightly higher. Twelve agencies reported using townhouses for their shelter facility, none use apartments, and nine work with extended stay hotels to provide bed capacity.

We did not ask these agencies to elaborate on the specific home(s) in which they operate, but we can infer from other questions, such as location, housing amenities and recreational activities, that the rural homes suggest a good amount of property, perhaps even a remote location. But is being "out in the boonies" an asset to the program? One informative comment from an agency (that reported now being permanently closed) suggested their hardships in selecting a property that was too remote:

> *We had selected a location that was 3 hours from headquarters to be more central to all of [our state]. This proved to be too difficult to manage and couldn't find appropriately licensed professionals willing to relocate to the rural community.*

Another agency, with three housing units reported:

> *We were given the funds to purchase a house over an hour's drive from our headquarters, because the funder really wanted the shelter home in her county. The daily commute and our inability to respond to crisis in a quick way was part of the reason we closed that house and moved elsewhere.*

Bed Count

The number of beds per housing unit was remarkably homogenous. The most frequent response was 6, and the average across the 46 responding agencies was 6.9. Fourteen agencies in this sample operate more than one housing unit. The average bed capacity for the second housing unit was 7.9. Six agencies reported operating a third housing unit, with an average bed capacity of 4.

SIDEBAR:

Number of beds is not necessarily an exact calculation of a program's capacity. Using The Samaritan Women (TSW) as an example, we operate three separate housing units. Clients move through these units as part of an overall therapeutic progression:

1. TSW's Assessment Center is a 90-day program with 6 beds. Assuming full capacity and 90-day turnover, that's a 24-bed annual capacity.
2. TSW's Restorative program offers 14 beds, but is an 18-month program, so calculating annual capacity must account for that overlap.
3. Similarly, TSW's Graduate program has 6 bedrooms, and is a 2-year program.

Rooming Strategy

Given the responses to dwelling type, we assume that these agencies are typically working within residential homes. How then, within these homes, are the clients situated?

35%	One client per room
46%	Two clients per room
2%	Three clients per room
7%	Dormitory-style/multiple clients in a single bedroom
11%	Room strategy varies by housing unit or program phase

We asked for feedback on why the agencies chose each particular rooming strategy and responses clustered into one of three reasons (with a sampling of respondent comments):

The building dictates the rooming strategy (50%)

> *The house is small so women should share a room so we can serve more women.*
>
> *To maximize our space*
>
> *It's a small apartment that residents share*

They chose their strategy believing it would be more responsive to survivor needs (38%)

> *Individual rooms tend to be more trauma-informed*
>
> *To make it feel less like a homeless shelter and more like a home*
>
> *So they can have their own space*
>
> *Establishing and building of community culture should be encouraged. This population can be divisive and not share*

They felt it would reduce conflict among residents (12%).

> *So they are less likely to form a romantic bond*
>
> *Because when survivors share they fight and there is a lot of drama*
>
> *2 women to a room helps our residents learn healthy conflict resolution*

Security Measures

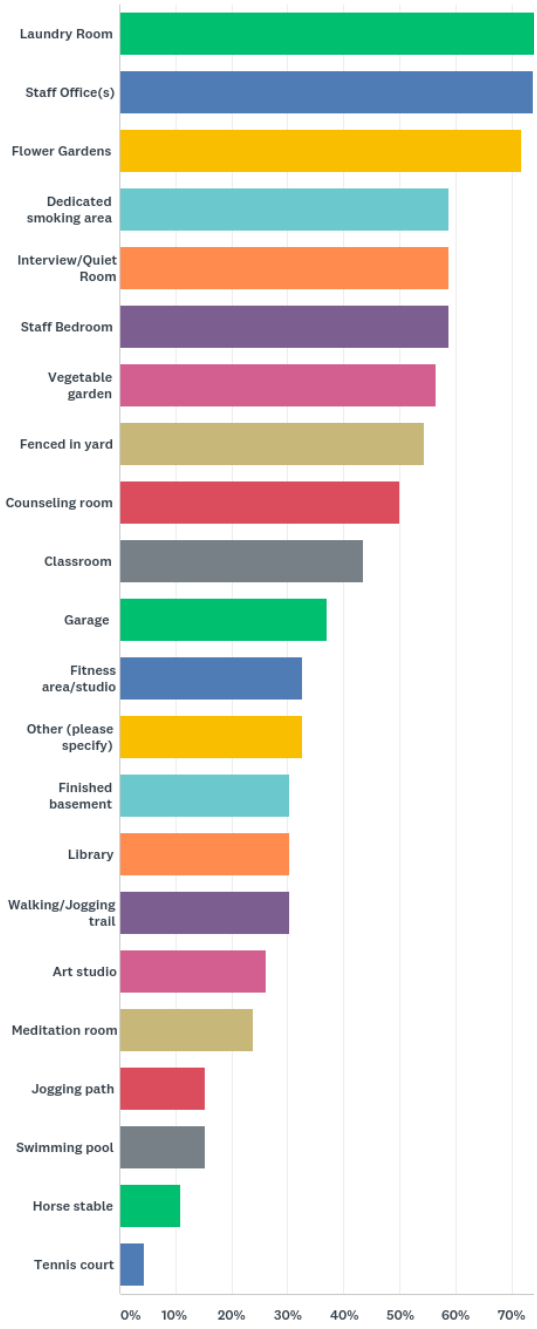
Much ado is made about security for residential programs serving victims of trafficking. We might be unduly influenced by Hollywood in that regard. What this data—and anecdotal feedback from service providers—suggests is that security measures are as much (if not moreso) to mitigate residents going out (or misbehaving inside), rather than intruders coming in. The following table offers the type of security measures currently in place by these agencies and a rank order of the top five deemed most valuable to ensuring safety and security.

Currently in place	Measure	Most Valuable (by priority)
48%	24/7 live-in supervision	
35%	24/7 on-site (but not live-in) supervision	3
74%	**Alarm system**	**2**
17%	Gated community	
13%	Guard dog	
39%	Motion lighting	
37%	Security or privacy fencing	
2%	Security patrol	
76%	**Surveillance camera system**	**1**
	Other: Remote location	5
	Other: Coded locks	4

Perhaps the most entertaining (albeit impractical) write-in response was: *You'll laugh, but we have frequent bears that drop in on our property and that the ladies see!* Presumably, the bears are effective at keeping the residents from wandering off.

Of the comments on security measures that have proven to be unnecessary, the few responses were security guards and unbreakable glass. One respondent offered, *"if they don't get access to a phone, you won't have a security problem."*

Housing Features



From the responses in this survey, it's apparent that the type of dwelling used to house survivors can vary, from simple urban apartment, to historic Victorian mansion, to expansive rural horse farm.

For those start-up agencies that are looking at prospective properties, or the mature agency looking at expansion, we wanted to get a sense of what amenities are currently in place at these homes, and what amenities these agencies deem important to survivor care.

Almost all survey respondents completed this question, and from that we learned that the following features could be considered standard:

- Laundry room on premise
- A staff office inside the home
- Gardens
- Dedicated smoking area
- Dedicated staff bedroom
- Quiet room/Counseling room

Of those features deemed to be most valuable to the program, the responses included (in priority order):

1. Gardens/private outdoor spaces
2. Large gathering room
3. Craft/art room
4. Multiple rooms that allow residents to "change scenery" throughout the day
5. Classroom space

Client Records Management

By reviewing their write-in responses, we get a picture of how data is being managed in these organizations. Many have created their own "systems" using Excel, Google Docs, and paper files. A few have migrated to a client management system (CMS) to store client data and track service consumption/outcomes, but several reported being new with that system and still unsure of the value. Four agencies mentioned Apricot as the tool employed in their enterprises.

24%	Yes, we have implemented a client management system
33%	We track client information, but not in a CMS (we might use Excel, Access, and/or paper files)
19%	We are hoping to get a CMS within the next year
17%	We have no plans for a CMS
7%	What's a CMS?

Apricot takes a bit to adjust to, but it has significantly increased our ability to serve clients well - though we work with about 500 a year, so we needed an CMS to keep current with everyone's service plan. When we were smaller we didn't need this level of CMS.

We use Goldmine. It's alright, it keeps track of statistics and info but it is not user friendly

Peachtree Developed for us

Starting to use SalesForce - it isn't particularly user friendly. Salesforce. We like it.

We are planning to use Clinic Tracker based on recommendations and availability to us.

Section I. Program Architecture

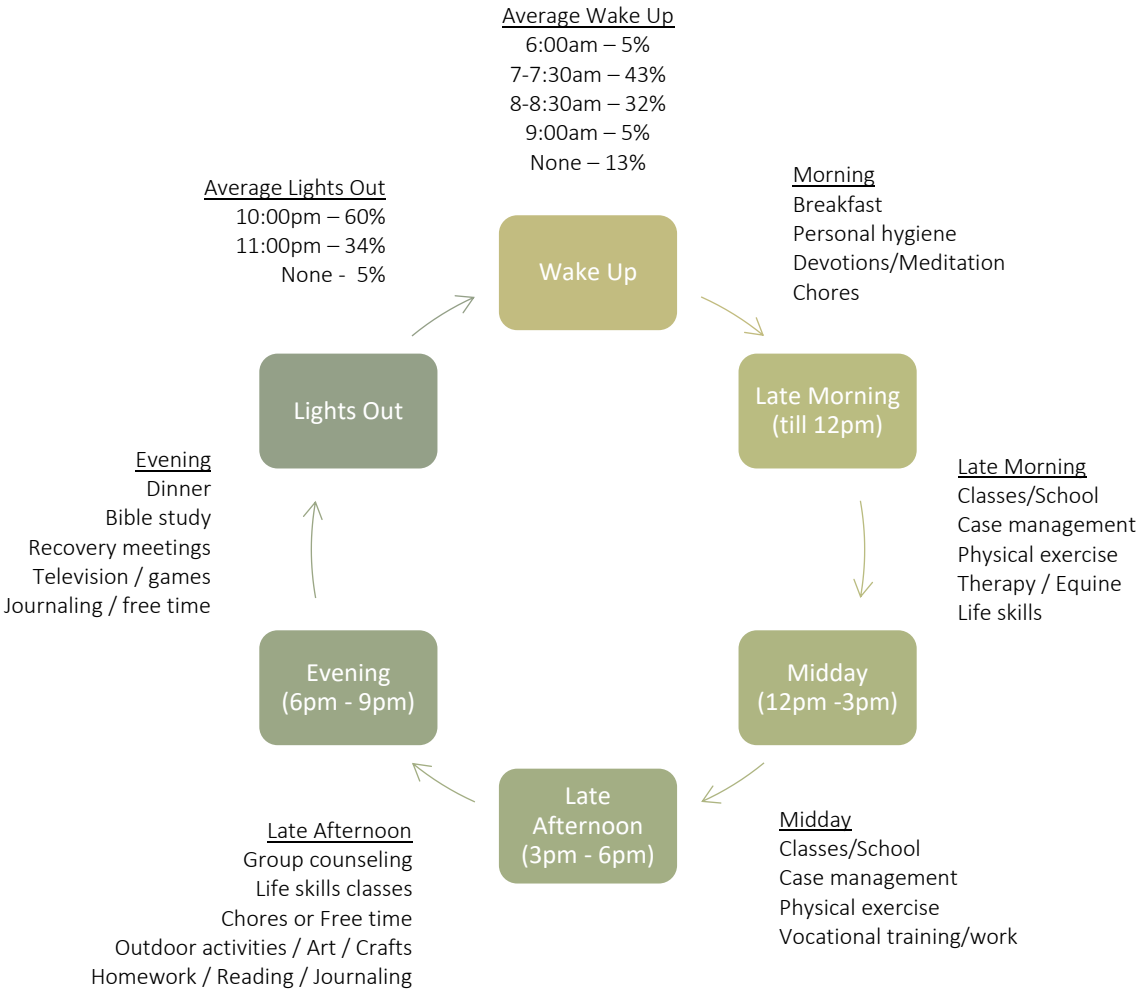
A federal law enforcement professional once made this distinction: "if I take a victim to a shelter, I expect her to be safe and fed, but that's about it. If I take a girl to a *PROGRAM*, I expect her to change." This statement speaks to two points: one, we need to be clear in our language about who we are, so that those seeking services know how to find us; and two, we need to more clearly communicate--internally and externally--our programs the changes we are seeking to affect within our service population.

Our first set of questions were about the general structure or architecture of these programs. In later sections we'll explore the challenges these victims present, the interventions in place, and these providers' opinions on outcomes.

12%	We don't have a program; we customize to each client and what the Case Manager says s/he needs.
2%	Our program is based on duration. Clients progress through the program based on time.
59%	**Our program is based on phases. Client promote through those phases as they accomplish certain objectives in each phase.**
17%	Our program is achievement based. Clients progress as they achieve prescribed milestones.
10%	Other

Day Format

We invited these agencies to describe their "typical day" for clients. From those narratives, the following composite schedule was created:



In future studies, we'd like to probe more into the specific programming (curriculum, therapeutic groups, enrichment activities) that these agencies are finding to be efficacious. As will be noted later in this report, the burden of therapeutic groups, tutoring, life skills training, etc. seems to reside heavily with in-house staff. This helps to explain why staff training is such a critical endeavor for these agencies.

Client Orientation

Much is said about being "trauma-informed" and sensitivity to the needs of victims with these types of experiences. Once a victim has been accepted into a program and becomes a client, what do these agencies do to help the client acclimate and get off to a solid start?

87%	We give each new client a walking tour of our property
94%	We have a routine orientation for each new client
83%	Each client is given a handbook of the program's rules and expectations
77%	Each client is given a personal schedule of activities
26%	Each client is required to meet with a psychiatrist as part of intake
70%	Each client is tested for drugs/alcohol at intake
21%	Each client is tested for STDs as part of intake
19%	New clients are assigned a "buddy" to help them acclimate

> *There is a welcome home party with all of her favorite foods as discovered during intake process. She has an application that she fills out during intake and an essay as to why she wants to come [here]. Doctor visits happen within first 10 days as required by the state so STD's diagnosed then. Meets with Psychiatrist also within first 10 days. A physical inventory of all her belongings are documented.*
>
> *Each client is required to meet with a counselor and case manager as a part of intake. The counselor will assess if a referral needs to be made for a psychiatrist.*
>
> *Once state insurance is obtained, each resident is required to have a full physical and blood work done. As well as a psych assessment done*

Meals

Thirty-five percent of these agencies have an "open" kitchen, meaning residents make their own meals, as they please. It is worth noting that some of the agencies that reported an open kitchen policy are the same who do not have continuous staff or volunteer coverage, or who operate Graduate programs where the residents may not be under constant supervision.

Most agencies (56%) have specified meal times and more often, dine together as a household. Appendix F – Peer-Recommended Policies and Practices offers reinforcement to the communal value of having meals together. How the meals are prepared, however, varies. Of the communal meal agencies, 37% reported that "each client is assigned a cook day and is responsible for the meal that day" whereas the remaining agencies assign meal prep duties to either staff or volunteers.

Along the same lines, we asked how grocery shopping is handled in these agencies. Sixty-three percent "buy all the groceries, according to the meal plan," or "buy certain groceries for the meals but allow clients to buy any additional food they want." A good question this survey failed to ask would be: "What is your food budget per diem?" because some agencies reported that their clients buy all their own food on food stamps (16%), or groceries are donated (3%), and a few write-in comments offered:

> *Women donate toward community food. House supplements the difference.*
>
> *We provide 50 gift card weekly, if the guests has no food stamps.*
>
> *We provide the majority of food through Harvesters but the women get food stamps and use them as they see fit.*

Ceremonial Activities

Recovery programs often have particular ceremonies that bind the members together in community. Reciting the Serenity Prayer is common within AA and NA communities, for example. We asked these agencies if their program includes any regularly practiced routine or ceremony. Of 38 responses, 65% mentioned having a time of "devotion" (reflection/meditation), most often in the morning, but some in the evening.

> *"Heart Talk" happens every night (group processing/discussion time including staff where we talk about highs/lows from the day and manage conflict and share ideas)*
>
> *We have a house "huddle" to celebrate wins from the week and build community in the home one evening a week combined with a community dinner that is prepared by a different resident (with staff support) each week.*
>
> *We open every day with circle time. This is a check in and gratitude time to start the day off right.*
>
> *we have family meeting, family dinner each week; cultural dinner each month; we celebrate all birthdays and holidays*
>
> *A quiet time for journaling or reading is at 3pm, though this can be done at other times. The quiet time is still at 3pm, though. Gratitude time is at supper. Everyone eats all meals together.*
>
> *Gratefuls at every meal as opposed to a prayer or blessings. Journaling and reading at bed time. Monthly character awards. Welcome home parties and monthly birthday parties.*

Weekend Activities

Weekend activities varied based on the location of the program, the options in those communities, the goals of the program and the initiative of the staff and volunteers (it's worth noting that several entries mentioned activities being volunteer-led).

Four organizations reported that there is no scheduled programming on the weekends, "participants can do what they want." Weekend activities are listed below in order of frequency of mention:

- Outings: zoo, museums, theatre, movies, sporting events
- Church attendance
- Physical activities: horseback riding, hiking, swimming, rollerblading, beach, yoga
- Volunteer-led groups: Art, music, games, crafts,
- Recovery meetings
- Family visits
- Eating out
- Volunteering
- Grocery shopping

Participant Voice

One of the Trauma-Informed Care guidelines (see Appendix C) suggests the importance of offering clients' clear opportunity to voice preferences and make decisions about their own care. We asked these agencies how that guideline plays out in their program structures and practices. Several of these agencies reported building "weekly check-ins" into their program, which are opportunities for clients to share with staff how things are going. Some wrote in responses that suggest an "open door policy." Some of the specific communication channels offered to their clients included:

73%	We have weekly "Community Meetings" for clients to discuss concerns or pose suggestions
66%	We have a grievance process where clients can pose objections to a rule or program element
61%	We have an Exit Interview process for departing clients
41%	We have a Suggestion Box where clients can leave notes
41%	We invite client feedback at the end of Groups
9%	We have a Survivor Advisory Panel that informs our program decisions
7%	We don't have a formal way for clients to give input

Section J. Therapeutic Client Services

In this section, we'll specifically attend to services and programming activities that are meant to address survivors' therapeutic/mental health needs. The survey did not ask agencies to report the clients' needs they have identified. Recall from the Section on Intakes that several of these agencies do not have confidence in the labeled diagnoses of a referral and instead opt to have clients reevaluated. Nonetheless, an effort is made here to understand what techniques or interventions are being used in response to client needs and behaviors.

"She was diagnosed right before coming to us. I accepted her knowing that girls are often misdiagnosed. Her diagnosis was reconfirmed by our therapist. She has presented several personalities while in our home and is increasingly flipping between them...The behavior problem is aggression, yelling, uncontrollable emotion. When she is in this state, we have not been able to get her to deescalate. We have to walk away because she won't stop and won't walk away. Eventually she calms down but it is disruptive to the whole house. After she has one of these events, she doesn't remember it happening. She says she can't control her behavior because she doesn't remember it. She often doesn't believe us when we try to address it later." – Agency staff

Trauma Counseling

We can all agree that victims of human trafficking are survivors of trauma. What is still open to wide interpretation and expression is how we most effectively attend to the needs of the individuals traumatized in this way. According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1) *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2) *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3) *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4) Seeks to actively resist *re-traumatization*."[18]

How, then, is the issue of trauma being attended to within these agencies? We asked first about mental health counseling. All but two of the 43 agencies that responded indicate that they offer individual trauma counseling to clients, albeit in a variety of ways:

37%	We use external service providers who bill client insurance
37%	We have a part-time staff therapist/counselor who is trauma-trained
35%	We have a full-time staff therapist/counselor who is trauma-trained
9%	Our lay staff is providing counseling to our clients
5%	We have a therapist/counselor but s/he is not trauma-trained
5%	We are not currently providing individual trauma counseling

[18] https://www.samhsa.gov/nctic/trauma-interventions

In-House Therapies

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Alternative therapies (equine, art, drama, etc.)	**29.55%**	**47.73%**	**40.91%**	15.91%	0.00%	0.00%
Medication management	**54.55%**	2.27%	**25.00%**	**25.00%**	9.09%	0.00%
Psychological testing	18.18%	2.27%	**52.27%**	36.36%	11.36%	0.00%
Trauma counseling	**40.91%**	2.27%	**45.45%**	20.45%	4.55%	0.00%
24-hour hotline (for clients to call you)	**45.45%**	2.27%	4.55%	11.36%	29.55%	11.36%

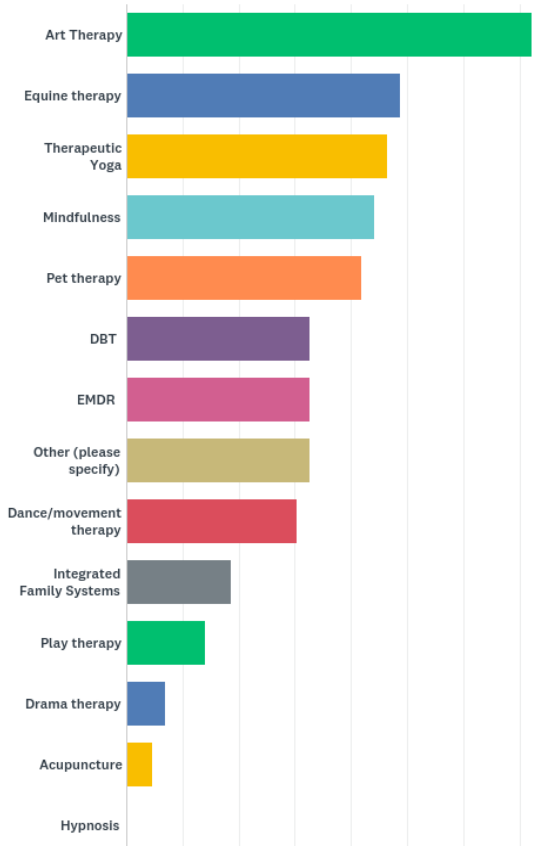
The corresponding table[19] helps us understand how keenly involved the residential staff are in the therapeutic/mental health needs of survivors. Note that the majority of Alternative Therapies (74%) are led by volunteers or agency staff. Trauma counseling is split between Staff and outside Service Providers. Notice, too, that some of these agencies are offering a 24-hour hotline in addition to 24-hour residential care.

The task of Medication Management should have been worded more clearly. It is appropriate for staff to facilitate access to medications and track consumption, but only appropriate for a licensed professional to advise the client on a pharmacology regime or step-down protocol. The 50/50 split in responses here is appropriate.

[19] MOU – Memorandum of Understanding. An MOU-based Service Provider is one with whom the agency has formed a specific agreement for services. This may be in the form of a contract, or a written understanding about their mutual approach to care.

We invited these agencies to report on the types of therapies offered, some that require specific training (even licensure) as well as those that do not. We did, however, clarify that to be included, the activity must be for specific therapeutic intent, as opposed to recreation, research, or other purposes. These agencies reported as follows:

72%	Art therapy
49%	Equine therapy
47%	Therapeutic Yoga
44%	Mindfulness
42%	Pet therapy
33%	Dialectical Behavioral Therapy
33%	EMDR
30%	Dance/movement therapy
19%	Integrated Family Systems
14%	Play therapy
7%	Drama therapy
5%	Acupuncture
0%	Hypnosis



Other therapies: music, MNRI, trauma release therapy, motivational interviewing

Diagnoses and Interventions

In the next several sections, we sought to determine the specific interventions being used for the most commonly-occurring conditions. Curiously, the responses were repetitive, almost redundant. Across these conditions, respondents offered "counseling," "appropriate therapies," "trauma-informed interventions," or "whatever our mental health provider advises" as the most oft-occurring responses. There may be several explanations for this:

1. The survey respondent may not be familiar with the actual therapies being used, particularly if counseling is outsourced;
2. The client may present confounding symptoms, so the agency is not able to clearly delineate for an appropriate intervention;
3. The conditions or symptoms may be similar or overlapping, such that redundancy is appropriate; or
4. We may not really know how to treat some of these conditions, and these agencies are doing the best they can.

Because we cannot be sure--and there are likely so many variables at play--the following sections report only where there were distinct interventions or therapies being offered.

Substance Abuse

Most cited responses: Celebrate Recovery, Alcoholics Anonymous and/or Narcotics Anonymous, IOP, Relapse Prevention Plans, Random drug testing and Outpatient recovery services

> *If needed, we will send a resident to and A&D treatment facility, we teach an Addiction Education class as well as a Relapse Prevention class*

> *We provide on-site chemical dependency assessments and work with treatment centers to access detox and inpatient for clients in need of those services. We also utilize outpatient therapy with partner agencies and run a chemical dependency support group.*

Commonly-Diagnosed Disorders

The following sections address the most commonly-diagnosed disorders among human trafficking clients. Reference Appendix D for definitions of the most commonly-referenced interventions.

Anxiety[20,21,22,23]

Symptomatic behaviors include…	**Typical interventions** include…

• Panic attacks: short/shallow breaths, sweating, trembling/shaking, needing to sit down due to feelings of dizziness
• Having a highly-sensitive fight/flight/freeze response
  ○ In other words, it is easy for the person to believe he or she is not safe
• Avoiding places or situations to prevent feeling worry/fear
• Feelings/reports of:
  ○ Intense and constant worry/fear that is *out of proportion to actual danger*
  ○ Upset stomach (nausea, diarrhea)
  ○ Chest pain
  ○ Suddenly cold or hot
  ○ Heart pounding
  ○ Headaches
  ○ Insomnia
	• Relaxation training
	  ○ Mindfulness/meditation
	  ○ Yoga
	• Cognitive-Behavioral Therapy (CBT)
	  ○ Focuses on understanding and changing thinking and behavior patterns
	• Exposure therapy
	  ○ Gradual exposure to feared situation/object, learning to become less sensitive over time
	• Dialectical Behavioral Therapy (DBT)
	  ○ Involves learning mindfulness strategies and skills for tolerating distress/regulating emotions
	• Eye Movement Desensitization & Reprocessing (EMDR)
	  ○ Helps person see disturbing material in a less distressing way
	• Anti-anxiety medication

Most cited responses: coping skills training, mindfulness, breathing exercises, medications, go for a walk, DBT, Narrative Therapy, Art Therapy, TF-CBT, Yoga, Art

> *We have a massage chair and will soon have a mini-spa, we have small candies for anxiety, an essential oil diffuser that has stress relief oil in it, and we offer guidance with techniques such as deep breathing, exercise, talking through the emotions, doing art, reading, etc., and do lay counseling.*
>
> *Counseling using the therapy of Trust Based Relational Interventions (TBRI) by Dr. Karen Pervis*
>
> *We do a lot of psycho-education, helping her become more attuned to her bodily responses, making her aware of her environment, and then activating her reasoning to make more accurate assessments of those things that provoke fear*
>
> *Normalization of experiences through talk therapy and survivor-exclusive programs*

[20] https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Anxiety-Disorders-FS.pdf
[16] http://www.mayoclinic.org/diseases-conditions/anxiety/home/ovc-20168121
[17] https://www.beckinstitute.org/detail/panic-disorder/
[18] https://adaa.org/sites/default/files/Treating%20Anxiety%20Disorders.pdf

Depression[24,25,26,27]

Symptomatic behaviors include…	**Typical interventions** include…

• Sudden, noticeable increase or decrease in:
  ○ Sleep
  ○ Eating/appetite
  ○ Weight
• Being unable to concentrate or make decisions
• Feeling tired/low-energy
• Feeling sad/tearful, and/or like one needs to cry, but can't
• Withdrawing from/losing interest in things that used to bring joy/contentment
• Bodily aches/pains
• Being easily irritated
• Voicing recurring thoughts, such as, "It's all my fault" (pointing to feelings of low self-worth)
• Suicidal thoughts or plans
	• Relaxation training
	  ○ Mindfulness/meditation
	  ○ Yoga
	• Cognitive-Behavioral Therapy (CBT)
	  ○ Focuses on understanding and changing thinking and behavior patterns
	• Light therapy
	  ○ Uses light box to regulate melatonin (hormone that controls sleep/wake cycle)
	• Exercise
	• Nutrition
	  ○ Getting recommended daily food-group doses for vitamins, minerals, and nutrients the body needs
	• Antidepressant medication

Most responses: talk therapy, counseling, medication, and peer support

> *We give the client a card with the 24-hour crisis line number, give lay counseling, and refer out to mental health counselors.*
>
> *We get them out of bed! Get them outside! Get them out of their own heads! Peer support is important, so are improved diet, exercise, and a good night's rest. And we work on medication reduction - so much of this pharma is making them sicker!*
>
> *Talking to them. Encouraging them. Again music helps we have also found that the animals are great therapy for depression*
>
> *Most of our clients are in some type of medication for depression. But we also do exercises, healthy eating and the Word of God*

[24] https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Depression-FS.pdf
[25] http://www.mayoclinic.org/diseases-conditions/depression/home/ovc-20321449
[26] https://www.beckinstitute.org/detail/depression/
[27] http://www.healthline.com/health/depression/recognizing-symptoms#overview1

Post-Traumatic Stress Disorder (PTSD)[28,29,30,31]

Symptomatic behaviors include…	**Typical interventions** include…

• Severe anxiety (having a highly-sensitive fight/flight/freeze response)
  ○ In other words, it is easy for the person to believe he or she is not safe
• Experiencing flashbacks, nightmares, and intrusive memories (i.e., remembering traumatic event(s) without warning or cause)
• Repressing thoughts/memories/feelings related to trauma
• Avoiding external reminders (places, people, or activities)
• Heightened sense of danger/threat, which could lead to:
  ○ Irritability
  ○ Angry outbursts
  ○ Reckless/impulsive decisions
  ○ Inability to sleep
• Change in thinking about self, others, and the world
• Detachment from others/environment
  ○ Withdrawing from current, positive relationships
  ○ Avoidance of developing new relationships
• Dissociation
  ○ Detachment from self, and sense of self
  ○ "Going somewhere else" in one's mind
• Inability to experience positive emotions
• Withdrawing from/losing interest in things that used to bring joy/contentment
	• Relaxation training
	  ○ Mindfulness/meditation
	  ○ Yoga
	• Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
	• Cognitive-Behavioral Therapy (CBT)
	  ○ Focuses on understanding and changing thinking and behavior patterns
	• Exposure therapy
	  ○ Gradual exposure to feared situation/object, learning to become less sensitive over time
	• Eye Movement Desensitization & Reprocessing (EMDR)
	  ○ Helps person see disturbing material in a less distressing way
	• Antidepressant, antianxiety, antipsychotic, mood-stabilizing medication combination

Most cited responses: Seeking Safety curriculum, DBT, Trauma-Focused Cognitive Behavioral Therapy, counseling

Activities related to TF-CBT that are modified for sexual exploitation survivors, art therapy

Additionally, providing information and vocabulary framework to help understand what the individual client is experiencing

[28] https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/PTSD-FS.pdf
[29] http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/home/ovc-20308548
[30] https://www.beckinstitute.org/detail/posttraumatic-stress-disorder/
[31] https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

Bipolar Disorder[32,33,34,35]

Two types of bipolar disorder:

- At least 1 manic + at least 1 hypomanic or major depressive episode = type 1
- At least 1 major depressive + at least 1 hypomanic episode = type 2

Symptomatic behaviors of a _____ include…	**Typical interventions** include…

Major depressive episode
• Sudden, noticeable increase or decrease in:
  ○ Sleep
  ○ Eating/appetite
  ○ Weight
• Being unable to concentrate or make decisions
• Feeling tired/low-energy
• Feeling sad/tearful, and/or like one needs to cry, but can't
• Withdrawing from/losing interest in things that used to bring joy/contentment
• Bodily aches/pains
• Being easily irritated
• Voicing recurring thoughts, such as, "It's all my fault" (pointing to feelings of low self-worth)
• Suicidal thoughts or plans
	• Relaxation training
	  ○ Mindfulness/meditation
	  ○ Yoga
	• Cognitive-Behavioral Therapy (CBT)
	  ○ Focuses on understanding and changing thinking and behavior patterns
	• Electroconvulsive therapy (ECT)
	  ○ Only for individuals for whom all other treatments have not worked
	• Mood-stabilizing medication

Manic/hypomanic episode • Feeling overly happy or "high" for long periods of time • Having a decreased need for sleep • Talking very fast, often with racing thoughts • Feeling extremely restless or irritated • Easily distracted • Overconfidence in abilities (feeling 'invincible') • Impulsive/risky behavior • *N.B.* Manic and hypomanic episodes look similar, but manic episodes are more severe, and in some cases may cause break from reality	

Most cited responses: counseling, medication, refer to another program

> *mostly psycho education. most of our ladies have no idea what this diagnosis means and say it's invalid once they understand it*
>
> *Individual Counseling, DBT, Yoga, Art Therapy*

[32] https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Bipolar-Disorder-FS.pdf
[33] http://www.mayoclinic.org/diseases-conditions/bipolar-disorder/symptoms-causes/dxc-20307970
[34] https://www.beckinstitute.org/detail/bipolar-disorder/
[35] https://www.healthline.com/health/could-it-be-bipolar-seven-signs-to-look-for#overview1

Complex Trauma

> Complex post-traumatic stress disorder (C-PTSD; also known as complex trauma disorder) is a psychological disorder thought to occur as a result of repetitive, prolonged trauma involving harm or abandonment by a caregiver or other interpersonal relationships with an uneven power dynamic. C-PTSD is associated with sexual, emotional or physical abuse or neglect in childhood, intimate partner violence, victims of kidnapping and hostage situations, indentured servants, slavery, sweatshop workers, prisoners of war, bullying, concentration camp survivors, and defectors of cults or cult-like organizations. Situations involving captivity/entrapment (a situation lacking a viable escape route for the victim or a perception of such) can lead to C-PTSD-like symptoms, which include prolonged feelings of terror, worthlessness, helplessness, and deformation of one's identity and sense of self. Some researchers argue that C-PTSD is distinct from, but similar to PTSD, somatization disorder, dissociative identity disorder, and borderline personality disorder, with the main distinction being that it distorts a person's core identity, especially when prolonged trauma occurs during childhood development.[36]

Most cited responses: DBT, mindfulness, art therapy, peer support, brain training

> *Mostly we're relational. We work hard to create connections and dispel the lies in their heads. We offer peer support*
> *We have used DBT for trauma, and have tried EMDR as well. However, the girls do not like EMDR for some unknown reason*
> *sand tray, EMDR, large body movement, art*

Support groups was mentioned repeatedly as vital to survivor healing. Whether formally directed, or defined by the survivor's peers, there is a wealth of evidence to suggest that "a sense of community" is a strong healing agent against the ravages of trauma.

> "Traumatic events destroy the sustaining bonds between individual and community. Those who have survived learn that their sense of self, of worth, of humanity, depends upon a feeling of connection with others. The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity. Repeatedly in the testimony of survivors there comes a moment when a sense of connection is restored by another person's unaffected display of generosity. Something in herself that the victim believes to be irretrievably destroyed---faith, decency, courage---is reawakened by an example of common altruism. Mirrored in the actions of others, the survivor recognizes and reclaims a lost part of herself. At that moment, the survivor begins to rejoin the human commonality..." [37]
>
> ~ Dr. Judith Lewis Herman

[36] https://en.wikipedia.org/wiki/Complex_post-traumatic_stress_disorder

[37] Herman, Judith L. (2015). *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*. New York, NY: Basic Books.

Self-Harming Behaviors

Most cited responses: safety planning, talk therapy, call 911

> *support groups for our girls that self harm and for our care givers*
>
> *we offer alternatives we talk A LOT about motivations and options*
>
> *Depending on what self-harm they do. We have had cutters so we make sure there isn't anything that they could use to cut themselves. We have had girls bang their heads on the walls so we just put a pillow up so they don't hurt themselves and talk to them. Just keeping them safe and having the counselor work on those areas*
>
> *Mainly prevention around the house*

Other Diagnoses

We asked these providers to identify the other diagnoses they encounter most often and their write-in responses included:

- Attention Deficient Disorder
- Borderline Personality Disorder
- Dissociation
- Dissociative Identity Disorder
- Night Terrors/Sleep Disorders
- Oppositional Defiance Disorder
- Parental abandonment
- Relational Attachment Disorder
- Satanic Ritual Abuse
- Schizoid-affective disorders
- Sociopathy

This write-in response was particularly pointed: *"Some of these girls don't have a mental disorder. Some just lack any kind of parenting, or were never taught, and as a result are exceptionally ill-behaved. Not everything is a disorder and we shouldn't label her for life as such. But to be sure: a Brat can create some serious disorder in the house!*

And to the point of disruption, how do these agencies achieve stabilization from outbursts? Surprisingly, 35% of the total number of respondents reported that they have not had to deal with outbursts. Over 40% indicated that they would not apply an intervention, but move directly to contacting 911 for assistance. Their responses are as follows:

21%	De-escalation techniques ("verbal judo")
26%	Temporary isolation
19%	Therapeutic holds
2%	Therapeutic restraints
7%	Medication
43%	None, we just call 911

Section K. Other Client Services

This helpful graphic from the Hands That Heal curriculum[38] by FAAST, depicts the scope of services that must be addressed in caring for survivors of sex trafficking. Consider across these domains of service, how comprehensive these agencies must be in order to respond to the needs of trafficking victims. In this Section, we obtained a snapshot of what additional client services are being offered to survivors, and by whom.

Physiological / Medical

As agencies respond to the physiological/medical needs of trafficking survivors, quite expectantly, most services are being offered through relationships with MOU- or non-MOU-based service providers.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Abortion	6.98%	2.33%	4.65%	13.95%	**55.81%**	23.26%
Cosmetic dental	0.00%	11.63%	9.30%	44.19%	34.88%	4.65%
Detox	4.55%	0.00%	20.45%	29.55%	**45.45%**	9.09%
Emergency medical	11.11%	4.44%	22.22%	48.89%	24.44%	2.22%
GYN	2.22%	4.44%	**44.44%**	**42.22%**	15.56%	0.00%
Pregnancy/Prenatal	2.27%	4.55%	**38.64%**	**29.55%**	**29.55%**	9.09%
Drug testing	**68.18%**	0.00%	13.64%	6.82%	15.91%	2.27%
Routine dental care	2.27%	9.09%	**38.64%**	**54.55%**	6.82%	0.00%
Routine med exams	2.27%	2.27%	**54.55%**	**43.18%**	9.09%	0.00%
Social service enrollment	**51.16%**	2.33%	18.60%	23.26%	9.30%	2.33%
Substance abuse counseling	37.78%	8.89%	37.78%	28.89%	11.11%	0.00%
STD testing	2.22%	0.00%	**53.33%**	**37.78%**	11.11%	2.22%
Tattoo/scar removal	2.27%	15.91%	18.18%	25.00%	31.82%	11.36%
Vision care	4.76%	0.00%	**30.95%**	**59.52%**	9.52%	0.00%

It is worth noting the low percentages in the "Not needed" column, which implies that these services may actually be oft-needed. Clearly these agencies are having to broker services for survivors across a wide range of issues. This may suggest an opportunity for pro bono or discount medical service providers to offer support to these agencies.

[38] http://faastinternational.org/

What was not represented in this inquiry were the other physiological needs of survivors, namely nutrition, exercise, and rest, as well as learning how to "read" one's bodily responses and adapt accordingly. Several of the agencies who provide emergency and short-term housing commented on how much energy goes into just getting the survivors to eat better, get on a sleep schedule, exercise, etc. Many of them know first-hand how profoundly this population can learn to disassociate their minds from their bodies. The Body Keeps the Score by Dr. Bessel van der Kolk, is a favorite among these agencies for such insights as:

> Trauma victims cannot recover until they become familiar with and befriend the sensations in their bodies. Being frightened means that you live in a body that is always on guard. Angry people live in angry bodies. The bodies of child-abuse victims are tense and defensive until they find a way to relax and feel safe. In order to change, people need to become aware of their sensations and the way that their bodies interact with the world around them. Physical self-awareness is the first step in releasing the tyranny of the past.
>
> In my practice I begin the process by helping my patients to first notice and then describe the feelings in their bodies—not emotions such as anger or anxiety or fear but the physical sensations beneath the emotions: pressure, heat, muscular tension, tingling, caving in, feeling hollow, and so on. I also work on identifying the sensations associated with relaxation or pleasure. I help them become aware of their breath, their gestures and movements.
>
> All too often, however, drugs such as Abilify, Zyprexa, and Seroquel, are prescribed instead of teaching people the skills to deal with such distressing physical reactions. Of course, medications only blunt sensations and do nothing to resolve them or transform them from toxic agents into allies. The mind needs to be reeducated to feel physical sensations, and the body needs to be helped to tolerate and enjoy the comforts of touch. Individuals who lack emotional awareness are able, with practice, to connect their physical sensations to psychological events. Then they can slowly reconnect with themselves." [39]

[39] van der Kolk, B. (2015). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. New York, NY: Penguin Books.

Legal

Trafficking survivors have often intersected with the law, not only in their role in the crime of trafficking and/or prostitution, but it is common for victims to also have incurred other (often related) criminal offenses. In 2003, a Department of Justice needs assessment of human trafficking survivors and service providers reported that 99% of sex trafficking survivors needed legal services in some capacity, which, notably, was higher than the reported need for medical services (98%).[40]

A 2015 national survey conducted by the National Survivor Network found that 90% of its respondents (all but one of whom were sex trafficking survivors) had been arrested at least once, and 52.9% of those survivors reported that all of their arrests were trafficking-related. The crimes for which survivors reported being arrested are shown in the table, recreated from page 4 of the National Survivor Network's report. [41]

Prostitution	63.6%
Solicitation	48.5%
Intent to Solicit	24.2%
Truancy	12.1%
Drug Possession	39.4%
Drug Sales	18.2%
Other	63.6%

Notably, arrests for non-commercial sex crimes were nearly as common as arrests for prostitution, even though all but one respondent were sex trafficking survivors.[42] Furthermore, 70% of respondents with criminal records have been unable to achieve partial or total clearance of their convictions.[43] Respondents from this survey report needing to address the following legal needs for clients.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Family law (custody, divorce, alimony, etc.)	4.44%	15.56%	20.00%	31.11%	26.67%	8.89%
Immigration services	2.22%	2.22%	20.00%	17.78%	31.11%	26.67%
Preparation for testifying	**31.11%**	**15.56%**	24.44%	26.67%	20.00%	8.89%
Education on victims' rights	**40.91%**	**9.09%**	15.91%	31.82%	15.91%	2.27%
Application for civil remedies/crime victim assistance funding	37.78%	6.67%	17.78%	17.78%	17.78%	15.56%
Emancipation of minors	6.67%	2.22%	4.44%	11.11%	**40.00%**	**40.00%**
Assistance in obtaining T-visa or U- visa or Continued Presence	8.89%	4.44%	22.22%	15.56%	24.44%	31.11%
Assistance in obtaining HHS certification	15.91%	2.27%	13.64%	11.36%	36.36%	27.27%
Protection from abuse orders	20.45%	4.55%	20.45%	18.18%	31.82%	15.91%

[40] https://www.ncjrs.gov/pdffiles1/nij/grants/202469.pdf
[41] http://nationalsurvivornetwork.org/templates/files/nsn-arrest-criminal-background-survey-report-jan-2016.pdf
[42] http://files.meetup.com/1567170/Expanding%20MDs%20Vacatur%20Law-%20Issue%20Brief.pdf
[43] http://nationalsurvivornetwork.org/templates/files/nsn-arrest-criminal-background-survey-report-jan-2016.pdf

Legal – continued

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Transportation to/from court appointments	**77.78%**	33.33%	2.22%	4.44%	4.44%	4.44%
Regular reporting to parole/probation officer	**66.67%**	17.78%	4.44%	4.44%	6.67%	13.33%
State-level identification	**68.18%**	9.09%	0.00%	13.64%	18.18%	4.55%
Passport application	33.33%	8.89%	6.67%	8.89%	26.67%	26.67%

The data table from this survey suggests that clients might actually be under-served in the area of their legal needs. The low percentages overall suggest that there is less of this service domain being offered, and yet other studies have indicated that the needs are great. In this survey we did not ask if these agencies have General Counsel or attorneys on staff or working as volunteers. The low percentage of MOU-based or non-MOU based service providers could suggest that these agencies do not have sufficient partnerships with legal services providers. Juxtapose that theory against the high percentage of staff and volunteers who are providing education and coaching about legal matters and we might infer that what "legal help" is being offered is from a lay perspective. Further inquiry into both needs and solutions needs to take place; however.

To offer a more specific snapshot, the accompanying case study summarizes the legal needs of survivors within The Samaritan Women program over a four-year period. The majority (69.56%) of residents from this timeframe had more than one legal need, and 10.87% reported having no legal needs.
This agency, located in the Baltimore-Washington area, has the advantage of several law schools, pro-bono legal centers and women's law centers that offer support to their clients.

CASE STUDY: Sample Data from The Samaritan Women

Criminal Law	
Expungement/sealing/shielding/*vacatur* of criminal records	60.87%
Coordination with LEA on open/active cases (defendant)	47.83%
Legal fines/fees owed	47.83%
P.O./LEA reporting	43.48%
Coordination with LEA on open/active cases (witness)	23.91%
Immigration Law	
Immigration services/LEA coordination	6.52%
Family Law	
Child paternity/custody issues	15.22%
Referral for adoption/parenting planning	10.87%
Divorce	8.70%
Civil Law	
Identity theft advocacy	23.91%
Appeal for public benefits	6.52%
Other	6.52%

Financial

Several agencies reported anecdotally that clients often come into these programs bearing the weight of considerable debt—much of which was not incurred by them, but as a result of identity loss and/or other criminal acts as part of the trafficking experience. While most of survivors are adept at accounting for money—given their very lives depend on it—these care-givers report that very few clients understand basic principles of money management. How are these agencies addressing the issue of money and financial management for their clients? Not surprisingly, more of the financial services were weighted "not providing" or "not needed" among minor-serving agencies.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Basic money management course(s)	**73.33%**	48.89%	6.67%	8.89%	0.00%	0.00%
Credit counseling / debt relief	40.91%	29.55%	13.64%	13.64%	18.18%	6.82%
Establish a bank account	**88.89%**	22.22%	0.00%	6.67%	4.44%	0.00%
Debt inventory	**56.82%**	29.55%	6.82%	13.64%	9.09%	13.64%
Personal budgeting training	**68.89%**	**51.11%**	2.22%	11.11%	4.44%	0.00%
Down payment or rent subsidy	24.44%	6.67%	11.11%	13.33%	42.22%	15.56%
Micro loans	6.67%	2.22%	0.00%	6.67%	**53.33%**	37.78%
Discounts on major purchases	6.67%	6.67%	2.22%	4.44%	**55.56%**	31.11%

Academic Services

The traditional classroom environment poses greater risk for harm than good to sex trafficking survivors. We begin to understand this by first understanding the science of the brain. The hippocampus region of the brain, which plays a major role in learning and memory, is profoundly impacted by stress hormones (like cortisol) and stress-related neurotransmitters, disfiguring its structure and making it smaller than it should be. Now, this memory-and-learning powerhouse is unable to function anywhere near as well as it once did[44]. Chronic, complex trauma forces the body's and brain's flight/fight/freeze response to go into overdrive, making it both very difficult to shut down and very easy to reactivate[45]. This hypersensitive flight/fight/freeze response (during which the person is focused solely on survival) impacts sex trafficking survivors' ability to engage in a mainstream classroom environment:

> "In order to learn – to change the brain…the right parts of the [brain] must be activated and receptive to learn traditional "cognitive" concepts such as we teach in schools… Classroom learning cannot occur if the child is in either a persistent state of…anxiety, or of dissociation. When in this state, the key parts of the [brain] are not receptive to cognitive information that is not relevant to survival. The traumatized child's brain is essentially unavailable to process efficiently the complex cognitive information being conveyed by the teacher….
>
> This principle is critically important in understanding why a traumatized child – in a persistent state of arousal – can sit in a classroom and not learn…. The capacity to internalize new verbal cognitive information depends upon having portions of [higher brain regions] activated, which in turn requires a state of attentive calm. Sadly, this is a state that the traumatized child rarely achieves"[46]

Minors

So how are these agencies addressing the need for academic achievement among survivors? The following table shows how only the minor-serving agencies in this study responded.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Individual tutor(s)	23.08%	**69.23%**	15.38%	23.08%	7.69%	0.00%
Language Interpretation services	0.00%	25.00%	16.67%	0.00%	33.33%	25.00%
College enrollment/ academic advising	**84.62%**	38.46%	23.08%	7.69%	0.00%	0.00%
Securing academic transcripts	**92.31%**	15.38%	7.69%	7.69%	7.69%	0.00%
Placement or aptitude testing	**53.85%**	7.69%	30.77%	23.08%	15.38%	0.00%
ESL classes or tutoring	15.38%	15.38%	7.69%	7.69%	**46.15%**	23.08%
Financial aid enrollment	**76.92%**	15.38%	7.69%	15.38%	23.08%	0.00%
GED classes or tutoring	**53.85%**	15.38%	23.08%	23.08%	7.69%	7.69%

[44] http://www.childtraumaacademy.com/amazing_brain/lesson04/page02.html
[45] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5403247/
[46] http://www.childtraumaacademy.com/amazing_brain/lesson05/page02.html

The residential programs in this study seem to have readily understood that chronic, complex trauma survivors are much more likely to struggle in the classroom because the human brain learns by experience, and experience has taught them that leaving their guards down long enough to focus on why "$y = mx + b$" is not an option. Without specialized learning environments, that customize education programming to survivors' unique educational histories and capabilities, it would be very difficult for survivors to bridge the gap between themselves and their same-age peers. Programs like The Children's Home (Catonsville, MD) has a Level III-certified school on its campus, and GraceHaven (Columbus, OH) is able to make online high school courses available to its residents.

CASE STUDY: GraceHaven

Our clients are enrolled in an online school curriculum that has been licensed by the state. This is one of the better ways to educate our clients since they are all at different stages within their educational program. So, you can't have one teacher teach them together…they are all on individual education plans. They are enrolled in this program that mandates that they spend 5 hours each day doing school work…so each day during the week, the resident assistants take them to this new location where they have their own computer and they study for 5 hours 5 days a week. There they get and complete all their assignments online as well as take their tests.

Adults

We don't have reason to think that the need is profoundly different for adult survivors. If anything, they have lived with chronic stress longer, and developed more entrenched neural pathways that could pose more stubborn barriers to traditional learning modalities. From the table below that contains data from the adult-only programs, we see that many of the strategies are the same as for minors.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Individual tutor(s)	32.43%	**72.97%**	13.51%	16.22%	8.11%	0.00%
Language Interpretation services	5.41%	29.73%	13.51%	8.11%	27.03%	27.03%
College enrollment/ academic advising	**70.27%**	32.43%	10.81%	27.03%	2.70%	0.00%
Securing academic transcripts	**75.68%**	27.03%	5.41%	21.62%	5.41%	0.00%
Placement or aptitude testing	**40.54%**	16.22%	10.81%	**37.84%**	13.51%	5.41%
ESL classes or tutoring	10.81%	24.32%	10.81%	18.92%	29.73%	24.32%
Financial aid enrollment	**58.33%**	13.89%	11.11%	22.22%	19.44%	0.00%
GED classes or tutoring	**40.54%**	**54.05%**	10.81%	35.14%	10.81%	0.00%

Note that for both populations, the burden of academic enrichment, tutoring and coordination with academic providers—for the most part—falls on the agency's staff (or volunteers).

Vocational

Securing employment is one of the metrics of "success" often regarded by funders and externals observers. For trafficking survivors, achieving that success is not as easy as going out and getting a job.

Barriers

The term *re/integration*, coined in Rebecca Surtees' report[47] on the needs of and challenges facing sex trafficking survivors when they leave 'The Life,' serves to clarify that most sex trafficking survivors have, in fact, spent most or all of their lives as marginalized persons, and thus cannot *re*integrate into mainstream society because they have never initially integrated into it. This likelihood makes employment preparation and obtainment all the more difficult for those survivors disconnected from a restorative program sensitive to their vocational needs. Some vocational obstacles trafficking survivors may face include, per the Office for Victims of Crime,[48] those challenges that:

- Result "from the mental and physical impact of trafficking (e.g., stress, anxiety, traumatization, lack of trust),"
- Relate "to the individual trafficked person's situation and characteristics (e.g., educational level, job readiness, and work experience; cultural or linguistic barriers; lack of confidence)," and
- Are "attributable to the broader social and economic environment (e.g., limited job opportunities and competitive labor markets, preconceptions of employers, inflexible resume screening systems)."

Below are some of the skills training and services being provided to help survivors become more economically independent.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Job search support	**64.44%**	33.33%	24.44%	15.56%	6.67%	4.44%
Vocational training program	27.91%	18.60%	27.91%	34.88%	13.95%	2.33%
Resume-writing support	**62.22%**	**51.11%**	17.78%	13.33%	4.44%	2.22%
Jobs program on-site (through your agency)	28.89%	6.67%	6.67%	4.44%	**51.11%**	6.67%
Jobs program through community partners	11.11%	15.56%	**35.56%**	**35.56%**	20.00%	4.44%
Transportation assistance (bus pass, metro cards, car buying support, etc.)	**62.22%**	26.67%	15.56%	11.11%	8.89%	8.89%
Dress for Success coaching	**48.89%**	40.00%	17.78%	15.56%	11.11%	2.22%
Workplace etiquette	**60.00%**	48.89%	22.22%	15.56%	6.67%	2.22%
On-site business enterprise	23.26%	9.30%	9.30%	4.65%	60.47%	9.30%

[47] http://lastradainternational.org/lsidocs/PUB_1850_issue1.pdf
[48] https://www.ovcttac.gov/taskforceguide/eguide/4-supporting-victims/44-comprehensive-victim-services/education-job-trainingplacement/

Note the cluster of "Jobs Program" responses under the two columns of Service Providers. Future study should examine what type of job partnerships have been created, and how those relationships came about. What's important to not miss, however, is that someone had to be instrumental informing those partnerships in the first place. Here again we assume this was a task delegated to agency staff.

Few agencies are offering jobs on-site, but here is one comment from an agency that has made that construct work:

> *We quickly realized that pushing our ladies out the door to get jobs was a set up for failure. They lacked basic workplace skills and a work ethic. So, we surveyed our organization for small, manageable tasks that became our paid internship program. Our residents can apply for these jobs (starting at no more than 4 hours/week), and in those she learns how to be on time, how to complete a timesheet, how to dress and conduct herself properly, how to work with a supervisor, etc. Jobs change every 3 months. As she moves through the program she can try other jobs and increase her hours, thereby building up a better sense of her own gifting and preferences, and also building her resume and bank account. This is one of the best things we've ever done.*

Solutions

Several agencies commented that they are looking at ways of incorporating a business enterprise into their operations, not only as a means of vocation for their clients, but as a source of funding for the program. This is an area where the business community could support the work of these agencies: by providing business acumen to establish microenterprises, or contract work that can be subcontracted out to these agencies.

CASE STUDY: The Well approaches vocational training and employment in this manner:

1. After 30 days, a participant is offered the opportunity to apply and interview at our thrift store/boutique for a part-time position with a commitment of three months. After successfully completing this, she may either request additional hours or seek employment elsewhere.
2. We connect our women with a local organization, the Bucks County Opportunity Council, to enroll in their Economic Self Sufficiency Program, which offers an individualized, strengths-based goal plan, based on a thorough personal assessment, backed up with coaching, counseling, and mentoring. They receive personalized support to reach their educational and vocational goals.

In her report, Rebecca Surtees observed that "social enterprises may provide an opportunity to address these employment and economic issues [that trafficking survivors face] …, although this is a largely under-developed component of re/integration work[49]" (emphasis added). Social and vocational enterprises, such as Thistle Farms'[50] (Nashville, TN) line of bath-and-beauty products handmade by trafficking survivors, and the Women's Academy at Wellspring Living[51] (Atlanta, GA), which offers intensive training in widely-applicable job skills before transitioning into paid apprenticeships, offer trafficking survivors the individualized employment and training opportunities they need in order to re-enter or enter the mainstream workforce.

[49] http://lastradainternational.org/lsidocs/PUB_1850_issue1.pdf
[50] https://thistlefarms.org/pages/our-mission
[51] [20]https://wellspringliving.org/academy/

Section L. Faith-Based Components

Of 43 agencies responding to this set of questions, 84% of those identified as faith-based in the Christian tradition. Four organizations reported as Client-Optional (*the agency facilitates access to the client's religion of preference, but the agency has no religious identity*) and three organizations reported as Secular (*the agency has no religious offerings or practices and does not facilitate access*). Among those that identified as faith-based, they reported having a Statement of Faith that is required of All Staff (56%), required of the Board of Directors (20%), or we do not have a Statement of Faith (20%).

We wanted to explore how faith plays a role in the design and practices of care. It's been made clear by such notable experts as Dr. Diane Langberg, global specialist in counseling victims of sexual trauma, that much of the wounding of victims is spiritual:

> "One of the reasons a survivor finds it so difficult to see herself as a victim is that she has been blamed repeatedly for the abuse: "If you weren't such a whore, this wouldn't have to happen." Each time she is used and trashed, she becomes further convinced of her innate badness. She sees herself participating in forbidden sexual activity and may often get some sense of gratification from it even if she doesn't want to (it is, after all, a form of touch, and our bodies respond without the consent of our wills). This is seen as further proof that the abuse is her fault and well deserved. In her mind, she has become responsible for the actions of her abusers. She believes she is not a victim; she is a loathsome, despicable, worthless human being—if indeed she even qualifies as human. When the abuse has been sadistic in nature…these beliefs are further entrenched."[52]
>
> — Diane Mandt Langberg, PhD.

Deeply-entrenched issues of self-blame, unworthiness, unforgiveness, and shame plague many victims of sex trafficking, and those issues are ones of identity and spirituality. What are these agencies doing—from their own faith positions—to attend to the spiritual needs of victims?

[52] Langberg, D. M. (1997). *Counseling Survivors of Sexual Abuse (AACC counseling library)*. Fairfax, VA: Xulon Press.

Relational/Spiritual Services

The following table suggests some of the spiritual or relational services offered by these agencies and by whom these services are provided.

	in-house staff	volunteers	MOU-based service providers	non-MOU service providers	not providing this service	service not needed
Family reunification counseling	**62.22%**	13.33%	15.56%	22.22%	17.78%	0.00%
Parenting classes	31.11%	17.78%	20.00%	28.89%	17.78%	6.67%
Worship attendance	**68.89%**	**42.22%**	4.44%	11.11%	17.78%	0.00%
Bible/Holy Book instruction	**68.18%**	**59.09%**	6.82%	11.36%	9.09%	0.00%
Individual spiritual director	37.78%	**44.44%**	4.44%	4.44%	31.11%	2.22%
Grief counseling	**42.22%**	13.33%	24.44%	24.44%	13.33%	0.00%
Parent (of victim) support group	9.09%	9.09%	18.18%	9.09%	**56.82%**	6.82%
Community service/volunteering	**54.55%**	36.36%	11.36%	11.36%	15.91%	2.27%
Forgiveness counseling	**55.56%**	22.22%	26.67%	20.00%	20.00%	0.00%

Predictably, the majority of the faith-centric practices are being offered by program staff and/or volunteers, with the exception of Spiritual Direction (the presence or absence of that service may have to do with denominational differences across the Christian tradition). It's also worth drawing attention to the fact that very few agencies are providing support services to the parents/families of victims. This may be an area of service expansion in the years ahead.

Faith Practices

Within the program itself, we wanted to have a more complete picture of how faith plays out in the day to day. What spiritual practices are a part of these agencies' approach, and how does faith intersect with the client population?

78%	Our curriculum materials align with our faith conviction (whenever possible)
76%	Staff or volunteers are encouraged to speak openly about their faith
65%	Our home is decorated with images/phrases that are part of our beliefs
51%	Clients attend conferences, events, concerts, activities that are faith-related
16%	We don't allow certain services to be offered (e.g., abortion, contraception, acupuncture, etc.)
5%	All external service providers must agree with our statement of faith

Because faith can be a topic of inclusion or division, we asked agencies to report on what is required versus optional when it comes to faith practices.

	Required	Recommended	Included but Optional	Not included
Weekly worship services	36.84%	28.95%	26.32%	7.89%
Daily devotions	**42.11%**	26.32%	23.68%	7.89%
Journaling	23.68%	**52.63%**	18.42%	5.26%
Silence / meditation	17.14%	**42.86%**	17.14%	22.86%
Fasting	0.00%	3.03%	12.12%	**84.85%**
Kosher/ Halal (consecrated foods)	0.00%	0.00%	3.13%	**96.88%**
Spiritual formation	11.11%	19.44%	33.33%	36.11%
Baptism	0.00%	14.29%	**54.29%**	31.43%
Meeting with a spiritual director/clergy	5.71%	14.29%	40.00%	40.00%
Deprogramming from cults or other religious oppression	3.03%	9.09%	21.21%	**66.67%**
Corporate Prayer	8.57%	22.86%	**60.00%**	8.57%
Individual Prayer	3.03%	30.30%	**60.61%**	6.06%
Holy Book reading (Bible, Torah, Koran, etc.)	19.44%	33.33%	38.89%	8.33%
Religious instruction	22.86%	20.00%	40.00%	17.14%

In their comments it's clear that the majority of these agencies distinguish between being *present* versus *participating*. In other words, clients may need to attend certain activities, but they are not required to perform those actions. Comments such as follows help us understand the balance:

> *During bible studies and worship times in the home, residents are allowed to opt out or choose an alternative activity. Worship services are attended together but participation is not required.*
>
> *We are a state licensed facility which limits us from mandating any religious practices, but if a resident initiates conversation and asks about our Christian beliefs, we are free to share with her.*
>
> *There is not mandatory participation in the required activities, but, residents must attend the activity*
>
> *While a majority of our staff and volunteers identify with having a faith-based relationship/belief system, we have a strict secular policy, all staff and volunteers must sign a statement of understanding that faith is a choice on the client's behalf. Should a client ask a staff or volunteer about their faith, they are more than welcome to share. However we strongly discourage the notion that a client must follow a specific faith in order to be "rescued from slavery".*
>
> *Our acceptance of where each resident is in their faith journey is the most beneficial aspect for our residents. They don't feel judged or forced to believe the way we do.*

When we consider their staffing ratios (later in this report), we might assume that some agencies simply do not have the surplus staff to allow some residents to opt-out of certain activities such as church attendance, concerts or conferences.

Faith: Asset or Detriment

While these agencies are careful about allowing survivors freedom to choose, they are also witness to whether or not their faith-based approach is having an impact. We asked, "In what ways (if any) have you found faith practices to be beneficial to clients?" This question allowed for unlimited, open-ended response. Some of those responses include:

We definitely see a spiritual hunger in our clients that they are looking to satisfy. Many have a faith background prior to entering our program, usually from family members, and reconnecting with that faith has proved very helpful.

Freedom from shame and hatred. Acceptance and confidence in Jesus' love for them transforms views of self and brings release of self-loathing and lack of self-value. Faith gives a new, genuine purpose and a perspective of the world that allows for hope, despite brokenness, evil and horrible abuses. Forgiveness is possible and healing is more complete in a way it could not be without Jesus. Faith doesn't take away the need for a healing process and trauma recovery, but it restores all areas of life and soul and allows for complete recovery.

Faith doesn't take away the need for a healing process and trauma recovery, but it restores all areas of life and soul and allows for complete recovery.

~ *Survey Respondent*

Almost all of the residents we have served identify faith as a primary source of recovery and healing from trauma, specifically as it relates to a renewed sense of worth, understanding of love, and letting go of shame.

This study also gave fair attention to where spiritual practices may prove to be detrimental to a survivor's healing.

Required faith engagement (church attendance, nightly devotions) seemed to consistently lead to reminders of feeling controlled and reduced a sense of self-determination and self-efficacy. Since self-efficacy and self-determination are values of our individualized model of care, we opted to make faith engagement entirely optional and move at whatever pace a resident is interested in.

Some use religion as their replacement "drug"

Girls want to go to the youth group only because "boys" will be there.

If trauma occurred at the hands of a representative of the Faith community/clergy or pastor, the impact of recovery is profound and not desired by the victim.

They sometimes feel left out if they don't participate. Some have made professions of faith to just please staff.

And lastly, we asked those agencies that claim to be faith-based if their faith practices have ever been questioned and if so, how and by whom. Not many of the agencies reported having conflict in this regard but a few comments included:

> *We have had people not support us or donate to us because of our faith.*
>
> *Several grants and donors disqualify us because of it.*
>
> *From both sides, for and against, we have been questioned, not enough or way too much!*
>
> *When we first opened, those who didn't know us, seemed angry when they met us thinking we were trying to shove religion down someone's throat. Once they met and talked to us they saw that was not true. We were not about "religion" with its law and judgment, but a connection with Jesus Christ. They relaxed then. This was true mainly by those who were caseworkers, judges, politicians and service providers.*

Respondents were invited to share a story of how faith played a significant role in a survivor's healing. There were many compelling stories offered. A few include:

> *One girl in particular comes to my mind. She had been judged harshly by the so called religious people. When she came to us she was a heroin addict who had been trafficked at the age of 7. She was 16 when we got her. When we talked the first time she told me her horrible story of being trafficked while at a babysitter, where the boyfriend would take her and sell her. It stopped after her family moved from that town. Her parents knew nothing of it and when she turned 13 began to act out, she was put in several foster homes again being sexually abused by the foster father. She had tried to commit suicide 3 times. The pastor of the church where she went with her parents told her she was going to hell. Her response was I'll save you a seat! As she told me her incredible story she would look at me and say stop judging me! You're judging me. Finally after hearing that again and again I looked at her and said here's the deal I won't judge you but don't you dare judge me for being a Christian. She looked at me and something clicked and she simply said ok. She grew slowly from that day and what she found out was that real Christians don't judge they simply love and listen! She accepted Christ in her heart and began sharing her story openly. Today she is serving in the navy learning Russian to be able to interpret messages that come through. She is in high security level. She is an amazing young woman who has changed her life because of her faith in Jesus!*
>
> *Most significantly is how many of our women are so enslaved in their thinking about their "man" and they are desperate for his love. when they come to feel the love of Christ, then "he" becomes replaced by the better "HE." Her standards improve and she sees herself as worth more*
> *We have seen that clients that grow in their faith do much better than those that don't. They have hope, they are in the process of healing and restoration*

Section M. Personnel

This section helps us to understand a bit about the human capital that is invested in these programs, and who the people are that are engaged in this work.

Prior to exploring these agencies staffing approaches, we must pause to recognize that the people doing this work are perhaps the single greatest agent for impacting survivor healing.

> "Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives."
>
> — Bessel A. van der Kolk

College Interns

Twenty-two agencies reported engaging college interns in their work. Of those agencies, the average number of interns was 2.2, with a high count of 5 and low of 1. None of these agencies utilize undergraduate college interns as supervisory staff and only one agency uses graduate interns for client supervision. The clear majority (74%) use interns in roles other than supervisory.

The Federal Government's Department of Labor: Internship Programs under the Fair Standards Labor Act, requires that all unpaid internships (under which academic internships would fall) conform to certain criteria, which may lend to the reasoning behind why college interns are not widely-used in residential care.[53]

Volunteers

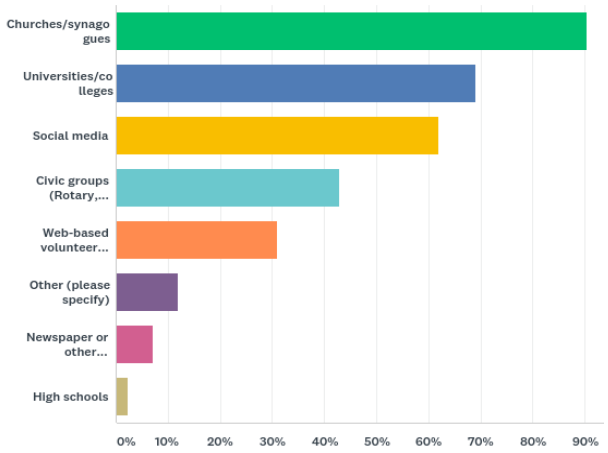
A small number of agencies do not (yet) use volunteers to augment their staffing needs. The majority (83%) are staff-run with volunteer support.

The average number of full-time (uncompensated) volunteers at these agencies is 4, with a high count of 10. The average number of part-time (uncompensated) volunteers is 24.5, with 200 being the highest headcount. It would be worth the effort to identify: "At what point of volunteer capacity do these agencies need to hire a full-time Volunteer Coordinator?"

[53] https://www.dol.gov/whd/regs/compliance/whdfs71.pdf

Agencies reported recruiting or receiving volunteers from the following sources:

91%	Churches/synagogues
69%	Universities/colleges
62%	Social media
43%	Civic groups
31%	Web-based volunteer portals
12%	Other: Public Speaking events
7%	Newspaper or other publications
2%	High schools



Given the security concerns and client sensitivity of this work, we asked if there were any conditions that might restrict someone from being a volunteer at these organizations. The top three restricting factors all relate to legal status of some sort:

Conditions that might restrict volunteering	
88%	Registered sex offender
69%	Under age 18
48%	Convicted felon
26%	LGBTQ
22%	Someone of another religion
21%	Male
19%	Under age 21
12%	Physically disabled
5%	Over age 65

These same organizations reported (by omission) that being Female, Single, Divorced or a Survivor, would not likely restrict a candidate from volunteering.

Agencies that serve a single gender population may be apprehensive about using the other gender in their program. If your agency has been successful in that regard, share how they have made that work.

We love having men involved in a safe way in our organization! We have men volunteer in outreach, rescue teams and safe home-maintenance teams. Intense vetting process and safety guidelines are in place, and we have seen a healing component to healthy interaction with a man that doesn't require anything in return.

We allow male volunteers to serve in supportive roles that are behind the scenes in our residential programs. We choose not to have male volunteers in the shelter and restorative home for direct service.

We've had very good luck using men as teachers, tutors, workshop leaders, and internship supervisors

> If we don't allow our ladies to be introduced to good men and women then we have done a disservice to them, leaving a void.
> ~ Survey Respondent

My husband has been with our girls and they know him as Poppa D. However, we use high guidelines. He is never alone with any of the ladies. There is always another female staff with him. We can use men on our board, fundraiser, speaking and in the administrative duties just not alone with the ladies

Our agency deals with only female clients, but we allow a few males into the home. I am the most likely male to be in the home. However, I don't transport the girls alone, and I'm never in a private room alone with the girls. With those provisions, I do see that providing the girls a chance to develop a relationship with a normal male is very healthy and desirable for them. I have had several girls ask if they can refer to me as "Dad", revealing their lack of a father figure and desire to develop a father/daughter relationship.

General Staff

On average, these residential service providers are being supported by 6.8 full-time, compensated staff, and 5.8 part-time compensated staff. The highest staff count for full-time was 31, and the lowest was 1. For part-time staff, the highest count was 45 and lowest was 1.

This survey did not ask respondents to elaborate on the various positions within their agency. At this time in the maturity of this field, job titles are non-standard and would not give us a solid indication of the duties associated with those titles.

What's important to keep in mind as we consider staffing at these agencies, is the breadth of skills and range of duties into which these staff are called. From the prior sections, if we extract only those services that are being conducted--50% or more--by in-house Staff, we compose a job description of:

Academic transcripts
Basic money management
Bible/Holy book instruction
Budget training
College enrollment
Community service/volunteering
Debt inventory/consolidation
Establishing a bank account
Family reunification counseling
Financial aid application
GED training/tutoring
Job searching
Medication management
Random drug testing
Regular reporting to parole/probation
Resume writing
Social service enrollment
State level ID
Transportation assistance for work
Transportation to/from appointments
Workplace etiquette
Worship attendance

Supervisory Staff

A question that is commonly asked of start-up agencies is, "What is your staffing model for inside the home?" According to the question about supervisory staff, 80% of these programs ensure that all hours of the day and night are covered by some form of supervision. A question that would give us more insight (but that we failed to ask) would be: "Have you always had this staffing model or did you change models in the course of your years of operation?"

56%	24/7/365 – all hours are covered by paid staff
24%	24/7/365 – all hours are covered by either paid staff or volunteers
7%	Daytime hours are supervised by paid staff and/or volunteers; there is no overnight supervision
7%	No supervision in the house, but there is a daily check-in with staff
2%	No supervision in the house, but there is a weekly check-in with staff
0%	Daytime hours are supervised by paid staff; Overnight is supervised by volunteers

Nearly all hours are covered by paid staff. Occasionally staff may be off-site for up to two hours.

There are residential volunteers (rvs) in the house, they live right next door in same building as residents. Rvs do curfew checks, devotionals, some meals together, movie night etc. They are good neighbors who do live together in community. There are bi-weekly check ins with case manager, life skill class with staff and recovery workbook meeting with staff all once a week.

Staff Qualifications

We offered an open-ended response for "What are the most important qualifications for your residential supervisory staff?" Respondents could value their answers as "Critically Important, Important, Somewhat Important, or Nice to Have." There was notable consistency in these responses: who these individuals are as persons (experience, disposition, faith) is valued far more than what they have acquired (education, credential). A word analysis showed those qualities that were the most commonly-occurring across all values, presented in descending order of occurrence with specific details interjected:

> "Relationships are the agents of change and the most powerful therapy is human love"
>
> ~ Dr. Bruce D. Perry

1. Experience

   Worked in residential settings
   Residential experience or experience with survivors of abuse or commercial sexual exploitation. Time-management. team management skills. Ability to manage self-care. Takes action in problem solving/team needs.
   Worked with survivors of PTSD
   It's more of experience and having a heart for ministering to this population. I've had staff that have all the credentials, licensing but they just didn't have what it takes to run a home and work with these girls
   Older age, motherhood experience

2. Disposition

   personal resiliency, not needing to be appreciated by clients
   Proven leadership and facilitator, recovery experience and personal healing- a called individual that is mature in faith and wisdom able to handle crisis-management, wise, loving and warm, healthy boundaries. Shows honor to fellow staff and residents
   emotionally healthy; life experience; teachable spirit, compassionate, able to submit
   Empathy for the population
   Maintains healthy boundaries
   Not a push-over but not controlling
   Willing to "do whatever it takes"
   Of good character
   Desire to work in uncertain situations

3. Faith /Christian

   Mature faith, well-grounded in their faith
   Higher calling for this type of work

4. Trauma-trained

   Knowledge of/experience with trauma-informed care and/or residential services to women; Knowledge of/experience with principles of Empowerment, Strength-Based skills, and knowledge of Trauma, PTSD, and Complex Trauma

5. Degree/Education

   CPA licensure for House Administrator, LPC with trauma informed and EMDR training, House Parents needed to be trauma trained

"Some of the most therapeutic experiences do not take place in therapy but in naturally-occurring relationships."
~ Dr. Bruce Perry

The most-often cited "Nice to Have" was licensure.

Credentials

Respondents were asked if any of their regular, paid staff held specific academic credentials. Only two agencies reported that staff held a medical degree/credential. One staff is a nurse, and the other has a degree in pharmacology. Similarly, we asked if they had regular, paid staff holding a mental health degree/credential. There were 38 responses.

Agencies reporting "none"	13 or 34%
Social work credential	11 or 29%
Psychology or counseling	7 or 18%
Other (Music Therapy, Pastoral Counseling)	3 or 7%

The remaining 12% included responses such as "yes" or "working on it" that could not be included in these categories. This is an area worthy of further exploration, such as:

- Are these agencies unable to afford credentialed staff?
- Are those with particular academic achievement not drawn to this type of work or setting?

- Do these agencies not need staff with specific credentials to do the work they are doing, or do they not know what they need?

In a follow-up to the survey, we invited those who reported "none" to elaborate on why they do not have mental health credentials on-staff. Some of those responses included:

> *We outsource our professional counseling to a local agency who is trained in many areas including trauma, complex trauma, rape crisis, PTSD, complex PTSD, EMDR, DBT, CBT, etc. We DO have a PhD Psychologist on our board who meets with each new client to give some mental health diagnosis and treatment plan input. Our current program director is working on her Masters in Social Work so will eventually be an LSW.*

> *It's not that we don't want staff with credentials, but other qualifications are far more important when it comes to the day-in and day-out of residential care. There's book-learning, life experience, and street-smarts. We need staff with that balance.*

> *We hope to one day when we have funds for [credentialed staff], we do currently outsource with community partners.*

There's book-learning, life experience, and street-smarts. We need staff with that balance.

~ Survey Respondent

Training

Training seems to be an ongoing endeavor within these agencies. While 57% reported that formal staff training occurs on a quarterly basis, one-quarter of these agencies are offering training monthly.

Most of the training offered to agency personnel is conducted in-person (50%), with 33% of the training being a combination of in-person and self-study. A list of the books and other resources recommended by these agencies can be found in Appendix E. In the section below, we asked how certain topics are being delivered to advance staff education.

On Human Trafficking

81%	We recommend certain books for them to read
79%	We recommend certain videos/DVDs for them to watch
55%	We recommend classes
69%	We encourage/require them to attend our public awareness programs

On Trauma and Trauma-Informed Care

5%	Certain staff are certified in trauma-informed care
86%	All our staff have received some level of training in trauma
5%	Only our staff who work with survivors have received training in trauma
5%	We have not provided specific training in trauma to our staff

Agency Policy and Protocols

79%	We offer specific training to our staff in our approach to care, our philosophy and practices
86%	We have a staff handbook/training manual, outlining our approach to care, our rules, and protocols
43%	We do most of our training as on-the-job training

These organizations, despite small staffs and modest budgets, are zealous about learning. When asked what additional topics have been presented as staff trainings, they responded:

88%	Trauma-Informed Care	36%	Motivational interview
83%	Conflict resolution	33%	Suicide prevention
57%	Documentation Protocols	19%	Eating disorders
55%	Substance abuse	19%	Prison culture
52%	CPR	19%	Street drugs
52%	Emergency Medical procedures	17%	Gang culture
52%	Mental disorders	14%	Traumatic brain injury
52%	Shame	10%	Narcan shot
50%	Self Harming behaviors	10%	Therapeutic holds
48%	Emergency evacuation	7%	Incest

Other trainings reported include: Non-violent interventions, Trauma Drama Triangle, De-escalation techniques, homelessness, domestic violence, racial equity, stages of change, Boundaries.

As these agencies continue to invest in their staff and volunteers, we wanted to know what topics of learning were most urgent for the future. Respondents selected the topics on which they intend to offer training and how soon.

Within the next 3 months	Within the next year	Welcome but not essential
Motivational interviewing	Suicide Prevention	Incest
Conflict resolution	Substance Abuse	Gang Culture
Mental Disorders	Shame	
Trauma Informed Care	Self-Harming behaviors	
	Eating Disorders	
	Emergency Med Procedures	
	Traumatic brain injury	

Staff Care

In the Peer-to-Peer Section of this report, "Staff Burnout" is listed as the most common challenge these agencies have faced. There is much written about Caregiver Fatigue, and Vicarious or Secondary Trauma. If these agencies have the majority of their staff trained in Trauma, we presume they have anticipated the need to attend to staff as well as clients. We offered an open-ended question for agencies to report the policies or practices they have in place to ensure that staff remain emotionally and spiritually healthy—and specifically, those practices that appear to be effective. Their responses were:

1. Time Off - The most common response suggested some form of break from the work. About half of those responses indicated a specific formula for breaks, such as *"residential supervisors are never on the schedule more than 30-32 hours/week. The rest of the time is held for admin work or learning."* Others offered specific activities like staff retreats, "God time," frequent breaks, etc.

2. Counseling – 20% of the write-in responses indicated that the agency provides access to a counselor/therapist for staff, either as needed or required.

3. Peer Support – several comments suggested that being a part of a team, uniting in their faith practices such as praying together, and openly speaking of the difficulties of this work were part of their staff care strategy.

It's worth a reminder from the Section on Other Client Services, that the residential staff in these agencies are being asked to serve in a wide range of capacities, across a myriad of disciplines. Is the high incident of "burn out" attributed to their exposure to secondary trauma, or do they have overwhelming job expectations—or both?

Section N. Policies

This section of the survey was a "popcorn" approach to identifying what policies are currently in place (versus have yet to be considered). We did not invite respondents to explain their policies or the challenges that brought them to these decisions. That may be topic for a subsequent study. This section merely endeavored to lay down some of the operating policies associated with this work and this population.

Background/Criminal Records Checks

21%	We conduct background checks on all clients before they come into our program
7%	We conduct background check on all clients once they are in our program
24%	We do background checks only when there's a prompting issue
19%	Our clients are minors and come with background files
29%	**We don't do background checks on our clients**

Future inquiry might include determining what sources are utilized for background checks and what these agencies do with this information.

Transportation to/from your Facility

33%	We provide for airfare/bus/train/car travel to our facility for incoming clients
19%	We provide for airfare/bus/train/car travel from our facility for departing clients
33%	We provide for transport of incoming clients within a limited distance or limited expense
36%	**We provide for transport of departing clients within a limited distance or limited expense**
17%	We have a third party that funds/provides for client transport
14%	We require that incoming clients fund their own transport
5%	We require that departing clients fund their own transport
24%	Usually law enforcement provides for client transport to/from our agency
21%	We do not have a client transport policy

Predictably, minor-serving agencies have more of a responsibility (and read: associated cost) to provide for client transportation to and from their program. For minor-serving agencies, law enforcement providing transport was also higher at 42%.

Black Out Period

"Black out period" was defined in this study as a finite period when the client is not allowed any outside contact, in any form). Yellowstone Recovery, a small network of addiction treatment facilities in California, describes the purpose of blackout periods in this way: "The people around you in your outside life carry triggers…that may not harm the average person, but can be toxic and, in some cases, even life threatening to you. The blackout period gives you the chance to build your defenses and develop strategies to manage such situations."[54]

[54] https://www.yellowstonerecovery.com/2014/09/16/what-is-the-purpose-of-a-blackout-period-in-treatment/

Over half of these agencies have some form of black out period:

2%	Our program restricts all outside contact for the duration
10%	We have a 90-day black out period
7%	We have a 60-day black out period
26%	**We have a 30-day black out period**
19%	We only have a black out period if the client's situation warrants it
19%	We have no black out period

This policy was most unique for minor-serving organizations, in that in many cases, they cannot legally restrict the minor child's access to family, etc. or the Court may dictate the nature and duration of the black-out period.

> *We have a 12-week no cell-phone period, but during that time clients are able to contact "safe contact" list people via home phone or email*
>
> *7 day black out period - the courts mandate who our residents are in contact with*
>
> *Ability and control regarding a black out period is established by court and county*

Personal Cell Phones

To describe how traffickers control their victims' Behavior, access to Information, Thoughts, and Emotions in order to exert *undue influence* over them, the Federal Bureau of Investigation uses the BITE Model of Human Trafficking,[55] which "focuses extensively on traffickers' and pimps' capacity to control victims by undermining their ability to think and act independently." For example, a tactic that traffickers use to exert undue influence over trafficking victims' access to information and the content thereof presented in the BITE model is: "controlling a victim's movements through texting, phone calls, and Internet tracking."

14%	We allow clients to have personal cell phones
2%	We are required to allow our clients to have personal cell phones
21%	We allow them for certain clients, or under certain circumstances
45%	**We do not allow clients to have personal cell phones *at any time* during the program**

This policy is currently being challenged by some regulatory bodies, suggesting that it's punitive or denies a person's civil rights. Many of us in the field of victim services know, however, that cell phones are heavily used in the recruitment, coercion, and control of victims and can serve as the primary channel by which these individuals are controlled. As one Maryland law enforcement officer claimed, "the cell phone is the portal to hell for these girls." Review Appendix F – Peer-Recommended Policies and Practices, as several agencies tout their "no cell phone" policy as being critical to client safety.

[55] https://leb.fbi.gov/articles/featured-articles/a-victim-centered-approach-to-sex-trafficking-cases
http://old.freedomofmind.com/Info/Human%20Trafficking/HumanTraffickingBITEModel.php

https://freedomofmind.com/wp-content/uploads/2017/04/BITE-Model-Handout-9-23-16.pdf

Family/Friend Phone Contact

19%	Clients are allowed to make phone calls to family or friends, as desired
19%	The Court dictates the terms of family contact
36%	Clients are granted a limited number of phone calls or phone time per week
57%	**Contacts are vetted to ensure that those persons are safe**
10%	Clients are allowed contact with family only

For this policy, 50% of minor-serving agency's report that family contact is dictated by the Court and not subjectively determined by the residential service provider. Respondents did not elaborate on how that vetting occurs.

> *We try to vet contacts but we also don't restrict contacts -- if they want to call someone we don't know, we won't control them by stopping them*
>
> *The custodian and TDP must approve all phone contacts, which are usually just family. all calls are on speaker*
>
> *If a woman is anxious about making phone calls and asking to make several new contacts, she's probably making a plan to leave. If she's not making any phone calls at all, she probably already has a phone hidden somewhere. Monitoring phone calls and their conversations has proven to be very helpful in anticipating a woman's stability in the program, as well as the safety of others.*

Social Media

17%	Clients are allowed to use social media to maintain outside contacts
24%	We allow social media for certain clients, under certain circumstances
60%	**We do not allow access to social media at any time**

Social media access is restricted at higher levels for minor-serving organizations, than those serving adults.

> *I'd be interested to know how many of the organizations that allow cell phones and social media have a higher than average run-away rate...it's been our experience that if she can keep one foot "out there," we're probably going to lose her.*

Overnight Passes /Home Visits for Clients

7%	We allow clients to have overnight visits with family
10%	The Court dictates the terms of home visits
43%	**Clients can earn this privilege, over time or with good behavior**
19%	We allow them for certain clients, or under certain circumstances
10%	We don't allow home visits at all
12%	We don't have an overnight/home visit policy

Here again, Court-placed juveniles often have their home visits determined outside of the agency's preferences.

Clothing

21%	We allow clients to wear whatever they want
69%	**We have a modesty or "appropriate dress" policy for clients**
5%	We provide clients with clothing that we've deemed appropriate
0%	We provide uniforms for our clients
5%	We have no policy about clothing

Imposing guidelines on clothing has a lot to do with mitigating threat. Some girls have gang-related insignia, racist or provocative T-shirts that they will wear intentionally to establish their position in the social order or to upset others. It's something we can easily neutralize by simply not allowing clothing or jewelry with any symbolism or statement.

Smoking/Vaping

12%	We allow clients to smoke/vape whenever they want
62%	**We have designated smoking/vaping times and/or smoking area**
2%	Clients can earn smoking privileges
7%	Our client are minors: we do not allow smoking/vaping at all
17%	We are a smoke-free program; we do not allow smoking/vaping at all

It sounds crazy, but we provide 2 free packs of cigs/week for a client in her first 90 days. It's radically cut down on the "selling and bartering" of cigarettes among residents which is prison behavior that we want to stop, plus we find that she ends up smoking less when she only has two packs. She has to make them last a week. After 90 days, she starts our jobs program and she has to buy her own.

Client Money

33%	Our clients hold and manage their own money/cards
14%	Our clients are allowed to hold a designated amount, but never more than that
38%	**Our clients are not allowed to hold money/cards; we safeguard it for them**
5%	We don't have a money/cards handling policy

Clients earn money holding rights over the course of the year
Clients open up bank accounts and [are] taught budgeting

Medication Administration

12%	Clients hold and administer their own medications
10%	Clients' medications are secured and there is a trained Med Tech or Dispensing Nurse on staff
79%	**Clients' medications are secured and staff provides the clients with access as prescribed**
0%	We do not allow medications in our agency
0%	We do not have a medication administration policy

Gifts to Clients

12%	We allow staff or volunteers to give gifts to our clients, as they deem appropriate.
14%	We allow volunteers to give gifts, but not staff
26%	We specify the types of gifts that can be given (or not given)
41%	**We only allow gifts for birthdays, holidays and graduations.**
7%	We do not allow staff or volunteers to give gifts to clients under any circumstance
12%	We don't have a gifts policy

Drug Testing

26%	We do regular drug testing on all clients
48%	**We do random drug testing on our clients**
7%	The Court dictates our drug testing protocol
21%	We do drug testing only when there's a suspicion
17%	We don't do drug testing

Over one-third of the minor-serving agencies reported that they do not do any drug testing of their clients.

Bedbug Prevention

38%	**We require all new clients to shower and have all his/her items laundered prior to moving in**
21%	We require showering and laundry if we are concerned about hygiene
0%	We regularly check our clients for bedbugs
36%	We have bedbug-preventing mattress and pillow covers on all beds
26%	We do not have a bedbug prevention policy

> *If a client has been into our center who has had a history of bed bugs, we use Clorox wipes around everywhere she went and wash any material she came in contact with.*
>
> *Quarterly check from pest control company*

Sex Toys

2%	We allow clients to have sex toys (*personal devices for sexual stimulation*)
2%	We allow sex toys for certain clients, or under certain circumstances
64%	**We don't allow sex toys at any time**
31%	We don't have a policy on sex toys

These personal devices were reported as disallowed in all minor-serving agencies.

Sexual Contact between Clients

2%	We do not interfere with their relationships
17%	We provide counseling
55%	**We implement program consequences and counseling**
14%	We dismiss the client(s) from the program immediately
12%	We don't have a policy on sexual contact

Client Public Speaking

12%	We encourage our clients to speak to the media or as part of awareness events when they are ready
24%	We prepare/coach our clients to speak to the media or in public
24%	We advise our clients against speaking to the media or in public
31%	**We do not allow our (adult) clients to speak to the media or in public while in our program**
21%	Our clients are minors and should not speak to the media
17%	We don't have a policy on clients speaking publicly

> There is a lot of healing that comes from the power of their testimony yet we need to be so aware of the backlash that often comes following after they have shared
>
> *~ Survey Respondent*

This is a topic for which there is a wide range of opinion. We invited their comments or suggestions about clients telling their stories publicly:

we are very protective over our women. if they are significantly down the road of healing and want to share their story we discuss with them...sometimes we video the hard part and let them publicly tell the happy ending leading them to recovery. We ALWAYS pay our speakers a fee for sharing their testimony

we've learned that letting them speak publicly can be detrimental to their recovery

we're dismayed at the survivors out there who are being re-exploited and choosing temporary fame as their new drug. it's most egregious from the organizations making them do it.

We approach this carefully, and typically wait for a client to tell us they are interested in telling their story and go from there. We do not approach clients with this request. We also make sure they go through some trial runs with a peer-support specialist who has done speaking events to get a feel for what it will be like. And they are always accompanied by a support person of their choice if they are sharing. We do believe survivors should have the choice to share when they are ready and we shouldn't manage that for them, but support them through it to prevent it from being retraumatizing.

use wisdom- get permission in writing-- wait until at least a year of recovery!

We have seen several 18-year olds go public to regret the triggering impact on them. We now recommend they wait for maturity and healing to be truly ready

This is such a hard one ... many want to then regret it later. The public longing to hear their stories. We defer to our mental health professional as to when the time is right.

We don't have clients, while in our program, share their stories in person publicly. At times a former client has shared her story after graduation, not in detailed about while she was in the life but more about what worked for her getting out and staying out of the life. There is a lot of healing that comes from the power of their testimony yet we need to be so aware of the backlash that often comes the following day(s) after they have shared. Pray for her before and definitely after she has shared. I give a big NO to churches that ask for a client to come and share her testimony for 5 minutes.....

Yes. We always let them take the lead and NEVER pressure them to speak. We NEVER exploit their story for purposes of fundraising. We don't discourage public speaking but we are cautious in helping them sift through what they feel comfortable with and what they don't.

I think a client should not tell their story while in a program, even if an adult. Prior to telling their story after release from a program, a survivor should be extensively counseled regarding the potential effects of going public with their story.

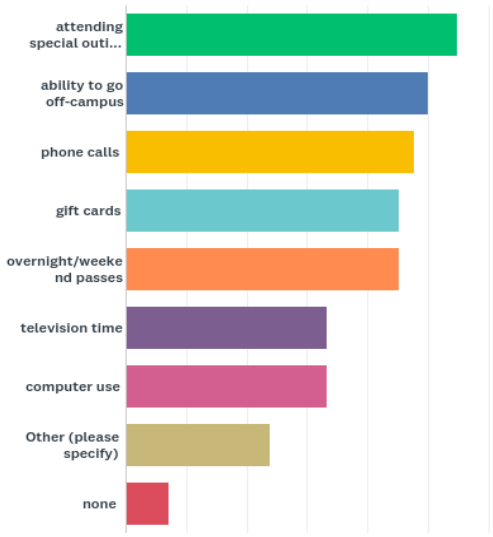
We advise clients about the pros and cons of sharing their story publicly. We also don't advise clients to share their story while they're still in the program, but once they graduate, we have a local survivor leadership group.

Two agencies reported encouraging/coaching minors to speak publicly, whereas the remaining agencies indicated that it was not allowed.

Section O. Incentives and Consequences

In this section we'll briefly explore how these agencies use incentives or consequences to positively impact client behavior and/or respond to the dynamics of the household. First, we asked what incentives are in place that "reward" a client for positive progress. They offered:

55%	Attending special outings
50%	Ability to go off-campus
48%	Phone calls
45%	Gift cards
45%	Overnight/weekend Passes
33%	Television time
33%	Computer use
24%	Other: shopping at their in-house boutique



Consequences

Second, we asked, "In general, what are the primary consequences of rule violation in your program?" The most common responses were Loss of privileges, Probationary status, Demotion in the program, and (interestingly) Writing a paper.

> *There are only five rules in our programs - all related to safety. If these are broken, it results in an immediate exit. Everything else is considered a "community agreement" and if those agreements aren't upheld, a conversation is had and the resident who broke the rule plays a role in deciding the consequence in partnership with the program supervisor. We tend to utilize a relationship-based and restorative justice model rather than black and white or zero tolerance policies.*
>
> *no phone, no tv, write a paper, read a book*
>
> *loss of phone/computer time. Then final warnings*
>
> *inability to participate in weekly outings, removal of family visits, removal of extended lights out, removal of TV, dismissal from the program*
>
> *"Reflections week" in which the client spends a week reflecting and learning from their experiences. We only have a few "red line" items that require immediate exit (ex: threats of violence, physical violence, using drugs in the home, recruiting other residents into the life)*
>
> *we have behavior plans and when there is a violation, a behavior incident report is completed; the client generally selects her consequence*

We invited these agencies to share up to three policies or practices that they believe are working exceptionally well. That list of suggestions is presented in Appendix F.

Incident Response

This can be a highly volatile population, accustomed to chaotic environments and prone to poor conflict resolution. Incidents of rule violation, conflict, even criminal activity are not uncommon in these agencies, so we wanted to get a picture of how these agencies have learned to respond to certain types of incidents.

	call 911	immediate dismissal	probation	reprimand /privileges withdrawn	counseling	don't know/ no protocol
Client commits a crime (shoplifting, etc.)	9.76%	26.83%	19.51%	**41.46%**	26.83%	14.63%
Client engages in sexual conduct with another client	0.00%	21.43%	28.57%	38.10%	**47.62%**	9.52%
Client goes AWOL from program and then returns	2.38%	38.10%	26.19%	28.57%	**50.00%**	2.38%
Client is drunk (alcohol)	0.00%	33.33%	33.33%	33.33%	**45.24%**	7.14%
Client is engaging in self harm (e.g., cutting)	12.20%	2.44%	14.63%	19.51%	**78.05%**	12.20%
Client has stolen from another client	0.00%	9.52%	42.86%	**66.67%**	42.86%	7.14%
Client is high (drugs)	4.76%	**45.24%**	28.57%	33.33%	42.86%	4.76%
Client is not medically compliant	7.69%	5.13%	28.21%	15.38%	**43.59%**	25.64%
Client is threatening to hurt him/herself	**57.14%**	2.38%	7.14%	11.90%	**50.00%**	2.38%
Client is verbally abusive	5.00%	5.00%	**57.50%**	**62.50%**	**55.00%**	2.50%
Client physically assaults a staff or volunteer	39.02%	**78.05%**	9.76%	12.20%	12.20%	2.44%
Client physically assaults another client	40.48%	**73.81%**	11.90%	11.90%	7.14%	2.38%
Client vandalizes program property	11.90%	**45.24%**	35.71%	40.48%	30.95%	4.76%

It's worth noting how much burden for client and program success is placed on counseling. It begs the question whether or not these agencies feel they have adequate credentials, skills, and staffing to attend to the range of behaviors expressed by the clients.

AWOL Client

We offered an open-ended response to the question of how these agencies handle a client who is absent from the program without leave approval (AWOL). Given the variance in location, staffing, nature of client - placement, age, and other factors, we anticipated a wide range of responses.

For Adults

After 48 hours in our shelter/assessment center we consider it a voluntary exit and they can re-screen for shelter in 7 days. In our residential program, we wait for up to five days to make contact and then consider it a voluntary exit (this has only happened once). They can reapply to move in within two weeks. We don't notify anyone unless there is reason to call 911 due to specific circumstance.

adults who go AWOL have to wait 30 days to reapply to the program

if she's case or court-affiliated, we call her contact. if she under parole or probation, we call her PO otherwise, we let her go

We don't have this happen- we are in the middle of nowhere!

We do not notify anyone unless they have given us written permission to contact their emergency contact.

They are not bound to be in our program so we don't not notify law enforcement or family. We try to get in contact with the client to help them or to invite them back to our program.

Depends on how long. If it overnight, they will be required to leave the program and cannot return for 3 months, and only if we have a bed available then

we've never had this happen - sometimes a client will leave for a few hours upset; but she always returns

We change the house access codes. If they want to return, they have to go to the Learning Center the next day and meet with the director and discuss options.

first time it is 90 days before she can return; second time up to a year before she can return

For Minors

Our clients were minors we called 911 and reported then staff would look. Parents are also notified and if there is another agency involved.

most [clients] are in DHS custody. After calling Emergency to report a missing child, we notify their state caseworker and our Program Director. We will hold a bed for a matter of days in case of their return.

Each episode of AWOL is handled separately with consultation with the courts and the child's county.

she will run. If the latter, they take her to detention. If she settles down while there and we think she is not going to run (we can keep her "safe") we take her back. An incident report is sent to the custodian within 24 hours.

Minors are allowed to leave in the state of CA. They are allowed to return. When they leave the property line we call the Sheriff Dept. as well as their representative and fill out an incident report for the state of CA.

The police are called immediately. We are not allowed to stop them, so a staff member follows them as best they can with a phone, letting the police know where they are at. The other staff are with the other girls in the home and contact the Director. When the police pick them up and bring them back, they discuss with us if we think we can keep her safe or whether we think

Section P. Program Outcomes

There is an on-going and yet-resolved discussion on what constitutes "success" for these types of agencies. There are both quantitative and qualitative measurements to consider.

Program Duration

The Emergency Shelters and Assessment Centers are the two types of program we would categorize as "short term" programs. There were 14 respondents operating these types of programs. With two exceptions, the majority of the short-term programs have designed their services within a range of one week to six months, with the greatest concentration in "up to 30 days."

The Restorative and Graduate programs we consider as "long-term" and there were 41 respondents identifying with those types of programs. Most of responses (38%) define their program as two-years in duration, with 20% citing "up to 12 months." One program allows clients to remain in its phased recovery program for up to four years, and five agencies claimed, "no limit."

The *National Survey of Residential Programs for Victims of Sex Trafficking* published in October 2013[56] interviewed 37 residential programs across the U.S. serving human trafficking survivors. Of those 37 programs:

21 (56.8%)	had a maximum cap on their programs' lengths of stay, the average of which was 16.8 months (range: 1 to 24 months).
3 (8.1%)	had maximum lengths of stay of less than one year.
10 (27%)	had no limit on the length of stay.
6 (16.2%)	had "until age ___" listed for the maximum length of stay (5 (13.5%) until age 18 and 1 (2.7%) until age 21).

In a 2007 article published in *Human Rights Quarterly*, the author reported that "service providers assert that the needs of trafficking survivors are far greater than those of other marginalized groups" because "they require more time-consuming, lengthy and structured services"[57] (p. 122). In an interview with a staff member from a shelter in California serving both human trafficking and domestic violence survivors, the staff member "estimate[d] that a survivor of domestic violence typically stays in a shelter between three and nine months, where a survivor of trafficking may typically need shelter for one to one and one-half years" (p. 128).

A 2003 Department of Justice survey of service providers for human trafficking survivors corroborated this estimate, reporting that 49% of respondents worked with survivors steadily for more than 12 months.[58]

We asked these agencies to report their actual length of stay, cumulative from the founding of their program (or the point at which they began tracking). The average across the 36 agencies who could provide a length of stay figure (both short- and long-term programs), was 8.2 months. For long-term only, the average was 9.3 months, and for short-term only, the average was 4.3 months.

[56] http://www.icjia.state.il.us/assets/pdf/ResearchReports/NSRHVST_101813.pdf
[57] http://lawprofessors.typepad.com/immigration/files/29.1shigekane.pdf
[58] https://www.ncjrs.gov/pdffiles1/nij/grants/202469.pdf

This will be a data point worth tracking over the next few years to determine whether offering 2- or 4- year programs is necessarily for this population, or what programmatic changes need to be put into effect to help survivors "settle in" for the full benefit of what these programs have to offer.

Reasons for Program Exit

The survey offered seven common reasons why a client would depart a program. Either we had not envisioned the most likely list of options, or it was not possible for these agencies to ascertain the reason for a client's departure, because "Other reason" was the second most common response. What shows here is the total number of clients reported by 46 agencies and (to the best of their knowledge) how those clients departed these programs.

1,226	Graduated or moved onto independence
877	Other reason
558	Drug or alcohol relapse
405	Client felt ready to be independent
384	Missed or felt called back to The Life
375	Expelled from the program for breaking a rule
323	Transferred to another program
305	Reunited with family
247	Left for a "romantic" attachment

Program Alumni

Long-term impact can only be measured by assessing how well a client faired after departing the program. Given that the average years of operations among these programs is under 6 years, we didn't expect to obtain much longitudinal data about client success. We asked, "Do you currently track clients who have left your program?" and were surprised how many agencies have a practice of keeping in touch with program alumni:

24%	Yes, we have a system for keeping in touch with former clients and we measure their outcomes over time
31%	Yes, we keep in touch, but we're not measuring long term impact
26%	Clients keep in touch with us, but we don't have a specific effort to reach out to them
12%	We don't currently track former clients but we hope to do that one day
7%	No, we don't currently track former clients

Do you have a documented set of outcomes by which you measure program efficacy?

45%	Yes
7%	No
48%	We're working on them

If “yes” or “working on them” which of the following are part of your measurements of success?

46%	Increasing the overall length of stay
62%	Helping clients secure employment
57%	Helping clients secure independent housing
51%	Facilitating family reunification
49%	Tallying days of sobriety
62%	Reducing self-harming behaviors
38%	Faith commitment / baptism
84%	Reducing the likelihood that s/he’ll be re-exploited

Placement into LT care, increase in self-management skills and emotional crisis stabilization, increased readiness

GED or high school graduation

reduction in measurements for depression, anxiety, dissociation & trauma indices

Reducing PTSD, depression, anxiety & increasing self-esteem

These responses merely beg more questions: How do you measure those outcomes? Do those measurements apply to all clients? In what timeframe do you conduct the measurement?

Section Q. Peer to Peer

The final section of the survey invited respondents to share a bit about their heart and spirit in this work. We wanted to know how they have felt, and how they are feeling now, about the significant task they face. Respondents were probably their most transparent in this section.

Looking Back

As these providers look back on their beginnings, we wondered, "For what aspect(s) of this work were you the least prepared?"

55%	How much staff would be more work than the clients
50%	This level of exhaustion
50%	Spiritual warfare: variety of ways it presents
48%	How much work volunteers really require
45%	The sheer darkness and evil within this work
43%	Level of chaos that is normal for clients; resistance to stability and consistency
36%	Coping with the high percentage of clients who leave (poorly)
17%	Client's resistance to connecting and building community
14%	Dealing with the parents of our clients and how much emotional drain they would be
10%	Having to do public speaking

Challenges

Dr Judith Lewis Herman, in her acclaimed work, Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror, offers this reality check:

> "It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering." [emphasis added]

These demands of the victim are placed on the "bystanders" --who are the care-givers. How are these care-givers holding up under the weight of these demands? We asked them to rank the spiritual and worldly challenges they have experienced. Not surprisingly, they noted "Staff Burn-Out" as most common.

69%	Staff Burnout
57%	Client brought drugs or alcohol onto the property
48%	Difficult relationships/Competition with other service providers
48%	Slander – people talking trash about what you're doing
41%	Runaway clients
38%	Staff not supporting program policies
36%	Someone donated a house
33%	Clients lied about their trafficking experience (and were never trafficked)
33%	Financial crisis (not sure you're going to make payroll)

26%	Staff doing “favors” for clients that are against your policies
26%	Clients had sexual relations with each other
19%	Attacks from the media
19%	Sudden “fame” in your community
17%	Client assaulted a staff person
14%	Major rift between the board of directors and the executive director
12%	Mutiny – the clients overtake the staff
10%	Major financial gift that you were unprepared for
10%	Temporary shut down
7%	Staff person assaults a client
5%	Lawsuit from former employee
2%	Lawsuit from former client
2%	Sexual misconduct of a staff person
2%	Tax exemption questioned or revoked
0%	Operating license revoked

Food stamps scrutinized. Had to change food prep policy

Being forced to relocate due to community being against our zoning request and against our being in the community. However, it turned out to be the best for us.

To put a finer point on the idea of emotional/spiritual burdens, we asked “What REALLY is the hardest part of this work? Predictably, these individuals who have felt a strong spiritual call to this work are most impacted when it appears that their efforts have failed or are insufficient.

38%	It hurts when they leave.
31%	Our money problems wear me down.
26%	I feel like I can never do enough.
26%	Volunteers are more work than I expected
24%	I feel very alone most of the time.
22%	Staff are my biggest headache.
22%	I’m not really sure we’re helping them.
19%	I never feel like I know what I’m doing.
17%	I’m tired of being criticized; I’m just doing what I can
2%	I don’t know what God wants from me.

Some of the write-in comments included:

the level of culture evil is astounding enough staff/residential volunteers and empty beds, are we really meeting a need? what is missing?

Seeing clients leave prematurely, turning clients away because we don't have enough space for them

Too many organizational details and administrative duties that never seem to get done. We get one thing organized and many other items demand attention so that if feels like we are often in an

emergency mode. This applies to staffing needs, also. Staff who are not involved in the day to day operations giving advice from afar has been very challenging, too.

How and where is everyone getting their funding

the work is draining

Help Needed

We offered a long list of business and operational responsibilities, and asked respondents to rank their first, second and third priority in terms of where they most need help. The results proved consistent.

1st Priority	→	Fund raising
2nd Priority	→	Human Resources (staff recruitment, training, retention)
3rd Priority	→	Day-to-day operations (I.T., communications, database mgmt.)

Not surprising for this particular group of individuals, when we asked them, "Who or what sustains you in this work?" their responses spoke loudly to their faith convictions and the people around them who offer support (responses summarized in this word cloud).

As beleaguered and isolated as this group of pioneers may be, there is still considerable optimism about their futures. Five agencies suggested that they need to make some significant changes. Forty-eight percent of respondents felt that while their agency needs to make a few changes, they are in good shape. Thirty-six respondents feel that they are doing great and there are big things ahead.

Looking Forward

What are your agency's plans for the next year?

33%	We will be opening additional home(s) in our area
29%	We are not opening more homes but expanding our services
24%	We're going to stay just as we are
17%	We intend to engage in more research
14%	We are will be opening additional home(s) outside of our area/state
5%	We are hoping to re-open in the next year or so
2%	We are just hoping to stay afloat in the next year or so
2%	We have absolutely no idea what the future holds

We will be consolidating operations into one larger home, opening transitional housing in the area and opening a second safe home in [another state]. We hope to improve quality of care utilizing increased staff training, research, and client input.

We have a barista program that is currently being developed, and in the next year we plan to have that fully running and to have at least several clients engaged in it. We are always working on developing a spa, and we want to eventually do a spa internship program. We also want to better equip ourselves for emergency intake situations.

We are looking to add additional employment support services to our program.

we are transitioning from minors to 18 and over. We are rebuilding our program hoping to get our cottage industry up and running for the ladies to run and operate giving them skills to run a business.

We are getting our best practices together over the next year. We only opened our 1st home 8 months ago. We are also looking to fund a referral line to assist women into getting into other programs, not just add them to our waiting list. We are also looking to begun better fundraisers and have begun a committee to assist us in that.

The provision of transitional living apartments and improved therapy as well as streamlining our process.

Expand housing network statewide. Replicate job training program in another city/region. Release qualitative and quantitative research data. Publish financial literacy curriculum and launch collaborative program nationwide.

Expand and increase our training. Tweak existing practices. Explore other programs, such as "foster care" families.

We would like to know how to better partner with other agencies who provide short term care to have them refer clients needing long term care to us.

Section R. Summary Observations

As noted in the preface to this report, this work was conceived of and executed for the purposes of peer-to-peer sharing. The following observations and suggestions are offered in that collegial spirit.

On this Landscape of Providers

- We are still a young field. The average number of years of direct service for these agencies is only 5.28. There is not a uniform lexicon, categories, or set of standards for this work. Agencies should anticipate—and participate in—future research, shared data and experiences, and play an active role in the definition of this emerging industry.

- All of these agencies serve female clients. While there was not data to suggest the full extent of the need, there are still only a few agencies in this sample providing services to Men/Boys, LGBTQ, and Women with Children. More research needs to go into understanding the need for gender-specific programs versus the efficacy of multi-gender programs.

- Client eligibility is not limited to the federal definition of human trafficking. For most of these agencies, we've define our service population to include sexual exploitation/prostitution. Does this inclusiveness impact the therapies, staffing, funding or referral sources of these agencies? More study into those questions needs to happen.

- Their primary sources of client referrals are Individuals/Families or Anti-Trafficking Agencies/Task Forces, and secondarily, Law Enforcement and the Courts. Additional awareness efforts need to go deeper into sectors such as hospital, social work, domestic violence, child protective services, foster care, etc.

- While these agencies reported that upwards of 2/3rds of the referrals they receive end up being declined, those declines are more based on an agency's inability to serve particular client conditions than on bed availability.

- It's also clear that agencies are making a concerted effort to assist in securing alternatives for the referral. This is currently being done through interpersonal/professional networking and not facilitate by any centralized and shared system.

- Most of these agencies are small (6 beds), and not operating at full capacity. Over 52% of these agencies indicated that their beds were not continuously filled.

- Most of the respondents to this survey (74%) represent agencies that identify as faith-based, specifically Christian.

- Most of these agencies operate on less than half a million-dollar budget, and yet this sample of agencies represents over $20 million in victim services across the United States.

- State and federal funding is not reaching these agencies; individuals, foundations, and congregations are carrying the financial burden for this work

- Staff within these agencies are most valued for their experience, disposition, faith, and education. Specific licensure or credentialing did not factor as high as the willingness and ability to engage in the breadth of duties required within this work.

- Thirty-eight percent of these care-givers reported that their greatest hardship in this work is "it hurts when they leave." Based on these responses, there is ample experience across these agencies with clients that go AWOL, both minors and adults. Start-up agencies should anticipate the toll that these unanticipated departures will have on staff morale.

- At the same time that staff are asked to serve as "jacks of all trades"—providing a wide range of services--there is also notable concern about physical, emotional and spiritual toil on these care givers. Faith was noted often as a source of strength and forbearance in this work.

- Collegial sharing, corporate prayer, and professional networking were oft-mentioned as antidotes to the hardships of this work

- While most staff and volunteers in these agencies have had some training in Trauma-Informed Care, additional training in complex trauma and addictions ranked as areas of need.

- These agencies have come to adopt policies and practices that restrict client's access (at least for a period of time) to outside influences (through black-out periods, no cell phones, controlled visitation, continual supervision, etc.). Such practices do not seem to be in conflict with being "trauma-informed," but rather are in direct response to understanding the trauma of these survivors.

- The home setting and "family-style" format of these programs (such as meals together, outings, routines, etc.) seem to be the norm, and touted as critical to their therapeutic approach and program culture.

- There remains a debate as to what it means to be "survivor-led" or how survivors can/should be engage in awareness, program support, mentoring, and fund-raising in heathy and productive ways.

- A range of faith practices are offered and valued in these programs, with a clear distinction between "presence" versus "participation." It seems evident that faith is valued by the agencies and staff, but is not compelled for the clients.

- There is not a unified set of metrics by which "success" is measured, either for these agencies or for the individual clients they serve. While "graduation" was the most common reason for program departure, it's yet unclear how graduation is defined.

- Most agencies aspire to "reducing the likelihood of revictimization" as the most important outcome, which is again, difficult to define and measure.

On Opportunities for Community Partnerships

- These agencies are financially dependent upon individuals, churches, and foundations for support. Therefore, these agencies need to be better-equipped to communicate service data and outcomes so donors and the larger philanthropic sector can understand this work and where charitable investments will have the most impact.

- Tracking referrals is a task that should be incurred by all agencies, and shared. This will provide our nation with a more accurate picture of the needs, and speak to the impact of public awareness and law enforcement intervention efforts. I.T. professionals could offer support in helping these agencies make better use of technologies to streamline operations and capture/analyze data.

- Direct service professionals (legal, financial, educational, etc.) are critical to helping these agencies provide the breadth of client services that are needed. Increasing human trafficking awareness among these professions may also help increase victim identification and referral.

- There is not yet a clear construct for how mental health professionals/therapists/counselors can engage effectively with residential service providers, for the good of the clients they share. At present, much of the therapeutic needs of clients are being met either by in-house lay counselors, or outsources to third-party providers. This does not afford an integrated approach and suggests opportunity for new models of collaboration to be created.

Appendix A: List of Survey Respondents

NOTE: Blue fill indicates the program is *in-progress* or *not yet open*.

Minor	Adult		State	Emergency	Assessment	Restorative	Graduate
		Abigail House	VA				
		Arrow Child & Family Ministries	TX				
		Atlanta Dream Center / Out of Darkness	GA				
		BeLoved Atlanta	GA				
		Cherished Precious Loved	FL				
		Coalition to Abolish Slavery and Trafficking	CA				
		Courage Worldwide	CA				
		Dawn's Place	PA				
		Denver Street School - Hope Academy	CO				
		Eden House	LA				
		Engedi Refuge Ministries	WA				
		Free Our Girls	CO				
		Generate Hope	CA				
		Glory House of Miami	FL				
		GraceHaven	OH				
		Hepzibah House	FL				
		Janus Youth Programs	OR				
		Lily Pad Haven	NC				
		Living in Liberty	PA				
		Mission 21	MN				
		Naomi's House	IL				
		New Day for Children	CA				
		New Life Refuge Ministries	TX				
		Next Step Ministries	MT				
		Oasis of Hope	PA				
		Ohio Women's Refuge	OH				
		On Eagles Wings Ministries	NC				
		Poiema Foundation	TX				
		RAHAB Ministries	OH				
		Real Escape from the Sex Trade	WA				
		Redeemed Ministries	TX				
		Redemption Ridge, Inc.	OR				

Minor	Adult	Continued	State	Emergency	Assessment	Restorative	Graduate
		Refuge for Women - KY	KY				
		Refuge for Women - Las Vegas	NV				
		Refuge for Women - N. Texas	TX				
		Refuge for Women -Chicago	IL				
		Refuge of Light	TX				
		Resilience Rising	CO				
		Restore NYC	NY				
		Samaritan Village	FL				
		Sisters in Shelter	OH				
		Source Anti-Trafficking	MN				
		Street Ransom	VA				
		StreetsHope	CO				
		The Daughter Project	OH				
		The Salvation Army	PA				
		The Samaritan House	VA				
		The Samaritan Women	MD				
		The Well	KY				
		The WellHouse	AL				
		Traffick911	TX				
		True Justice International	NC				
		Truth for Women - Truth Home	PA				
		Unbound Seattle	WA				
		Veronica's Voice	KS				
		Wellspring Living	GA				
		Worthwhile Wear- The Well	PA				

Appendix B: Services Available to Foreign Victims of Human Trafficking

Eligibility

Between U.S. citizens and foreign nationals who are victims of human trafficking, only foreign nationals are eligible to receive HHS certification letters.

References:

https://www.acf.hhs.gov/orr/resource/fact-sheet-certification-for-adult-victims-of-trafficking
https://www.acf.hhs.gov/otip/victim-assistance/certification-and-eligibility-letters-for-foreign-national-victims

Benefits Summary

In addition to receiving eligibility to apply for the same federal programs available to U.S. citizens (e.g., SSI, Food Stamps, WIC, housing vouchers), HHS-certified human trafficking survivors are *guaranteed* to be able to receive: Access to a State Refugee Coordinator/Regional Representative who oversees all benefits administration for refugees and HHS-certified human trafficking survivors.

- Refugee Cash Assistance
- Refugee Medical Assistance
- Free medical screenings
- 'Matching Grant' program, which includes:
- Case management
- Cash assistance
- Housing assistance
- Employment services
- Unaccompanied Refugee Minors program, which consists of:
    - Specialized foster care
    - Family reunification services
    - English-language training

Adult U.S. citizens who are human trafficking survivors are only eligible for non-refugee equivalents of the above-named programs (e.g., Temporary Assistance for Needy Families/Temporary Cash Assistance, Medical Assistance) if they meet the criteria established by their states of residence.

References:

https://www.acf.hhs.gov/orr/resource/fact-sheet-victim-assistance-english
https://www.acf.hhs.gov/otip/victim-assistance/services-available-to-victims-of-trafficking
https://www.acf.hhs.gov/sites/default/files/orr/traffickingservices_0.pdf

Appendix C: Trauma-Informed Care

The six key principles fundamental to a trauma-informed approach include:[24,36]

1. **Safety:** Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety. Understanding safety as defined by those served is a high priority.

2. **Trustworthiness and Transparency:** Organizational operations and decisions are conducted with transparency with the goal of building and maintaining trust with clients and family members, among staff, and others involved in the organization.

3. **Peer Support:** Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their stories and lived experience to promote recovery and healing. The term "Peers" refers to individuals with lived experiences of trauma, or in the case of children this may be family members of children who have experienced traumatic events and are key caregivers in their recovery. Peers have also been referred to as "trauma survivors."

4. **Collaboration and Mutuality:** Importance is placed on partnering and the leveling of power differences between staff and clients and among organizational staff from clerical and housekeeping personnel, to professional staff to administrators, demonstrating that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. As one expert stated: "one does not have to be a therapist to be therapeutic."[12]

5. **Empowerment, Voice and Choice:** Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. The organization fosters a belief in the primacy of the people served, in resilience, and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma. The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services, and/or who come to the organization for assistance and support. As such, operations, workforce development and services are organized to foster empowerment for staff and clients alike. Organizations understand the importance of power differentials and ways in which clients, historically, have been diminished in voice and choice and are often recipients of coercive treatment. Clients are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Staff are facilitators of recovery rather than controllers of recovery.[34] Staff are empowered to do their work as well as possible by adequate organizational support. This is a parallel process as staff need to feel safe, as much as people receiving services.

6. **Cultural, Historical, and Gender Issues:** The organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender-identity, geography, etc.); offers, access to gender responsive services; leverages the healing value of traditional cultural connections; incorporates policies, protocols, and processes that are responsive to the racial, ethnic and cultural needs of individuals served; and recognizes and addresses historical trauma.

Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach by 2014
https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

DOMAIN 1A SAFETY:	Ensure physical and emotional safety
DOMAIN 1B TRUSTWORTHINESS:	Maximise trustworthiness through task clarity, consistency, and interpersonal boundaries
DOMAIN IC CHOICE:	Maximise consumer choice and control
DOMAIN 1D: COLLABORATION:	Maximise collaboration and sharing of power
DOMAIN 1E: EMPOWERMENT:	Prioritise empowerment and skill-building
SERVICE POLICIES:	Ensure formal policies are based on the above principles and are consistently implemented and monitored
SCREENING FOR TRAUMA:	Ensure a mechanism for screening of underlying trauma that is implemented in a service/organisational context which is fully trauma-informed

Source*:* The Practice Guidelines for the Treatment of Complex Trauma & Trauma Informed Care and Service Delivery, published by the Blue Knot Foundation, Australia
http://www.blueknot.org.au/ABOUT-US/Our-Documents/Publications/Practice-Guidelines

Appendix D: Commonly Referenced Interventions

Dialectical Behavioral Therapy (DBT)[59]

DBT has individual and group-based components. Its treatment strategies serve four functions:

1) ***Learning new skills***	2) ***Generalizing those skills***
Regulating emotions Paying attention to the present moment Effectively navigating interpersonal situations Tolerating distress without making situations worse	Making sure that the new skills are applied outside of the therapy session/therapist's office in the person's natural environments
3) ***Overcoming barriers to change***	4) ***Structuring the environment***
Improving motivation to change Reducing problematic behaviors	Teaching individuals how to take active role in structuring their environments to reinforce progress and/or to *not* reinforce problematic behavior

To prevent burnout, DBT therapists also support and encourage one another through their own group meetings to provide validation, continued training and skill-building, and feedback.

Eye Movement Desensitization and Reprocessing (EMDR)[60]

EMDR is an individual therapy that aims to lessen the suffering experienced from the stress- and depression-related symptoms of Post-Traumatic Stress Disorder (PTSD). The EMDR therapist and client focus on one "target" traumatic memory per session, paying attention to the client's bodily sensations and negative beliefs/feelings about the traumatic memory. While the client focuses on the traumatic memory for 30 seconds at a time, he/she completes a small physical task (usually, moving his/her eyes from side to side following the therapist's finger) until the negative feelings are gone. Then, the EMDR therapist asks the client to think of a positive belief regarding the traumatic event and to focus on this while continuing the exercises.

You might think of it like this:

Car accident → Broken leg → Debris in the wound → Cleaning the wound → Healing

Traumatic event → PTSD → Stress- and depression-related symptoms → EMDR → Healing

[59] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2963469
[60] http://legacy.nreppadmin.net/ViewIntervention.aspx?id=199

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)[61]

TF-CBT was originally designed for ages 3 through 18, but has been successful with adults over 18 as well. It targets PTSD and complex PTSD symptoms (for example, stress-related behavioral and emotional problems) that can come from a wide range of traumas, including childhood sexual abuse, domestic violence, human trafficking, and war. The eight components of TF-CBT[62] are:

Psychoeducation →	Relaxation →	Emotional regulation →	Cognitive processing →
Learn about TF-CBT Collaborate with counselor on treatment course	Explain physical signs of stress and importance of relaxation Practice relaxation techniques (yoga, guided imagery, breathing, etc.)	Describe feelings and range of intensity associated with daily thoughts and behaviors	Typically completed in 2-3 sessions Detail 'thought-behavior-feeling triangles' associated with traumatic memories
Trauma narrative →	Cognitive reprocessing →	Safety skills →	Family/parent inclusion
Create timelines of their trauma In cases of avoidance or denial, counselors give firm but validating statements	Identify unhealthy thoughts, feelings, and behaviors Make goals for healthy changes	Taught using role play of procedures to follow in different unsafe situations (just like a fire drill)	If possible/desired, family/parent(s) are included in final sessions or given parallel sessions

Trauma Recovery & Empowerment Model (TREM)[63]

TREM may be delivered as a once-weekly group intervention for 18 to 29 sessions, or as a three- to five-part intervention. It addresses both short-term and long-term emotional, psychological, and interpersonal consequences of experiencing violence. The three core areas TREM addresses are:

1) Empowerment	2) Trauma Recovery	3) Relationships
Physical and emotional boundary-setting Self-soothing Self-esteem	Relationships between physical/sexual/emotional abuse and psychological or emotional symptoms Relationships between addictive or compulsive behaviors and trauma	Family and family life Communication and decision making Feeling out of control Blame, acceptance, and forgiveness Personal healing

TREM also has suggestions for modifying the intervention for women who are: diagnosed with serious mental illness, incarcerated, parents, or abusers.

[61] http://nrepp.samhsa.gov/ProgramProfile.aspx?id=96
[62] https://www.mensenhandelweb.nl/system/files/documents/30%20Sep%202015/TF-CBT_Feasibility_Report_Cambodia_2011.pdf
[63] http://www.nrepp.samhsa.gov/ProgramProfile.aspx?id=90

Appendix E: Peer-Recommended Resources

The following resources have been recommended by your peers as particularly helpful and worth passing along:

TOPIC	BOOKS	VIDEOS/ WEBSITES
Abortion/Miscarriage	Forgiven and Set Free	
Abusive relationships	Boundaries in Dating	www.gettingoutofthegame.com
Anger	Anger workbook by Carter	"Overcoming Emotions that Destroy" videos by Chip Ingram
Bullying	And Life Continues by Wendy Barnes	
Childhood sexual abuse	Counseling Victims of Childhood Sexual Abuse by Dr. Diane Langberg The Wounded Heart by Dan Allender Redeeming Love, by Francine Rivers Father-Daughter Incest by Dr Judith Herman Courage to Heal Workbook	Trust (online predator)
Codependency	Co-Dependent No More	
Evil / Sin	People of the Lie by M. Scott Peck Mending the Soul by Steven Tracey	
Gender questioning	Divine Design	
Grief		"Rebuilding Your Broken World" videos by Chip Ingram
Healthy relationships	Boundaries books The Bride Wore White	"Love, Sex, and Lasting Relationships" videos by Chip Ingram
Prostitution / Trafficking	Girls Like Us by Rachel Lloyd Not For Sale White Umbrella by Mary Frances Bowles Paid For by Rachel Moran Road to Redemption, Rebecca Bender Prostitution, Trafficking and Traumatic Stress by Melissa Farley	Nefarious Very Young Girls Trade CNN Freedom Project Flesh

Shame	The Soul of Shame by Curt Thompson	Videos by Brene Brown
Substance abuse/Addiction	Seeking Safety AA/NA Handbook	Celebrate Recovery
Trauma	Suffering and the Heart of God by Dr. Diane Langberg The Body Keeps the Score by Dr. Bessel van der Kolk Trauma and Recovery by Dr. Judith Herman The Boy who Was Raised as a Dog by Dr. Bruce Perry Healing the Wounded Heart by Dan Allender TREM The Brain Bible Remembering Trauma Coping with Trauma Related Dissociation SERVE model by Bonnie Martin and TBRI	Understanding Complex Trauma – Dr. Diane Langberg – https://youtu.be/otxAuHG9hKo Complex Trauma – Going Deeper – Dr. Diane Langberg – https://youtu.be/4n8ydiaWmNc

Appendix F: Peer-Recommended Policies or Practices

Individualized and/or trauma-informed treatment

"Utilizing principles of high-fidelity wraparound that focus on individualized, strengths-based and survivor voice and choice in the service plan development and delivery"
"Individualized service plans"
"Not a cookie cutter program, customized for each participant"
"Individual care plans"
"Trauma-informed"
"Survivor led"
"Weekly "Out of the Life" conducted by a survivor"
"Peer to peer counseling"
"We celebrate cultural differences"
"Balancing structure with autonomy to create opportunity for self-efficacy to increase – this looks like walking with survivors through their mistakes and helping them learn as they develop new skills"
"Autonomy on decisions"
"Empower them with choices"
"Self-transportation"
"If a client presents a financial request, she had to complete a budget with us and if it seems reasonable that she needs money, we then consider helping her"
"Money management program. Teaches the importance of paying rent and other bills, necessities that than wants and importance of savings"
"Love & acceptance"

Therapeutic modalities and program aspects

"TREM (Trauma Recovery Empowerment Model)"
"Seeking safety model"
""Roadmap to redemption" by Rebecca Bender, together with our alumni advocate we take the women thru this workbook individually"
"Cycle of change"
"Maintaining a calm and tranquil atmosphere – not a lot of busyness"
"Presence of in-house counselor"
"Providing brain & trauma training for survivors so they can understand their trauma responses and begin to identify new coping strategies for dealing with reminders of past trauma"
"Daily therapy of different modalities"
"Counseling relationship"

Phones, Internet/social media, and television

"No cell phones – best policy we ever put into effect"
"No cell phones"
"No cell phone use"
"No cell phones allowed at program"

"Limited phone calls inside the house"
"Safe contact procedure and monitor calls"
"No Internet access of any kind for the first 6 months"
"No social media"
"Limited tv"

Program phases and points/privileges

"Clients earn points by working on goals, chores, and doing classes, and they get to spend those points on hygiene products, clothing, jewelry, and house items"
"Phases of progression and slowly releasing freedom"
"Three phase program"
"Tiered achievement with privileges"
"Trust Tracker – level system that values character building"
"The point and phase system"
"Leadership level"
"Earned privileges"
"Free day earned"

Program structural components/rules

"Well documented resident guidelines"
"Chores shared among the residents"
"Set waking and going-to-bed hours with routines that go along with those times"
"Daily program structure"
"Morning and evening 'house meetings' make sure everyone is on the same page for the schedule and concerns are addressed"
"Having all residents in the same bedroom"
"Mandatory attendance to classes at the Learning Center"

Security

"Internal video surveillance"
"Crisis prevention plan"
"Requiring that all mail be opened and reviewed before mailing"
"No going anywhere without a staff or volunteer"
"Not locked facility"
"Having large animals on the premises"

Food

"Shopping and preparing their own food"
"Having dinners together builds community"
"Eating dinner meal together"

Spiritual and relational

"Devotion time daily"
"Morning devotions"
"Participate in church and volunteer in community"
"Spiritual development"
"Do not have a required religious agenda"

Physical activity

"Exercise or physical activity daily"
"Walks and personal outing time"

Staff-related

"No overnight staff"
"Staff consultation with trauma therapist"
"House Moms building relationships with the girls and caring for them"
"Required HT and trauma training"
"Staff all on same campus"
"Staffing model – as qualified as possible"
"Encouraging (and accepting) open and honest feedback between all staff members keeps us improving and humble, and better able to serve our clients well"
"We have an open system; this works well"

Outside service providers

"Partnership Agreements"
"Collaboration with providers for D&A, MH, medical, dental"
"Clients receiving medical detox for certain drugs"

Other

"We have large decal trees along the wall, and when we find out a positive update about anything regarding our center, we write it on paper fruit cut-out and tape it to the tree to have a visual representation of the "fruit" that is growing in our clients' lives. It keeps staff encouraged, and also helps motivate and inspire clients."
"Field trips"

SHELTERED: National Practices Survey Report 2017

To request reprints of this publication, please contact:
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