Flying Blind?
Implementing a Trauma-Informed Care Approach in the Treatment of Trafficking Survivors

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Abstract

Millions of people are exploited for labor or sex throughout the world. Governments and non-profit organizations have increasingly explored how to best help trafficking survivors overcome their adversity through services such as counseling, job assistance, financial assistance, family reunification, and housing. However, there are few evidence-based practices for how to best care for trafficking survivors due to transitory contact between survivors and care providers, a lack of organizational capacity for research, and the need to not withhold potentially beneficial treatment from any survivor. In 2018, the United States Office to Monitor and Combat Trafficking in Persons suggested that one best practice is using trauma-informed care (TIC) due to survivors' likelihood of having experienced complex trauma. This study examines 18 anti-trafficking organization employees' perceptions and use of TIC in the treatment of trafficking survivors through interviews. A meta-analysis of research about the best practices of meeting the mental health needs of survivors shows in what ways providers using TIC to meet survivors' mental health needs are not flying blind, but rather using evidence-based practices. A meta-analysis of research about the mental health needs of trafficking survivors is used to further develop providers' understanding of survivors' mental health needs and identify areas for further research.

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Acknowledgements

Introduction

Trafficking is the trade or recruitment of human beings for exploitative purposes

(United Nations Human Rights Office of the High Commissioner, 2000).[1] Trafficking is seen

in the forms of forced labor, bonded labor, debt bondage and involuntary servitude, forced

child labor, child soldiers, and sexual exploitation (U.S. Office to Monitor and Combat

Trafficking in Persons, 2008). It happens domestically and internationally (U.S. Office to

Monitor and Combat Trafficking in Persons, 2008).

The International Labour Organization (ILO) estimates that 40.3 million people

were trafficked in 2016, including 24.9 million people in forced labor, 15.4 million people

in forced marriage, and 4.8 million people in sexual exploitation (International Labour

Organization, 2017). Additionally, the ILO estimates that 25 percent of these victims were

children, and 71 percent of these victims were women and girls. Though there is no official

estimate of the total number of trafficking victims in the United States, Polaris, an anti-

trafficking organization, estimates that the current number of domestic victims is in the

hundreds of thousands (Polaris, n.d.).

In 2006, the Office of the Assistant Secretary for Planning and Evaluation within the

United States Department of Health and Human Services (HHS) noted a lack of evidence-

based research focusing on trafficking survivor services (Heather Clawson et al., 2009; Jay

Albanese et al., 2004). A practice that is evidence-based is supported by an evidentiary

basis, meaning it has been proven to have positive effects through research (Oregon

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[1] Trafficking is defined as "the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" in the Palermo Protocol (United Nations Human Rights Office of the High Commissioner, 2000).

Research Institute, n.d.). The HHS noted a research gap in services for trafficking victims in

their 2006 report. Since the HHS published their report, other researchers have cited the

lack of knowledge about mental health services for trafficking survivors as the reason for

their research on the mental health of trafficking survivors (Atsuro Tsutsumi, Takashi

Izutsu, Amod Poudyal, Seika Kato, & Eiji Marui, 2008; Jill Domoney, Louise Howard,

Melanie Abas, Matthew Broadbent, & Sian Oram, 2015; Kristin Heffernan & Betty Blythe,

2014; Livia Ottisova et al., 2018; Stacy Cecchet & John Thoburn, 2014).

In the face of a lack of evidence-based practices for caring for trafficking survivors,

the United States Office to Monitor and Combat Trafficking in Persons suggested one

possible best practice would be to implement a trauma-informed care (TIC) approach

when caring for survivors due to the shared experience of trauma between trafficking

survivors (U.S. Office to Monitor and Combat Trafficking in Persons, 2018). Trauma is a

psychological or emotional response to a disturbing event and can characterize a wide

array of events (The Center for Treatment of Anxiety and Mood Disorders, n.d.). Trafficking

survivors often experience complex trauma, which occurs when someone has been

exposed to multiple traumatic events that are often characterized by being invasive,

interpersonal, and having long-term effects (U.S. Office to Monitor and Combat Trafficking

in Persons, 2018). TIC is an approach to working with survivors that requires the providers

to understand the survivor's experiences in order to increase the survivor's engagement,

treatment adherence, and outcomes, as well as the provider's own wellness (Menschner &

Maul, 2016).

These two opinions co-exist in academia about trafficking survivors: there is a lack

of evidence-based services for caring for trafficking survivors, and a trauma-informed

approach to caring for survivors should be applied. This study aims to accomplish two things in response to these opinions. First, do people working with trafficking survivors perceive a lack of evidence-based practices, and in what ways do they employ a TIC approach in their work with survivors? Second, in what ways are mental health providers using a TIC approach with survivors using evidence-based practices, and what research exists on the mental health needs of survivors to further expand providers' understanding of survivors' experiences and increase the likelihood of improving patient engagement, treatment adherence, health outcomes, and staff and provider wellness? Though a variety of after care services could be studied, this research focuses on services for survivors' mental health.

Anti-trafficking organization employees' perception of evidence-based practices and use of TIC

Methodology

Eighteen interviews were conducted with employees of anti-trafficking organizations in a semi-structured format. Interviewees were recruited through emails and verbal consent was obtained. Anti-trafficking organizations were identified through the Global Modern Slavery Directory—a list of anti-trafficking organizations categorized by location and created via a joint collaboration between Polaris, The Freedom Fund, and Liberty Asia—and the snowball method (some interviewees volunteered the contact information for employees at other anti-trafficking organizations). Only organizations headquartered in the United States were contacted in an effort to control for different governmental approaches to combatting trafficking.

Only organizations headquartered in the following four areas were contacted: Georgia, Washington, D.C., North Carolina, and Louisiana. Georgia and Washington, D.C. were chosen because Atlanta, Georgia and Washington, D.C. had the two highest rankings for the number of cases of human trafficking per capita from December 7, 2007 to December 31, 2016 when compared with the top 100 most populous U.S. cities (Human Trafficking Hotline, n.d.). Washington, D.C. saw 87 cases per 100,000 people. Atlanta, Georgia saw 84 cases per 100,000 people (Human Trafficking Hotline, n.d.). New Orleans, LA is ranked as number 12 on this list with 39 cases per 100,000 people and Raleigh-Durham, NC is ranked as number 50 with 15 cases per 100,000 people (Human Trafficking Hotline, n.d.). The lower-ranked cities were chosen to increase the likelihood of having a variety of opinions. Also, the lower-ranked locations were chosen over other lower-ranked locations because interviewees from the other two locations gave the interviewer the contact information for employees at organizations in these areas.

Although the data from the Human Trafficking Hotline was for specific cities, any organization headquartered in the state that the city was located in was contacted in order to interview as many organizations as possible, except for Washington, D.C. Eighteen of the 54 contacted organizations agreed to speak (33 percent).

Each interviewee either belongs to an organization that provides direct care services (i.e., counseling and medical services) or belongs to an organization that directs survivors to organizations that provide direct care services. However, there are three interviewees who belong to organizations that facilitate communication between providers, labeled as information-sharing organizations. Due to their familiarity with the direct care organizations, their interviews are included in this study.

Before conducting each interview, the interviewer gathered the following

information from each organization's website: demographics of the survivors that the

organization works with (males/females, adults/children, foreign/domestic), whether the

organization provides direct services or shares information between organizations, what

type or types of trafficking survivors that the organization works with, and what services

the organization offers, if any. If any of this information was not on the website, it was

addressed in the interview. Organizations were not disqualified based on the demographics

of the population they work with in an effort to increase the quantity of interviews and

examine a variety of opinions. All of the interviewed direct care organizations work with

sex trafficking survivors. Some interviewed organizations work with children or adults,

men or women, and domestic or foreign-born survivors. The specifics of each interviewed

organization are listed in Table 1. Additionally, each interviewee provided a list of their job

responsibilities.

The interviews were semi-structured with open-ended questions. Each interview

was altered based on whether the organization is a direct care organization or an

information-sharing organization, what services the organization provides, and what the

interviewee's job entails. A sample interview structure is included in Appendix A. No

interview lasted longer than thirty minutes. Every interview was conducted over the

phone.

I took notes and, when possible, direct transcriptions of the interview, which were

then transferred into a qualitative coding software program called NVivo. NVivo was used

for the following purposes: (1) to organize the interviews by organization type, (2) to

organize the interviews by the demographics of the survivors they work with, and (3) to

identify themes in the interviews. After the interviews were coded, the researcher

identified thematic patterns using NVivo.

Results

The characteristics of each interviewed organization are detailed in Table 1. Of the

interviewed employees, one is stationed in an international location while the rest are

within the US. Of the direct care organizations in the US, three are located in NC, two in

Washington, D.C., six in LA, and three in GA.

Characteristics of population and organizations represented in this study's interviews

Direct services	Information-sharing	Adults (>18)	Children (<18)	Males	Females	Domestic	Foreign	Sex trafficking	Labor trafficking
X		X	X	X	X	X	X	X	X
X		X	X	X	X		X	X	X
X		X	X	X	X	X		X	
X		X		X				X	
X		X	X	X	X	X		X	
X			X	X	X	X		X	X
X		X	X	X	X	X	X	X	X
	X								
	X								
	X								
X		X	X	X	X		X	X	X
X			X	X	X	X		X	X
X			X	X	X	X		X	X
X	X			X			X	X	X
X	X	X	X	X	X	X		X	X
X			X	X	X	X		X	X
X			X	X		X		X	X
X			X	X	X		X	X	X

(Table 1: Each row represents an organization interviewed in this study. The table lists each organization's characteristics.)

Two major themes were identified through the interviews. First, the interviewees

perceived a lack of evidence-based services for trafficking survivors. Second, the

interviewees use TIC while working with survivors.

Interviewees' perception of the amount of evidence-based services for survivors

Six employees of anti-trafficking organizations commented on a lack of evidence-based services for trafficking survivors when asked about the biggest research needs in the field of trafficking:

"I don't think most agencies are concerned with developing evidence-based practices and I think that's a detriment to a lot of these programs."

"We are in the early stage of trying to develop evidence-based and trauma-informed services."

When asked about what areas need further research, 17 of 18 interviewees identified areas. The one interviewee who did not provide an answer asked to have time to think about the question and did not respond when prompted with an email. Sixteen different themes emerged from this open-ended question. The three most frequently mentioned themes were after care services (mentioned by seven interviewees), therapy modalities (mentioned by four interviewees), and how to best incorporate survivors' voices into discussions about their treatment (mentioned by three interviewees). Therapy modalities and survivor voice relate to how service providers interact with survivors and correspond with TIC as explained in the following section.

How interviewees are using TIC when working with survivors

Six interviewees mentioned the importance of integrating a trauma-informed approach into trafficking survivor services in order to meet the immediate needs of survivors.

"Victims of human trafficking have experienced repeated trauma beginning often in early childhood. What we also know is that not everyone experiences trauma in the same way. So we try to provide an individualized treatment program to the women and we deliver that through intensive and therapeutic case management."

"Using specialized service plans that are tailored to the trauma and the issues that individual survivors have is critical because trafficking is such a broad term."

In a trauma-informed approach, anti-trafficking organizations individualize care to the needs of each survivor. Three themes that correspond with a TIC approach were repeatedly mentioned in the interviews: building rapport with the survivor (mentioned by 10 interviewees), incorporating the survivor's voice into the decision-making process (mentioned by six interviewees), and working collaboratively with all individuals involved in identifying and caring for the survivor (mentioned by 14 interviewees) (Diagram 1). Building rapport or establishing trust makes the survivor feel comfortable voicing their opinion which increases patient engagement, treatment adherence, and improves health outcomes (Anita Ravi, Megan Pfeiffer, Zachary Rosner, & Judy Shea, 2017b, 2017a; Anne Renz, Douglas Conrad, & Carolyn Watts, 2013; David Langer & Amanda Jensen-Doss, 2016; Deborah Gibbs, Jennifer Walters, Alexandra Lutnick, Shari Miller, & Marianne Kluckman,

2015). Collaboration amongst care providers improves provider and staff wellness, and has positive effects on survivor outcomes (Amy Goldberg & Jessica Moore, 2018; Jordan Greenbaum, 2014) .

A trauma-informed care approach with trafficking survivors
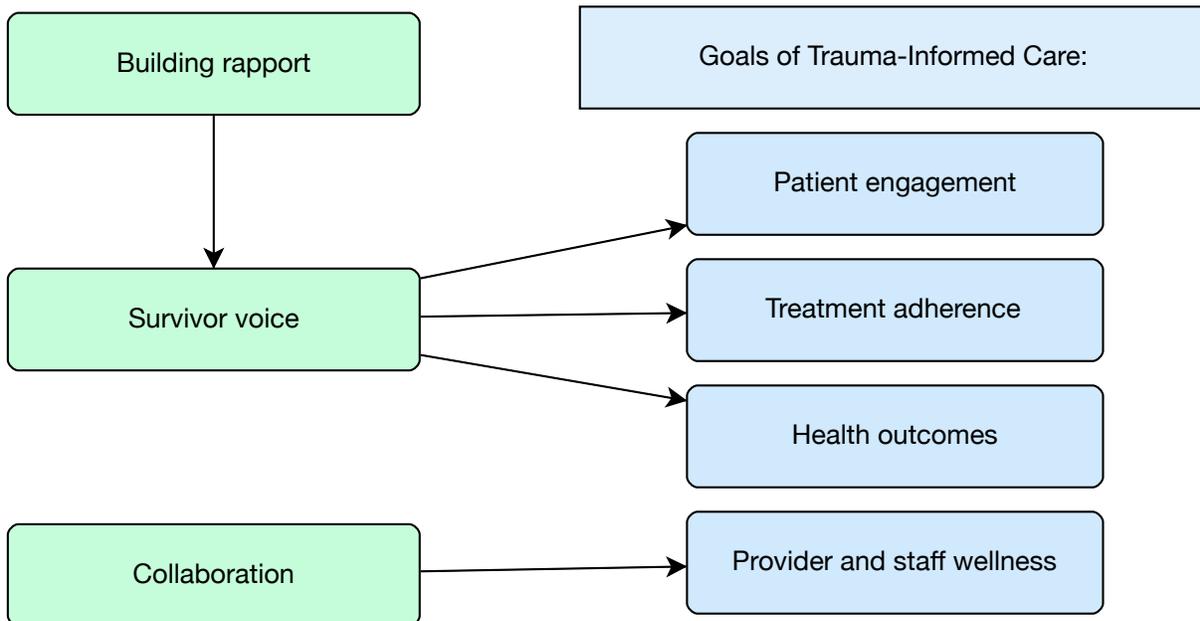
(Diagram 1: The goals of TIC are increased patient engagement, treatment adherence, health outcomes, and staff and provider wellness (Menschner & Maul, 2016). Building rapport, survivor voice, and collaboration are how the interviewed anti-trafficking organization employees employ TIC when working with trafficking survivors.)

In the face of a lack of evidence specifically for trafficking survivors, providers are left to figure out which methods to use. Many, including the organizations represented by these interviews, are using a TIC approach, as suggested by the U.S. Office to Monitor and Combat Trafficking in Persons (2018). But, how appropriate is providers' reliance on TIC? Below, I address the interviewed organizations' use of building rapport, incorporating survivor voice, and collaboration using interview excerpts and existing literature to identify whether they are indeed accomplishing the four goals of TIC.

1. *TIC with trafficking survivors: Building rapport*

Engaging survivors in treatment planning is essential for achieving the goals of TIC (Menschner & Maul, 2016). Treatment providers must develop rapport with the survivor so that the survivor feels comfortable engaging in their treatment and voicing their opinion about their treatment options. In interviews with 21 female survivors of sex trafficking from ages 19 to 60 in Rikers Island Jail in New York, Ravi et al. noted the importance of rapport to the survivors (2017). The survivors voiced that providers who communicate with empathy and are non-judgmental earn the trust of the survivors, thus setting the basis for survivors to feel comfortable sharing their needs and desires with caregivers.

Ten interviewed anti-trafficking organization employees discussed the importance of developing rapport between themselves and trafficking survivors. Additionally, all 10 discussed the importance of individualized services and all but one discussed incorporating the survivor's voice into their care planning. The statements included:

"It was more important to build trust and rapport and do whatever it took to build that trust and rapport at the front end even if that person was still involved in their trafficking...But you're getting to know them and they're slowly telling their story."

"From my experience, [building rapport is] going to be more successful in the long-run."

"They've been disempowered and when you build rapport, meet them where they are, let them guide the interaction, you're empowering them."

"I think rapport is always extremely important. If you're going to go anywhere with a client, they need to feel comfortable."

Providers believe that they have to develop trust with survivors so that survivors are comfortable voicing their needs and opinions about the services offered to them.

2. *TIC with trafficking survivors: Incorporating the survivor's voice*

Incorporating the survivor's voice means giving trafficking survivors the opportunity to contribute to discussions about their care plans, rather than care providers making decisions fully on behalf of the survivors. Listening to and respecting survivor voice is part of TIC and can happen once rapport is established (Beth Sapiro, Laura Johnson, Judy Postmus, & Cassandra Simmel, 2016). Six interviewees described listening to survivor voice as an important part of caring for trafficking survivors. It is appropriate to present the research on adult and youth voice separately because the literature about listening to adult voice and listening to youth voice is separate.

Bringing together the voices of providers and adult patients in mental health services is considered to be consistent with patient-centered care, and results in an improvement of treatment outcomes and an increased engagement in restoration activities (David Langer & Amanda Jensen-Doss, 2016). In a study on a shared-decision making model that would incorporate patient voice in health care decisions, the model is shown to increase patient engagement, but take longer to implement (Anne Renz et al., 2013). Maintaining treatment engagement also happens by delivering the services that clients think they need (Deborah Gibbs et al., 2015).

In the context of health care for sex trafficking survivors, providers identified incorporating survivors' voice as "critical in optimizing health care delivery" (Anita Ravi et al., 2017b). Ravi et al. suggested that providers should incorporate survivors' voice by asking survivors for their preferred method of receiving test results and asking whether the treatment is feasible (2017b). Ravi et al. said incorporating survivors' voice in such a way could improve care delivery (2017b). This is important when working with trafficking survivors because the survivors are likely to change their place of residence, which makes maintaining contact more difficult (Anita Ravi et al., 2017a). By listening to the survivor's needs and opinions, obstacles such as the transitory nature of survivors can be anticipated and addressed. There may be additional barriers that providers have to work through to include the survivor's voice, such as speaking different languages.

Though the opinions on the effects of incorporating adults' voice into care decisions are positive, opinions on incorporating children's voice into care decisions are mixed. The United Nations General Assembly encouraged government workers, medical providers, and other individuals working with vulnerable children to seek and respect the opinions of children they serve in the Convention on the Rights of the Child (United Nations General Asembly, 1989). When deciding whether a child should be separated from their parent, Article 9, Paragraph 2, of the Convention says "all interested parties should be given an opportunity to participate in the proceedings and make their views known." Professionals working with minor trafficking survivors should encourage the minors to participate in their treatment planning to uphold children's rights.

Current child participation in the health care setting is low, despite the United Nations' encouragement for children to participate in care discussions in the Convention on

the Rights of the Child and research showing positive outcomes from incorporating

survivor voice (Imelda Coyne, 2008; Imelda Coyne, Aislinn Amory, Gemma Kiernan, & Faith

Gibson, 2014).

One interviewee believes that anti-trafficking organizations and government

systems act paternalistically towards minor victims rather than listening to their voice:

"[Children] interact with these systems, like the child welfare system and juvenile

justice system, that take away their voice because they're designed to act

paternalistically to kids."

Six interviewees suggested that anti-trafficking organizations should move towards a

trauma-informed approach by incorporating children's voice and move away from a

paternalistic approach:

"I think [youth voice] is really important. And the reason why is, first of all, we know

that if the child's not happy with their plan, they're going to run again. I think we need

to take a more harm-reduction approach to children…A lot of folks take a more

protectionist approach with children…For long-term recovery for the client, if they're

not feeling respected or heard by the service providers, there's no trust…If we're telling

kids what to do, that's essentially the same as the traffickers. That's another power

dynamic that's really scary."

Traffickers manipulate children, according to this interviewee. A paternalistic approach

towards children—making decisions on behalf of the child—models the power dynamic of

the trafficker and the child. An opposite approach that contrasts the power dynamic of the

trafficker and the child would include the child's opinion in the decision-making process:

"One of the things that's most important is providing individuals who have been

trafficked opportunities to make their own decisions."

"It's very important to me that we don't treat [trafficking survivors] the way they've

been treated."

"If we're telling the kids what to do, that's essentially the same as the traffickers. That's

another power dynamic that's really scary."

To contrast the power dynamic of the trafficker and the trafficking survivor, survivor voice

must be respected, even as a child, according to the interviewees.

Another benefit of respecting the child survivor's voice is that incorporating the

child's voice can decrease the likelihood of the child running away from their support

network (Beth Sapiro et al., 2016). Twelve interviewees mentioned they view running

away as a common occurrence among trafficking survivors. To convince the child to stay,

the child has to feel more listened to and cared for by the system than their trafficker.

Providers can listen to survivors' thoughts by asking survivors for best methods for

maintaining contact and completing treatment. Research on incorporating survivor voice

into care planning is overwhelmingly positive, with the exception of research on

incorporating children's voice, which shows mixed results. The interviewed anti-trafficking

organization employees are in favor of taking child survivor's opinions into account.

Organizations, such as those represented in this study's interviews, are accomplishing TIC's

goals of increasing treatment adherence, patient engagement, and health outcomes by

incorporating survivor voice and developing rapport with survivors (Menschner & Maul,

2016).

3. *TIC with trafficking survivors: Collaboration*

     Collaboration between professionals working with trafficking survivors maps onto

the fourth goal of a trauma-informed approach to care: staff and provider wellness

(Menschner & Maul, 2016). Fourteen interviewees mentioned their personal use of

collaboration and belief that other providers should also work together.

     It is important to care for staff and providers working with trauma victims because

of the possibility of experiencing secondary trauma. Secondary trauma is the "emotional

duress that results when an individual hears about the firsthand trauma experiences of

another" (National Child Traumatic Stress Network, Secondary Traumatic Stress

Committee, 2011). Secondary trauma can lead to "chronic fatigue, disturbing thoughts,

poor concentration, emotional detachment and exhaustion, avoidance, absenteeism, and

physical illness" (Menschner & Maul, 2016). One interviewee in this study mentioned

secondary trauma:

"It's not just addressing the trauma that victims have experienced, but also the secondary trauma."

One employee interviewed in this study cited over-work as another reason for collaboration:

"[Collaboration] makes it so nobody has to overreach. That's one challenge we see. Some folks try to do something they're not [equipped in]...A lot of these clients are engaging with multiple systems and so we're duplicating efforts...We are a lot of folks already doing the work of two or three people."

A multidisciplinary approach by individuals, organizations, and local and national governments is essential to meet the complex needs of child commercial sexual exploitation and trafficking survivors (Jordan Greenbaum, 2014). Such an approach would be exemplified by creating teams of all people involved in the care of survivors to determine best care plans for each survivor. A multidisciplinary approach would increase the effectiveness of treatments for the complex needs of domestic minor sex trafficking survivors (Amy Goldberg & Jessica Moore, 2018). It would encourage the individuals that are involved in identifying and caring for trafficking survivors to come together to discuss care plans. Two interviewees discussed the importance of a multi-disciplinary approach:

"I think [multi-disciplinary teams] are really critical because survivors are touching so many different systems…We can make sure the client gets exactly what [they] need when we work together."

In summary, the organizations represented by the interviewed employees of anti-trafficking organizations in this study are accomplishing the goals of a TIC approach by building rapport with survivors, incorporating survivor voice, and collaborating with other people that are helping the survivors.

Because therapy modalities were the second most frequently mentioned area needing further research following general after care services, this study will focus on mental health services. I will conduct a meta-analysis of existing research on the best practices for meeting survivors' mental health needs in order to accomplish the following: (1) determine in what ways providers using TIC are using evidence-based practices despite their perception of a lack of evidence and (2) further develop providers' understanding of survivors' mental health experiences to improve TIC outcomes and identify areas for further research.

Meta-analysis of research on the mental health of trafficking survivors

Methodology

It is appropriate to conduct a meta-analysis of existing research to identify known best practices for mental health providers working with trafficking survivors and to

identify survivors' mental health needs. Findings about the best practices for serving the mental health-related needs of survivors will be used to identify ways in which providers using TIC are using evidence-based practices. Findings about survivors' mental health needs will be used to enhance TIC and to identify what remains to be researched in each area.

All searches were conducted through Google Scholar's Advanced Search option. The following search criteria was used: "trafficking" and either "mental health", "counseling", or "trauma" in the title of the article.

Included researchers published articles in an academic journal and used systematic data collection. Systematic data collection in this context is defined as gathering and measuring information on the mental health of trafficking survivors in a way that enables researchers to answer research questions. Systematically collected data decreases the amount of errors in the research, assuring the quality of data before collection and maintaining the quality of the data during and after collection ("Data collection", 2005). Systematically collected data in this study include structured and semi-structured interviews, questionnaires and surveys, uniform statistical analyses, and electronic health records. Articles were not excluded based on the demographics of participants in an effort to expand the search as wide as possible. Articles were excluded if the article's conclusion was not published, and the researcher or researchers did not return an email request for the article. Only articles with findings about best practices for meeting the mental health needs of survivors and articles with findings about the mental health experiences of survivors were included.

Each eligible study was coded for the following information: *(a)* what measures were used in the research, *(b)* the location of the research, *(c)* whether the article was published in a journal or as a dissertation, *(d)* the number of participants in the study, *(e)* the gender of the participants, *(f)* the age range of the participants, *(g)* the purpose of the research, and *(h)* the findings related to the mental health of trafficking survivors.

Results

Nine articles met the criteria for inclusion in this meta-analysis. The details of each article are listed in Table 2.

Characteristics of qualifying studies

References	Research methodology	Location	Journal or dissertation	# of Participants	Participant gender	Participant age range	Purpose	Findings
(Atsuro Tsutsumi, Takashi Izutsu, Amod Poudyal, Seika Kato, & Eiji Marui, 2008)	Questionnaires and statistical analysis	Nepal	Journal	164	Female	11-44	Explore mental health status of survivors supported by NGOs	-Anxiety -Depression
(Nicolae Ostrovschi et al., 2011)	Longitudinal study, structured interview	Moldova	Journal	120	Female	>18	Identify mental distress of survivors	-Confidentiality -Sensitivity -Empowerment -Anxiety -Substance abuse
(Jill Domoney, Louise Howard, Melanie Abas, Matthew Broadbent, & Sian Oram, 2015)	Qualitative study of electronic health records, content analysis, thematic analysis	South East London, England	Journal	130	Male and female	Unspecified (both <18 and >18)	Understand trafficking identification in mental health services and challenges in meeting needs	-Collaborating to share information about trafficking status
(Rohan Borschman	Logistic regression	South London	Journal	84	Male and	18-45	Understand correlates of	-Self-harm

n et al., 2017)	models comparing clinical records of trafficked and non-trafficked patients	n, England			female		self-harm among trafficking victims (correlates and mental health service responses)	
(Louise Howard et al., 2013)	Compare case records and diagnoses of trafficked to non-trafficked, both with psychiatric care	South London, England	Journal	135	Female	Unspecified (adults)	Co-morbidity of disorders in trafficked versus non-trafficked, and outcomes of care for trafficked versus non-trafficked	-Importance of staff training and support
(Bita Ghafoori & Rachel Taylor, 2017)	Questionnaires, voluntary reporting of mental health services usage	Unspecified	Journal	27	Unspecified	Unspecified (adults and transition-aged youth)	Compare trauma, mental health, and service use in youth and adult survivors	-Depression -Anxiety
(Tiffany Richards, 2016)	Semi-structured interviews, data analysis	Southeast Texas	Dissertation	13	Female	15-38	Describe impact of trafficking on mental and physical health and determine how they encountered health care providers and their experience in the health care system	-Communication
(Kristin Heffernan & Betty Blythe, 2014)	Participant observation, content analysis of case folders, preliminary client feedback	New York	Journal	12 case files, 7 interviewees	Males and females	Unspecified	Evaluate program adherence to TIC, process success of case management services	-Empowerment

(Anita Ravi et al., 2017b)	Interviews	New York City, NY	Journal	21	Females	>18	Examine trauma experiences and elicit advice about health care delivery	-Shame and fear inhibiting disclosure, necessitating collaboration -Substance abuse
Total				**n= >713**	**Males and females**	**Children and adults**		

(<u>Table 2</u>: Each qualifying study was coded for the factors in the table.)

The findings from the nine articles can be separated into two categories: findings about the best practices for serving the mental health-related needs of survivors and findings about the specific mental health needs of survivors. The articles include data from at least 713 survivors, including males, females, children, and adults.

Findings about the best practices for serving the mental health-related needs of survivors each relate to the three ways the interviewees are using TIC with survivors: building rapport with survivors, incorporating survivor voice in care decisions, and collaborating with one another. I will describe how each of these findings serves as an evidence-base for the ways in which mental health providers are interacting with survivors.

Findings about survivors' mental health may be used to further inform the practices of mental health providers. Since the foundation of TIC is to understand survivors' experiences, research on these findings should enhance the knowledge of providers and improve TIC outcomes (Menschner & Maul, 2016). Additional research in these areas would further expand providers' understanding of survivors' experiences. I will describe what is known about each of these findings from the nine-article meta-analysis to inform

providers about survivors' mental health and assess what remains to be researched in each area.

Best practices for serving survivors' mental health-related needs

Best practices for serving survivors' mental health-related needs, identified through the nine-article meta-analysis, include confidentiality, sensitivity, communication, empowering survivors, and sharing information on survivors' status. Rapport is built through confidentiality, sensitivity, and communication. Incorporating survivor voice empowers survivors. Collaboration involves sharing information on survivors' status. Research on each of these findings shows how mental health providers are using evidence-based practices when addressing mental health issues through building rapport, incorporating survivor voice, and collaborating with one another.

1. *Building rapport with survivors is evidence-based in mental health settings*

Because confidentiality, sensitivity, and communication are evidence-based practices for addressing the mental health needs of trafficking survivors, building rapport with survivors being served for mental health needs is evidence-based in those areas. The evidence-base for each practice and how the practice builds rapport are explained below.

Confidentiality, refraining from sharing a survivor's information, is essential to a survivor's recovery because the survivor has to re-learn that they are autonomous and in control of their body and their story (US Office for Victims of Crime Human Trafficking Task Force, n.d.). Confidentiality assures that the decision about how and when to disclose the details about a survivor's experience remains their own. Ostrovschi et al. said all

approaches to addressing the mental health needs of survivors should employ

confidentiality, based in a longitudinal study of the mental health diagnoses of female adult

survivors of trafficking (n=120) (Nicolae Ostrovschi et al., 2011). By increasing the

likelihood of the survivor feeling comfortable enough to disclose their experience to

professionals who can help them, this protection builds rapport with survivors (US Office

for Victims of Crime Human Trafficking Task Force, n.d.).

Sensitivity, being aware of the attitudes, feelings, and experiences of others, is

described in Menschner & Maul's definition of TIC as understanding the experiences of

patients (2016). Sensitivity is essential for building trust with survivors and achieving the

outcomes of TIC. Sensitivity is a best practice for helping with the mental health issues of

survivors (Nicolae Ostrovschi et al., 2011). One example of acting sensitively towards

survivors is being aware of the possible effects of placing labels on the patient's diagnoses

and experiences due to the stigma associated with mental health diagnoses combined with

the stigma experienced as a trafficking survivor (Nicolae Ostrovschi et al., 2011). Providers

develop rapport with survivors in mental health settings by acting sensitively towards

them.

Good communication allows for clear expectations to be conveyed between the

provider and the survivor such that the survivor can see the fulfillment of what was

promised to them. This helps the provider develop rapport with the survivor by

establishing trust. Based on interviews with 13 survivors recruited from a social service

agency providing assistance to trafficking survivors, the interviewer recommended

enhancing communication between mental health providers and survivors by educating

providers about survivors' experiences (Tiffany Richards, 2016). Menschner & Maul said

the basis of TIC is to understand survivors' experiences (2016). Therefore, mental health

providers with an understanding of survivors' experiences are enhancing communication

and adhering to TIC by building rapport.

Organizations practicing confidentiality, sensitivity, and communication when

addressing trafficking survivors' mental health needs are using evidence-based practices.

2. *Incorporating survivor voice in mental health treatment discussions is evidence-based*

Because empowering survivors is an evidence-based practice and ensuring

survivor's opinions are heard and respected is part of empowering survivors, mental health

providers that listen to and respect survivors' opinions are using an evidence-based

practice.

Ostrovschi et al. recommends that mental health providers empower survivors

based on his longitudinal study of trafficked women (Nicolae Ostrovschi et al., 2011).

Empowerment means helping the survivor believe that they are competent and can exert

control by influencing outcomes (Marc Zimmerman, 2012). Empowerment happens by

helping survivors develop skills to become independent or live confidently on their own in

an area of their choosing (Kristin Heffernan & Betty Blythe, 2014; Marc Zimmerman, 2012).

In an evaluation of a trauma-informed mental health organization that worked with

trafficking survivors, empowerment through TIC resulted in the survivors experiencing

increased autonomy (n = 19) (Kristin Heffernan & Betty Blythe, 2014).

Mental health providers who are listening to and respecting survivors' opinions are

empowering survivors. Because empowerment theory is evidence-based for working with

survivors, inviting survivors to participate in discussions regarding their mental health

care is a part of TIC that is evidence-based for the mental health treatment of trafficking

survivors.

3. *Collaborating with all providers working with survivors in mental health settings is evidence-based*

Survivors are hesitant to disclose their trafficking experience (Anita Ravi et al.,

2017b; Tiffany Richards, 2016). TIC can address concerns in a patient-centered way

without necessitating disclosure (Anita Ravi et al., 2017b). Because of a survivor's

hesitancy to disclose their experience, providers have to, at times, rely on each other for

information about a patient's status as a trafficking survivor, which is part of collaboration

(Jill Domoney et al., 2015). Because sharing essential information between necessary

mental health providers working with survivors is an evidence-based practice and is

collaborative, organizations collaborating as such as part of TIC are using an evidence-

based practice.

Domoney et al. identified the importance of ensuring that all providers are aware of

a survivor's status in their study of the electronic health records of trafficked people in

South London, England (2015). In this study, 43 percent of adult records (n = 95) and 63

percent of children's records (n = 35) recorded that mental health professionals were

informed that their patient was a potential trafficking victim by another provider involved

in the patient's care (Jill Domoney et al., 2015).

Because survivors may be hesitant to disclose their trafficking history and

understanding a patient's history is the foundation of TIC, sharing information between

mental health providers about the trafficking status of survivors is important (Jill Domoney

et al., 2015; Menschner & Maul, 2016). Organizations sharing the status of survivors with essential personnel are using an evidence-based practice.

The above research shows how mental health providers building rapport through confidentiality, sensitivity, and communication; empowering survivors through listening to and respecting survivors' opinions; and collaborating by sharing essential information on the status of trafficking survivors are not flying blind. Instead, they are adhering to evidence-based practices.

Survivors' mental health-related needs

To improve the TIC outcomes of patient engagement, treatment adherence, health outcomes, and staff and provider wellness, mental health providers may work to better understand mental health risks specific to trafficking survivors (Menschner & Maul, 2016). Findings about the specific mental health risks of trafficking survivors were identified through existing research in the areas of anxiety, depression, self-harm, and substance abuse. To inform mental health providers about the mental health risks specific to trafficking survivors and to set the basis for remaining research in each area, I will describe what literature says about each finding.

1. *Anxiety*

Women trafficked for sexually exploitative purposes have higher rates of anxiety than women trafficked for other purposes (Atsuro Tsutsumi et al., 2008). Tsutsumi et al. administered the Hopkins Symptoms Checklist-25 to assess anxiety levels among female

trafficking survivors supported by non-governmental organizations in Katmandu, Nepal (2008). The survivors who were sexually exploited showed more anxiety symptoms (97.7 percent, n = 44) than survivors engaged in non-sex work (87.5 percent, n = 120) (Atsuro Tsutsumi et al., 2008). However, this difference is statistically insignificant.

In a study comparing the mental health needs and service use in youth and older adult sex trafficking survivors, Ghafoori and Taylor found that mental health service use was positively correlated with anxiety symptom severity (Bita Ghafoori & Rachel Taylor, 2017). Participants completed mental health diagnostic questionnaires and provided the researchers with information regarding their mental health service use (n = 27). Providers working with sex trafficking survivors should be aware that the survivors they work with are likely to have symptoms correlating in severity and their investment in services.

Ostrovschi et al. found that 18 percent of female survivors aged 18 or over who returned to Moldova between December 2007 and December 2008 and were registered as a trafficking survivor were diagnosed with an anxiety disorder upon returning to the country (n = 120) (Nicolae Ostrovschi et al., 2011). Eighty-five percent of women diagnosed with anxiety, PTSD, or a mood disorder sustained their diagnoses for two to twelve months after their return (Nicolae Ostrovschi et al., 2011). Based on this finding, Ostrovschi et al. recommended mental health providers offer treatment to female survivors found to have anxiety immediately after escaping their trafficking situation for at least one year (Nicolae Ostrovschi et al., 2011).

Providers can improve the outcomes of TIC by keeping in mind the research findings that women trafficked for sexual exploitation may have slightly higher rates of anxiety than women trafficked for other purposes, level of service use may correlate with

the severity of anxiety, and anxiety symptoms may endure beyond escaping the trafficking

situation (Atsuro Tsutsumi et al., 2008; Bita Ghafoori & Rachel Taylor, 2017; Nicolae

Ostrovschi et al., 2011). Providers should be aware that Ostrovschi et al. and Tsutsumi et

al.'s research is with female trafficking survivors in international locations (2011; 2008).

Providers should also be aware that Ghafoori and Taylor's research is specific to sex

trafficking survivors (2017). More research should be completed to determine if these

findings are consistent for survivors of other genders, other countries, and other types of

trafficking.

2. Depression

Women trafficked for sexually exploitative purposes exhibited higher rates of

depression (100 percent, n = 44) than women trafficked for other purposes (80.8 percent,

n = 120) in Tsutsumi et al.'s study of female trafficking survivors supported by non-

governmental organizations in Katmandu, Nepal (2008). Tsustumi et al. said this was a

statistically significant difference (2008).

In Ghafoori and Taylor's research comparing the mental health needs and service

use of youth and adult trafficking survivors, service use positively correlated with

depression symptom severity (n = 27) (Bita Ghafoori & Rachel Taylor, 2017). Providers

working with sex trafficking survivors should be aware that the survivors they work with

are likely to have depression symptoms correlating in severity with the survivors'

investment in services.

Providers can improve the outcomes of TIC by keeping in mind the research

findings that women trafficked for sexual exploitation may have higher rates of depression

than women trafficked for other purposes and that survivors' level of service use may correlate with depression symptom severity (Atsuro Tsutsumi et al., 2008; Bita Ghafoori & Rachel Taylor, 2017). Providers should be aware Tsutsumi et al.'s research is limited to Nepal and female sex trafficking survivors (2008). Providers should also be aware that Ghafoori and Taylor's research is limited to sex trafficking survivors (2017). More research should be completed to determine if these findings are consistent for survivors of other genders, other countries, and other types of trafficking.

3. Self-harm

In a study comparing the clinical records of trafficked and non-trafficked patients in South London, England, self-harm was prevalent among trafficking survivors accessing mental health services (Rohan Borschmann et al., 2017). Thirty-three percent of trafficking survivors engaged in self-harm prior to receiving treatment and 25 percent engaged in self-harm during care (n = 84) (Rohan Borschmann et al., 2017). Neither of these rates is significantly different from those of non-trafficked individuals. Thirty-four percent of non-trafficked individuals engaged in self-harm prior to receiving treatment and 32 percent engaged in self-harm during treatment (n = 287) (Rohan Borschmann et al., 2017). However, the rate at which trafficking survivors were admitted to inpatient treatment after self-harm (57 percent) was higher than the rate at which non-trafficked people were admitted to inpatient treatment after self-harm (21 percent) (Rohan Borschmann et al., 2017).

Providers can improve the outcomes of TIC by keeping in mind the research findings that trafficking survivors do not present significantly more frequently with self-

harm than non-trafficked individuals in mental health settings and that trafficking survivors may be admitted to inpatient treatment for self-harm more frequently than non-trafficked individuals (Rohan Borschmann et al., 2017). Providers should be aware that Borschmann et al.'s research is limited to South London, England (2017). More research should be completed to determine if these findings are consistent for survivors in other locations.

4. *Substance abuse*

Substance use disorders may persist between the time of escape from a trafficking situation and at least two to twelve months after the escape, according to data recorded in Ostrovschi et al.'s longitudinal study of female Moldavian women returning to Moldova after being trafficked (n = 120) (2011). Eighteen percent of these women presented with substance use disorders in both their first and second diagnoses (Nicolae Ostrovschi et al., 2011).

Interviews with 21 imprisoned female sex trafficking survivors at Rikers Island Jail in New York City revealed a pattern of women primarily coping with their trauma through substance abuse (Anita Ravi et al., 2017b). All participants used illegal substances while trafficked (Anita Ravi et al., 2017b). Some of the interviewees said they prioritized substance use over seeking care, suggesting substance dependence (Anita Ravi et al., 2017b).

Providers can improve the outcomes of TIC by keeping in mind the research findings that substance abuse disorders may persist long after escaping a trafficking situation and that survivors frequently depend on substances to cope with their trauma

(Anita Ravi et al., 2017b; Nicolae Ostrovschi et al., 2011). Providers should be aware that

Ravi et al.'s research is limited to New York City and female adult sex trafficking survivors

(2017). Providers should also be aware that Ostrovschi et al.'s research is limited to

Moldova and female survivors (2011). More research should be completed to determine if

these findings are consistent for survivors of other genders, other countries, and other

types of trafficking.

The above research about survivors' mental health experiences in the areas of

anxiety, depression, self-harm, and substance use may expand mental health providers'

understanding of survivors' experiences, increasing patient engagement, treatment

adherence, health outcomes, and staff and provider wellness. Additionally, the review

shows what research has been done and what research remains to be done in each area.

Future research will continue to increase mental health providers' knowledge of survivors'

mental health experiences and improve TIC outcomes.

Discussion

Nine years after the United States Department of Health and Human Services

attempted to start filling what they perceived as a gap in evidence-based services,

interviews with 18 anti-trafficking organization employees suggest there remains a dearth

of evidence-based research (Heather Clawson et al., 2009). Thematic patterns in the

interviews show how the interviewees or their colleagues are applying TIC while working

with survivors. The interviewees accomplish the four goals of TIC—patient engagement,

treatment adherence, health outcomes, and provider and staff wellness—by building

rapport with survivors, listening to and respecting survivors' opinions, and collaborating

with one another, each of which helps providers more deeply understand survivors'

experiences (Menschner & Maul, 2016).

This study's meta-analysis of existing research about best practices for caring for

the mental health needs of survivors reveals that though there is more research to be done,

mental health providers working under the TIC framework are not flying blind. Instead,

providers who build rapport through confidentiality, sensitivity, and communication;

empower survivors through listening to and respecting their opinions; and collaborate by

sharing information on the status of survivors are adhering to evidence-based research.

This study's meta-analysis of existing research on the mental health-related needs of

survivors gives mental health providers additional information to more accurately shape

their understanding of survivors' experiences to improve the outcomes of TIC (Menschner

& Maul, 2016). Researchers may expand the evidence-base of these needs by doing

additional research on anxiety, depression, self-harm, and substance abuse patterns for

survivors of all genders, domestic and international survivors, and survivors of all types of

trafficking.

Conclusion

Providers would benefit from having additional research about anxiety, depression,

substance abuse, and self-harm patterns in survivors. The anti-trafficking organization

employees interviewed in this study mentioned three barriers to developing evidence-

based practices for caring for trafficking survivors. First, interviewees in this study

mentioned the difficulty of maintaining contact with survivors, which increases the

difficulty of conducting longitudinal studies. Second, interviewees mentioned it would be unethical to treat a survivor in a potentially beneficial way and deny another survivor the same treatment, which increases the difficulty of having control and experimental groups. Third, interviewees mentioned that oftentimes any research completed using the survivors in their care as subjects is conducted by an internal employee of the organization who is not hired as a researcher, but rather as a case manager or counselor. This diminishes the quality of the research because the researcher is at risk for being biased towards the organization they work with and because the researcher often is trained in what they are employed to do rather than research. Researchers have to overcome the research barriers of longitudinal studies and the ethics of providing a potentially beneficial service to one group and not another. Of the research in this study's meta-analysis, there was one longitudinal study completed in Moldova (Nicolae Ostrovschi et al., 2011). No longitudinal study was completed domestically. No study was found that used control and experimental groups. More research should be done to determine how to overcome these barriers. One suggestion for overcoming the barrier of having an internal evaluator would be for the government to increase funding to direct care organizations for the purpose of hiring an external evaluator for their services.

Seven interviewees noted a lack of research about after care services for trafficking survivors, which includes more services than mental health services. Examples include housing, financial assistance, and job training. Future researchers should conduct more meta-analyses into each after-care service to identify how TIC can be applied in each area, what research has been done in each area, and what research needs to be completed in each area.

Future research should be conducted to determine whether or not the TIC framework used by the organizations represented in this study is used by more domestic organizations and international organizations. This study was limited by having incomplete access to some research. Given more time, I would have continued reaching out to the authors of articles that were not public in order to identify more mental health needs of survivors.

In conclusion, mental health providers who build rapport, incorporate survivor voice into care discussions, and collaborate with one another are accomplishing the goals of TIC: increased patient engagement, treatment adherence, health outcomes, and staff and provider wellness. They should continue doing these things. Despite their perception that there is little evidence-based research, which seems to be accurate, they are not flying blind. They are using evidence-based practices to meet the outcomes of TIC.

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Appendix A

Sample interview questions

1. Why does your program provide the services you do to trafficking survivors?

2. What are some of the biggest obstacles you face, if any, in delivering care to trafficking survivors?

3. Do you perceive that there is a gap in services for trafficking survivors? If so, what are they?

4. What do you think are the biggest research needs for trafficking survivors?