



Identifying Gaps in Human Trafficking Mental Health Service Provision

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IDENTIFYING GAPS IN HUMAN TRAFFICKING MENTAL HEALTH SERVICE PROVISION

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Abstract

Human trafficking is a global concern resulting in complex, long lasting mental health consequences for survivors. The United States non-governmental sector has emerged as a key service provider in facilitating and directly providing comprehensive services for survivors, including crucial mental health services. This study aimed to better understand barriers to and potential improvements for human trafficking survivor mental health service delivery by applying a deductive framework analysis to semi-structured interviews with 15 United States based non-governmental organizations. Analysis of interview data underscored key challenges, including extensive and complex human trafficking survivor mental health needs, limited service provider capacity, and a fragmented multisector response. Themes for strategies to improve mental health service delivery included improved multisector collaboration, as well as increasing mental health professional capacity through human trafficking specific training. Implications and recommendations to improve comprehensive, trauma-informed, and client-centered human trafficking survivor care, including future research directions, are discussed.

Keywords: human trafficking, mental health, trauma-informed care, health services, health

Human Trafficking in the United States

Human trafficking is a human rights violation in which exploitation occurs through force, fraud, or coercion, and often entails physical and psychological abuse of its victims (United States Department of State [USDS], 2016). Trafficking may take the form of forced labor, sexual exploitation, or a combination of both. Globally, human trafficking is described as a lucrative, \$150 billion criminal industry (USDS, 2016). Estimates of its prevalence are difficult to

determine given the hidden nature, as well as the use of diverse methodologies for data collection (Logan, Walker, & Hunt, 2009; Macy & Johns, 2011; Tyldum, 2010). With this caveat on estimates in mind, the United States (US) Polaris National Human Trafficking Hotline reported 7,572 cases of potential human trafficking in 2016 (National Human Trafficking Resource Center [NHTRC], 2016).

Mental Health Consequences of Human Trafficking

The mental health effects of human trafficking are substantial and long-term (International Organization of Migration [IOM], 2007; Palmer, 2010; Yakushko, 2009). Survivors' extreme trauma experiences and subsequent psychological and emotional effects are compounded by stigma and feelings of shame (Baldwin, Fehrenbacher, & Eisenman, 2014; Briere & Spinazzola, 2005; Zimmerman et al., 2008). Depression, anxiety, and post-traumatic stress disorder (PTSD) are commonly cited mental health consequences (Abas, et al., 2013; Kiss, et al., 2015; Oram, Khondoker, Abas, Broadbent, & Howard, 2015; Oram, Stoöckl, Busza, Howard, & Zimmerman, 2012; Turner-Moss, Zimmerman, Howard, & Oram, 2014; Zimmerman et al., 2006). In one study of over 100 trafficked women, 41.5% reported attempted suicide (Lederer & Wetzel, 2014).

Consequently, mental health service provision is an essential component of comprehensive services for survivors (Clawson & Dutch, 2008; Gibbs et al., 2015; Macy & Johns, 2011; Muraya & Fry, 2016). Not surprisingly, therefore, mental health services are in high demand from both US and foreign-born trafficking survivors (Dewan, 2014; Gibbs et al., 2015; Potocky, 2010).

Human Trafficking Service Delivery in the United States, a Conceptual Framework

Figure 1 outlines a conceptual framework of the barriers to human trafficking general service delivery. Recent evaluation research studies, which capture both client and provider perspectives, found that effective delivery of comprehensive human trafficking survivor care must overcome numerous barriers resulting from an asymmetry between client needs and provider capacity in a multisystem framework (Davy, 2015; Potocky, 2010).

In general, service delivery designed for survivors begins with the presence of available and appropriate services (Aron, Zweig, & Newmark, 2006; Clawson & Dutch, 2008; Gibbs et al., 2015; Reid, 2010). However, a lack of human trafficking-specific services (health, mental health, legal, housing) continues to be a barrier, resulting in a fragmented patchwork of care (Aron et al., 2006; Clawson & Dutch, 2008; Macy & Johns, 2011; Muraya, & Fry, 2016; Reid, 2010).

Access to services is determined by cost, citizenship status, and proximity of service provision (Aron et al., 2006; Clawson & Dutch, 2008; Clawson, Salomon, & Goldblatt Grace, 2008). Human trafficking survivors who are non-US citizens and unable to access legal services for certification find that access to other services remains either nonexistent or limited (Aron et al., 2006; Dewan, 2014; Potocky, 2010). Furthermore, where available, services are thinly spread over vast areas resulting in clients being forced to travel long distances, sometimes via lengthy public transportation (Aron et al., 2006).

Successful delivery and utilization of services depends on systems, survivor, and service provider features. In terms of systems issues, Clawson and Dutch (2008) found that survivors

lacking a case manager or point of contact did not receive a full array of services due to miscommunication and poor interagency coordination (see also Aron et al, 2006). Policies which intend to protect minors can actually complicate service delivery or even discourage minors from pursuing assistance for fear of being reported to child protective services (Gibbs et al., 2015).

Moreover, services which are not sensitive to victim characteristics, including culture, gender-identity, trauma, or language limit or preclude the use and benefits of offered services (Aron et al., 2006; Clawson & Dutch, 2008). For clients with unstable housing situations, long term service delivery may be hampered if only short-term housing options are available (Aron et al., 2006; Clawson & Dutch, 2008; Gibbs et al., 2015). Feelings of shame and stigma due to the trafficking experience may also prevent clients from accessing services (Clawson et al., 2008).

Purpose of Study

While the body of evidence around general human trafficking survivor service delivery is growing, and despite demand and need for mental health services, there remains a significant dearth of evaluation research specific to mental health service delivery. Furthermore, few studies have attempted to understand mental health service provision, particularly the challenges faced by NGOs in delivery of such services and their ideas for service delivery improvement (Goldenberg, 2015).

Methodology and Data Analysis

This study employed a qualitative approach to examine the barriers to and potential improvements for human trafficking survivor mental health service delivery (Yin, 2014). Semi-structured interviews, based on the conceptual framework above, were conducted with 15

representatives of US-based NGOs. Interviews explored barriers to and suggested improvements for human trafficking mental health care delivery.

Data Collection

NGO Selection. In order to limit selection bias, 25 randomly selected states, and then NGOs in those states, were invited to participate. Fifteen NGOs consented to an interview. NGOs were identified through a combination of Google searches and inquiries to the NHTRC and screened by the following inclusion and exclusion criteria:

- 1) The NGO must be working within the US state which was randomly selected
- 2) The NGO must be currently providing mental health services to survivors of human trafficking
 - a. “Providing mental health services” in the context of this study means providing direct provision or facilitating access to mental health services
- 3) The NGO cannot have already been selected to participate in this research project. This exclusion criterion was pertinent for those NGOs operating in multiple US states.

Each NGO was first contacted by email with basic information about the nature of the study, with the majority of the sample contacted in April 2015. NGOs received follow-up phone calls in order to encourage participation. Each NGO designated its respondent to represent the organization’s perspective on mental health service delivery. All respondents were reminded at the time of the interview that participation was voluntary and that they could withdraw at any time. Interviews with these 15 respondents led to saturation, meaning that no new concepts were being introduced, so no further NGO recruitment was undertaken.

Interview Procedure. Semi-structured, individual, phone interviews were conducted with representatives of 15 US-based NGOs either directly providing or facilitating mental health services for survivors. An interview protocol was constructed based on the literature-informed conceptual framework (see Figure 1).

Respondents were first asked to describe the characteristics of populations served, including insurance and citizenship status. Next, features of mental health service delivery were queried, such as the location of service delivery, type of professionals providing care and their qualifications, and the average length of service provision. Finally, the interviewers inquired about challenges in mental health service delivery and strategies to address these challenges. For each interview, the interviewer transcribed interviewee responses and later transferred them into a centralized repository of data for analysis. Interviews were not audio recorded. Any possibly personally identifying information was removed prior to analysis.

Data Analysis

Based on the RATS qualitative research guidelines (Relevance of study question, Appropriateness of qualitative methods, Transparency of procedures, Soundness of interpretive approach), a deductive framework qualitative analysis was used to interpret the research findings (Clark, 2003; Smith & Firth, 2011). After the research assistants familiarized themselves with the interview content, codes were derived. These codes were based on themes from the conceptual framework (reflected in the interview protocol), as well as developed *in-vivo* for new concepts that emerged from the data (Creswell, 2013; Gilgun, 2014). These codes were used to index each case. Then three authors (CP, EL, MA) conducted a cross-case comparative analysis, collectively

comparing and contrasting cases in order to identify themes and patterns. These typologies were organized to construct two thematic frameworks for 1) barriers to and 2) potential improvements for survivor mental health service delivery (Figures 2,3).

Findings

The sample was comprised of 15 NGOs in 15 US states and captured a broad swath of experience and geography (Tables 1, 2, 3). More than half the NGOs served survivors of both labor and sex trafficking. Three NGOs exclusively served minors. Eight only served women; no NGOs exclusively served men or survivors of labor trafficking. The range of time in operation providing mental health services ranged from six months to 25 years, with an average of 8.1 years.

With one exception, each NGO was represented by one respondent. The majority of the respondents held administrative/director positions within the NGO; three of these respondents specifically indicated having a clinical background (Table 3).

Barriers to Mental Health Service Delivery

Themes related to barriers to mental health service delivery included systemic, survivor, and service provider features. NGO respondent illustrative quotes are shared below in italics.

Systemic Features. Respondents reflected chiefly on how survivors accessing mental health services had to navigate a complex, multisystem labyrinth, however attention was also directed towards the NGO's relationship to donors and government entities.

NGOs characterized mental health care system as often as short-term, involving multiple providers, premature mental health diagnoses, and multiple medication prescriptions. One NGO explains the deleterious effects of chaotic, uncoordinated mental health care:

Numerous diagnoses...many ER visits, minute clinic visits, or [being] quickly labeled after a 15-minute mental health session with psychologist or psychiatrist [leaving a survivor] with a chemistry soup of prescriptions.

This disjointed mental health care was in part attributed to the highly mobile, itinerant nature of survivors, which in turn was understood to be a result of numerous factors, such as substance use disorders, difficulty separating from life on the streets, and mental health concerns.

Transitions and frequent visits among numerous providers were often challenged by cost, transportation, and employment limits. One NGO describes the logistical difficulties that may arise:

[Mental health service provision] is compounded by the difficulty of securing appointments in a large city with bad public transport and our clients' inflexible work schedules.

Some NGOs mentioned the need to address reintegration issues, such as assisting survivors to secure and maintain employment and affordable, long-term housing, as a means to providing stability and thereby improving the likelihood of receiving consistent mental health services. One NGO had even placed an offer on nearby real estate to serve as a semi-independent home for clients transitioning to the next stage of self-care.

NGOs also described delays in being able to provide services due to slow legal processes involved in verification of clients as victims of human trafficking. This finding was consistent

across NGOs working with foreign nationals. Here one NGO describes the delays on the order of years:

We serve many foreign nationals who are trying to get a T-visa which can take 4 years.

Furthermore, even those clients who possessed US citizenship or a T-visa and were eligible for various types of mental health services, were entangled by federal and state policies that often dictated the resources that survivors could and could not use.

Finally, minors in particular were recognized as being thrust into a vortex of systems, each guided by different principles and therefore seeking certain goals. For example, some minors were described as being “owned” simultaneously by the legal, criminal justice, and child protection systems. Two respondents independently commented that minors face challenges in the legal and criminal justice systems in being classified as victims of human trafficking, while one respondent continued that during this process minors are facing the inherent challenges of the foster care system. In summary, respondents expressed the need for collaboration and coordination among NGOs, health care professionals, and mental health providers.

Regarding NGOs and their ability to facilitate services, there was recognition that services, facilities, and staffing support are highly dependent on external funding. Without substantive resources, program activities may be hampered or not undertaken at all. For example,

A continuous two year program for them would be ideal but is not realistic, given our staffing and local resources.

Some NGOs receive limited financial support from civic and or faith-based organizations, as well as through state and county bodies. In some circumstances pro bono work is offered, for

example, legal assistance. Although specifics of funding for programs was only superficially discussed during the interviews, one NGO's remarks highlight the strategizing necessary to navigate ever-changing funding landscapes:

We need a voice and a seat at the table with the grant-makers. When the State Secretary of Health and Human Services was one of our co-founders, we had personal support and effective linkages with other national organizations and donors.

Service Provider Features. The respondents overall expressed frustration about the lack of absolute numbers of mental health counselors as well as lack of qualified mental health professionals. Even beyond serving in a directly therapeutic role, NGOs saw mental health providers as an essential component for holistic care necessary for all of their clients because they are uniquely positioned to assess client mental well-being, recognize the interaction of maladaptive coping mechanisms, and provide overall support to survivors. In addition, several respondents shared the need for professionals able to provide more specialized, intensive mental health services congruent with the trauma pathology unique to human trafficking survivors. For example:

There are too many clinicians and therapists just using the same outdated approach; we need staff who are specifically trained in evidence-based, trauma-informed care. In some instances, institutions many not even have staff trained in the basics of such care nor experience in its application. In those cases, we need resources to bring in outside trainers to train these staff before we can effectively move forward.

We have counselors who can come on site, but we need someone with special skills [and without these special-trained MH professionals this NGO often refers "out" for mental health services].

We need more trauma-focused clinicians who are competent in foreign languages...as we see more trafficking for the purposes of labor exploitation and serve more clients who are Spanish-speaking.

Furthermore, a need for advocacy for research to validate therapeutic interventions tailored for the trafficked population and training for mental health professionals were noted by respondents.

Survivor Features. Physical ailments periodically impeded survivors from attending mental health counseling. Dental care needs, hepatitis, hypertension, sexually transmitted infections, and diabetes were frequently mentioned. NGOs recognized that as survivors entered mental health and substance use disorder treatment, unanticipated medical needs sometimes emerged and preempted the existing mental health plan.

When she quits the drug or alcohol, [which] was masking her issues...now she can feel physical discomfort due to for example diabetes, dental pain [from crack], Hepatitis C, high blood pressure...

All NGOs experienced that the severity of the mental health sequelae of trafficking, including post-traumatic stress disorders, dissociative states, and avoidance behaviors added complexity to service provision. For example:

[The] very nature of their trauma [makes it] very hard to focus on what they [survivors] need to focus on.

[Survivors] face so many barriers in finding healing...this adrenaline-filled lifestyle and [seeking] the attention of men [which is reflected] in a trauma-bond...

These barriers were especially profound shortly after leaving a trafficking situation. One NGO respondent expressed frustration in a “paranoia from pimps” based on her observations of new

survivors who express conflict, wanting to separate from the street and a reluctance to completely leave their traffickers because of fear.

Survivors were described as turning to sporadic and single visit care, such as emergency departments or urgent care, to meet their health care and mental health needs. Moreover, survivors' trauma history, coping mechanisms, emotional, physical, and other characteristics were not typically considered in the initial assessment and management by external providers. Survivors' sporadic participation in mental health service programs limited sustainable progress. Commonly cited was the cyclic process of survivor acceptance into a mental health services program, unexplained disappearance, and random return to the program some time later. In line with this, one respondent indicated having a 70% attrition rate within the first 90 days.

Other respondents spoke of trafficking's role in delaying in survivor development, resulting in difficulty engaging those survivors in mental health care:

Developmentally, all our survivors are like teenagers, who cannot reason out their situation, cannot see the long-term consequences, and cannot self-regulate. They are under the power of addictive relationships, have no self-esteem, and no modeling of good relationships.

Substance use was also noted as hindering receipt of mental health services. Eleven respondents noted the need for provision of on-site or coordination of off-site services to address substance and alcohol use disorders. In particular, working with survivors to understand the relationship between trafficking-related trauma and substance use disorders was pivotal, but challenging:

[We] are trying to educate them [survivors] that pain pills are not the answer... and if they have anxiety and go to the doctor...they can get addicted to Xanax.

They [survivors] try to find a job in the community and they work in an environment that is not recovery based and are around people using and get suck into that...sometimes feel they [survivors] are not properly equipped and they don't know how to ask for help which can lead to self-sabotage.

As discussed, citizenship status affected some survivors' ability to utilize mental health services (see systemic barriers). More than half the respondents indicated that survivors either lack insurance or have Medicaid.

Lastly, other considerations included a lack of gender sensitive, language and culture specific services for clients. One respondent, representing an urban NGO serving foreign nationals expressed how survivors' cultural perception of mental health care could be a barrier:

...[Yet, even with access to services], they [foreign nationals] struggle to understand mental health, for example, they don't understand the need.

In an effort to better work with non-native English speakers, nine NGOs reported either working directly with interpreters or employing staff with foreign language capabilities.

Improvements and Future Modifications

Themes related to improvements/modifications to mental health service delivery for trafficking survivors fell into two main categories: (1) increasing general and mental health provider capacity to care for trafficking survivors through training and hiring (2) facilitating system changes, including promoting and engaging in multisector collaboration activities (Figure 3).

Provider Capacity- General NGO staff: Respondents expressed that further developing all NGO staff was welcomed and a priority. Ideas proposed for training ranged from specific,

trauma therapy orientations to training activities with other external stakeholders and systems

more familiar with trafficking survivors. For example:

[In addition to] providing more training concerning a specific type of therapy, we would like to provide education for other staff who don't have mental health knowledge.

{Given the illicit drug use and substance abuse by our clients}, we depend on licensed clinical social workers with certification in addiction training. We don't advertise that we have these services, but these services are frequently needed on the front end before we can deal with the mental health issues of our clients.

We are trying to get them [NGO staff] to understand the needs of trafficking clients – we try to do a lot of training with them.

Provider Capacity- mental health staff: Respondents most consistently commented on the overall shortage of mental health professionals in the workforce trained to address the unique mental health needs of trafficking survivors. Thirteen respondents indicated a need to hire more full time professionals qualified to work with survivors of human trafficking. For example:

We are trying to get mental health professionals who understand the needs of trafficked victims.

It took us a long time to find a specific, well-trained, informed person [mental health professional].

We need more access to therapists with training and experience with trauma focused therap[ies].

The shortage of trained mental health professionals was more pronounced in terms of working with foreign nationals:

99% of our clients are immigrants and so we are seeking trained mental health professionals, but also those who are trained in language...or we need to increase the number of interpreters, but it is still difficult to work with an interpreter.

In addition to professionals with foreign language abilities, one respondent had a goal of a more diverse team with a specific interest in more trained and qualified African American mental health professionals and staff. Some of the service providers saw integration of faith as important in the culturally-sensitive approaches used with survivors:

They are not simply “poor wounded birds”; they need crutches and leg braces, so to speak, to be able to walk by themselves; a grounding in faith provides that foundation.

Managing the System. Respondents shared extensively about ways in which service delivery could be improved; they called for streamlining of services and care coordination which would facilitate access, proximity, and timeliness of services. Two NGOs were considering providing more on-site mental health services; another expressed interest in increasing its presence in the community by offering wrap-around services, with a particular interest in expanding into serving minors. For example:

It would be helpful if we had [in house] a clinical team to complete assessments because we have to go to different places for psychiatric assessments or substance abuse assessments.

We are playing with the idea of bringing more services ‘in house’ ...but of course there are pros and cons with this...however since client access to the Department of Mental Health is hard, as bureaucracy is difficult, we try to refer to NGOs instead.

We could streamline a little better ...also improve community services, particularly wrap-around services.

Two NGOs had a goal of developing a transitional care center which could provide more intensive physical and mental health care just after a survivor initially leaves his/her trafficking situation. This idea stemmed from the concern that survivor needs in the acute setting are more pronounced and require specialized attention. The respondents proposed that the client would

enter this acute-care center for a certain period of time until they were ready to transition into a more long-term, communal (group home) living situation.

Discussion

Analysis of interview data underscored the challenges of addressing severe human trafficking survivor mental health needs with limited service provider capacity and poor accessibility. These findings are consistent with other studies examining general human trafficking service delivery (see Figure 1) (Clawson & Dutch, 2008; Domoney, Howard, Abas, Broadbent, & Oram, 2016; Potocky, 2010). In regards to mismatch of capacity, in an evaluation of three human trafficking service programs, Davy (2015) noted inadequate organizational capacity and resources as negatively impacting service delivery. Furthermore, Davy (2015) cited untrained NGO staff in terms of human trafficking pathology and cultural and language needs as inhibiting service delivery.

Moreover, the findings of our study highlight the multifactorial barriers to service access. In particular, past and current substance use disorders further exacerbates already complex physical and mental health concerns. Jaffé et al. (2004) and Clawson et al. (2008) both note the inextricable relationship of mental health trauma with physical health concerns. In addition these findings further elucidate the pattern of disproportionate long-term survivor needs met with a service delivery environment characterized by short-term service delivery opportunities (Gibbs et al., 2015; Macias-Konstantopoulos et al., 2015; Zimmerman et al., 2008). Also, our findings aligned with other reports of chaotic, intermittent health care service delivery represented by

urgent medical care provision either in an emergency or clinic setting, with limited or non-existent follow-up for long-term medical concerns (Aron et al., 2006; Potocky, 2010).

In response to these barriers, there is a general consensus that there is a need for building the capacity of delivery models to be tethered to the unique personal, cultural, and contextual features of the survivor (Dewan, 2014; Gibbs et al., 2015). In other words, the development and exchange of care models may provide a starting point for NGOs delivering and facilitating mental health services, but the heterogeneity of this population leads NGOs to tailor models in accordance to the survivor population(s) being served. Evidence of this ongoing and constant modification process is seen not only in the literature cited, but also in this study. For example, NGOs serving primarily indigenous and non-US citizen populations are seeking to mitigate language and cultural barriers with multilingual and culturally competent mental professionals. NGOs serving sexually exploited women are searching for mental health professionals and care models which account for sexual trauma and the role of traffickers in their clients' lives.

However, our respondents' general frustration with the current, multisector service delivery system seems to be an impetus for considering and developing more on-site mental health services. Even if survivors are granted access to the established (current) systems of service delivery, respondents questioned the quality of care and often deemed it unable to address the distinct, and often heterogeneous human trafficking experience. Our study's finding is corroborated by an evaluation of three human trafficking programs from which the authors

concluded that “the single most successful approach to encouraging service utilization was in-house or colocated services” (Gibbs et al., 2015).

Increasing mental health professional capacity was imperative as a means to improve mental health service delivery. Our findings are in line with the body of human trafficking literature, which highlights a need for mental health professionals who are trained in trauma intervention and able to provide culturally sensitive and multilingual services (Baráth et al., 2004; Hemmings et al., 2016; Muraya & Fry, 2016; Yakushko, 2009). Unfortunately, the lack of evidenced-based practices persists, and there is concern as to whether traditional mental health approaches can address the extreme trauma experienced by victims of human trafficking (Doherty, Oram, Siriwardhana, & Abas, 2016; IOM, 2007; Oram et al., 2012; Roxburgh, Degenhardt, & Copeland, 2006; Wilson & Butler, 2014; Yakushko, 2009).

Study Limitations

Although this exploratory study was limited by the small sample size and the selection of NGO respondents, the sampling methodology and the multi-pronged approach to initial contact and follow-up were chosen to minimize selection bias. Regarding the sampling methodology, the decision to select NGOs with Google and the NHTRC likely resulted in larger, better resourced NGOs being disproportionately represented, thus excluding smaller, but equally engaged NGOs. A sixty-percent response rate to agree to be interviewed may not have captured differences in perspective between responders and non-responders, however data saturation was reached. It is acknowledged that theoretically more interviews of direct service providers may have uncovered other aspects of service delivery. Findings should not be considered representative of the broader

mental health provider community for human trafficking, but provide important insights nonetheless. Directors and administrators of participating NGOs provided crucial organizational-level information about mental health services, but they may not have always been aware of nuances in mental health service provision.

Another limitation to this study was the relative superficial of exploration of specific services related to gender, sexual orientation, and cultural needs of human trafficking populations. These more granular explorations, while important, were beyond the scope of the study. The services offered by NGOs selected in this study were predominantly focused on heterosexual girls and women. Consequently, the findings do not capture data on services to boys, men, and the LGBTQ community. This is may be a reflection of the lack of these services dedicated to human trafficking in general, and as well as in mental health service provision broadly.

Recommendations

The findings offer several opportunities for future research and collaboration among stakeholders in the anti-trafficking community. First, the mental health NGO community has reiterated the need to better streamline services and work more collaboratively with other systems and stakeholders. Goldenberg (2015) also emphasized the need to prioritize “the development, assessment, and financing of community-based health and social services” as a means to “improving the lives of human trafficking survivors” (p. 1049). Building referral pathways and protocols, through partnerships between the NGO community and the health care system, could produce strategies to better address the mental health needs of the human trafficking population. Funders are encouraged to incentivize NGO collaboration with other

sectors to develop multidisciplinary responses to meet the acute and long-term mental health care needs of survivors.

Secondly, and in line with promoting multisector collaboration, a great need exists to improve survivors' access to mental health care through improving provider capacity. As our findings suggest, this starts with developing a workforce of trafficking-trained mental health providers. Moreover, by ensuring all human trafficking NGO staff are trained in trauma-informed services for their clients, earlier identification and care of mental health needs will result.

Thirdly, the great desire for, but limited availability of evidenced-based practices appropriate for unique human trafficking, mental health pathologies underscores an abundance of research opportunities between service-provider stakeholders and the academic community. Research could develop evidence-based approaches to improve the capacity of a much-needed cadre of mental health providers. Such capacity could possibly be built through partnerships with universities, hospitals, and mental health centers interested in more directly shaping the mental health knowledge base concerning human trafficking. NGOs engaged in service delivery are highly encouraged to record and evaluate aspects of their service delivery models and approaches, as their experience is invaluable and would greatly enhance the nascent human trafficking service delivery and evaluation literature (see also Muraya & Fry, 2016).

Conclusion

Human trafficking survivors often suffer from debilitating, long-lasting, and complex mental health trauma. There exist numerous systemic, provider, and survivor barriers to mental health service delivery, including the lack of a service delivery model to meet the needs of survivors. Yet this study revealed key systems and provider – level changes which may build the anti-trafficking community’s ability to respond. This study reiterates the need for a comprehensive, multisector response which seeks to tether overarching service provider principles and frameworks with a need for flexibility in order to address a unique and diverse population."

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Figure 1. Barriers to General Human Trafficking Service Delivery: a Conceptual Framework

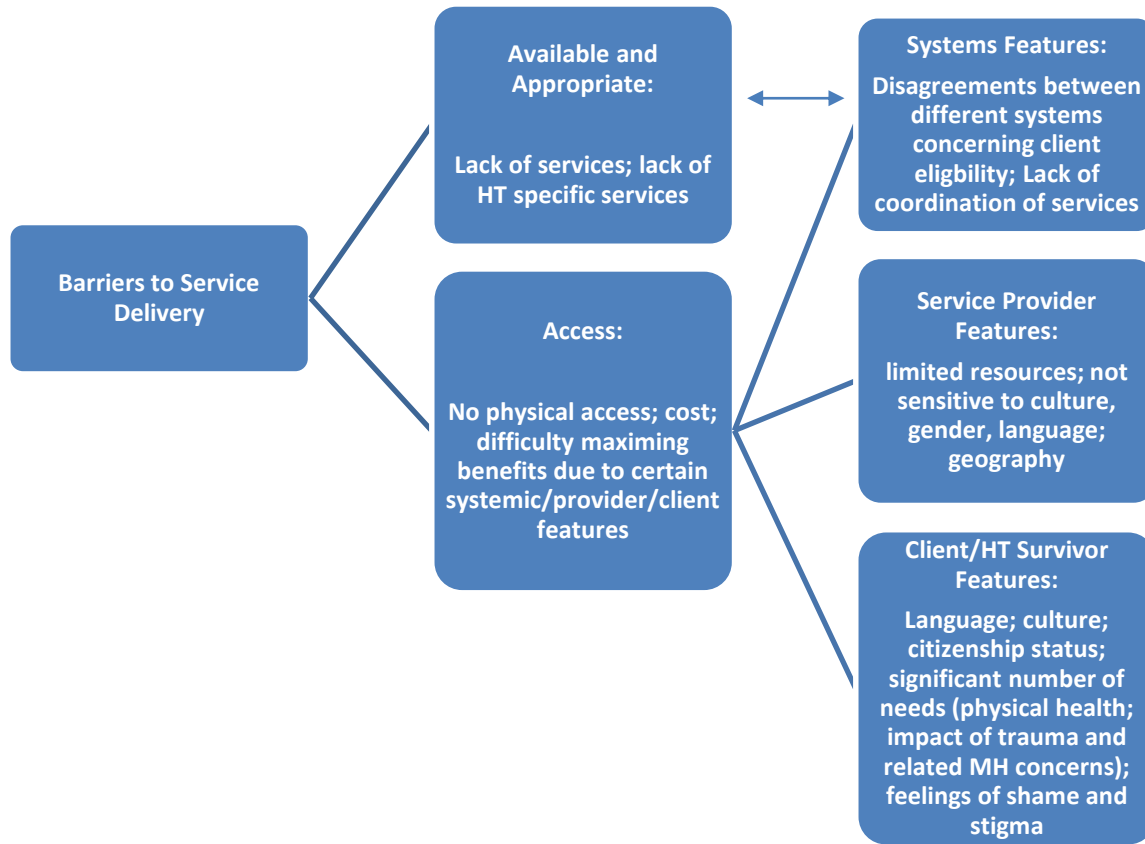


Figure 2. Thematic Framework of Barriers to Mental Health Service Delivery

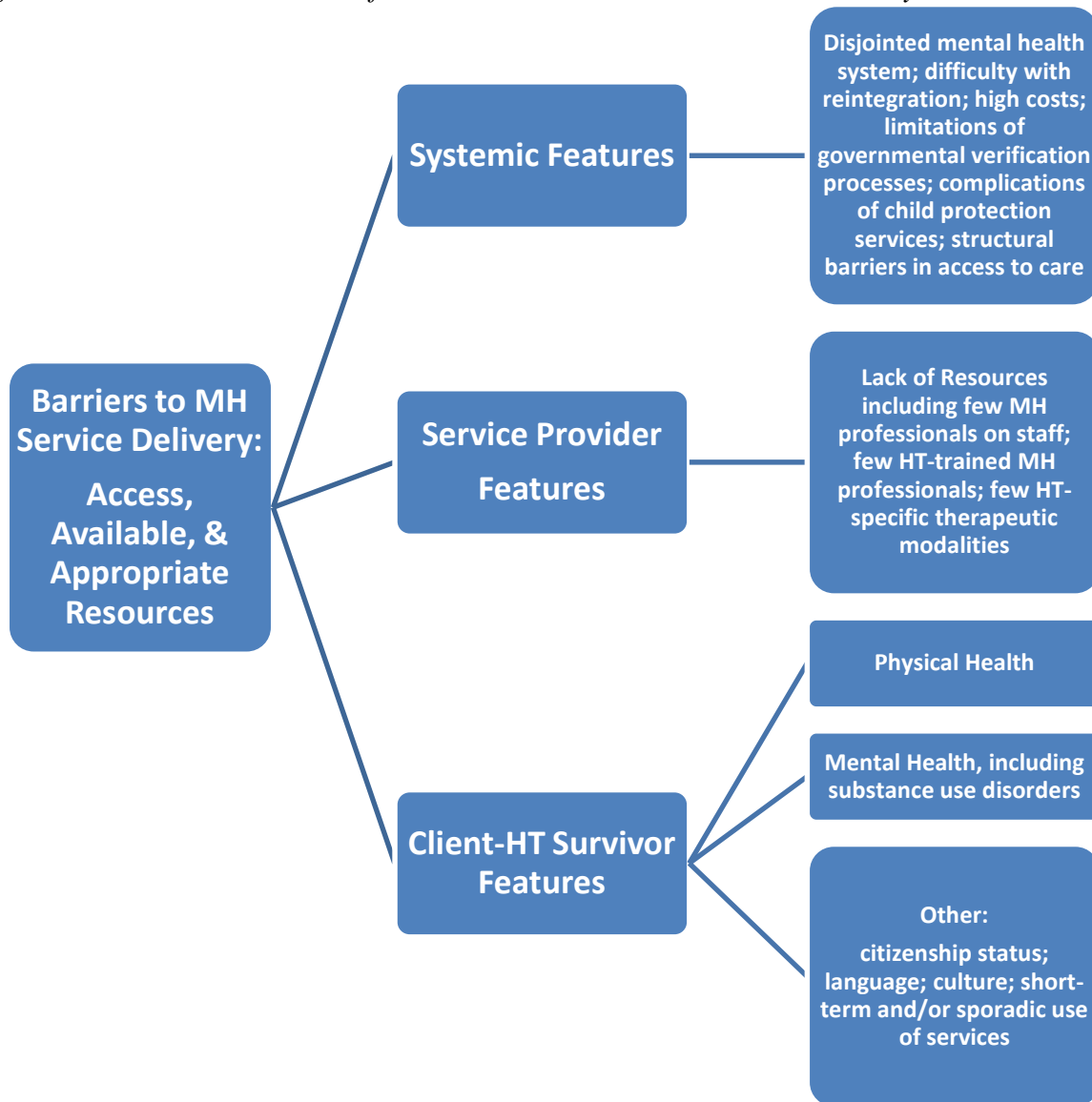
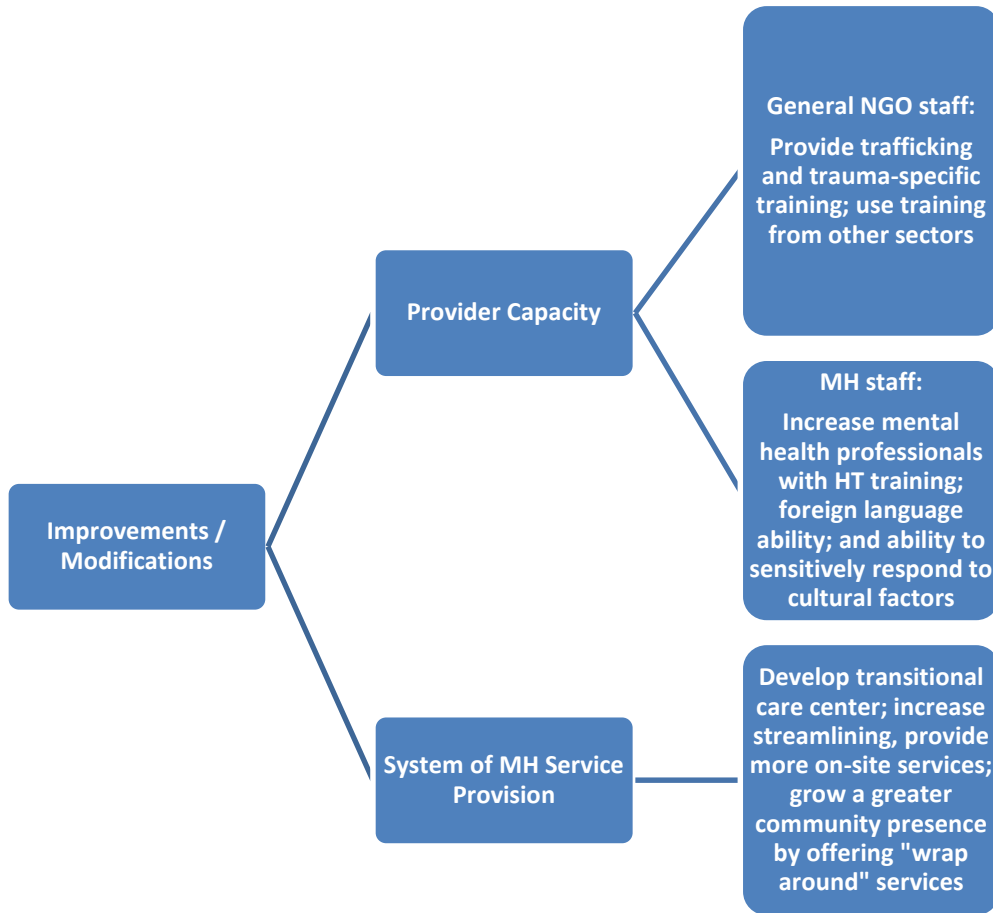


Figure 3. Thematic Framework of Improvements/Modifications to Mental Health Services Provision



Tables

Table 1

Non-Governmental Organization locations, state-level (N=15)

Alabama	Arizona	California
Colorado	Delaware	Florida
Georgia	Iowa	Louisiana
Maryland	New Mexico	Oklahoma
Tennessee	Virginia	Washington

Table 2

Non-Governmental Organization Service Delivery Characteristics

	NGOs
Nature of Trafficking	
▪ Labor	0
▪ Sex	5
▪ Both	10
Age of Population Served	
▪ Adults	9
▪ Minors	3
▪ Both†	3
Gender of Population Served	
▪ Male Only	0
▪ Female Only	8
▪ Both	7

†3 NGOs indicated rarely serving minors

Table 3

Position of Respondents (N=16)

Position	Quantity¹
Administrator/Director	12 ²
Case Manager	2
Licensed Professional Counselor	1
Client Support Advocate	1

¹ Note that the total of number of NGOs included was 15, but the total number of individuals interviewed was 16, as one interview included two respondents

² Three administrator respondents indicated having a clinical background as either a Licensed Clinical Social Worker (LCSW) (n=2) or as a Clinical Psychologist (PsyD) (n=1)