

**A Description of Services Provided by U.S.  
Rehabilitation Centers for Domestic Sex Trafficking Survivors**

BY

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THESIS

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I dedicate this dissertation to my Lord and Savior, Jesus Christ. By surrendering daily to his plan, he has made the completion of this dissertation possible. A special dedication to my beloved, family and friends for their unfailing support, guidance, patience, and love.

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## LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CPS	Child Protective Services
CSEC	Commercial Sexual Exploitation of Children
DMST	Domestic Minors of Sex Trafficking
ECPAT	End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes
FBI	Federal Bureau of Investigation
GED	General Educational Development
HIV	Human Immunodeficiency Virus
NGO	Non-governmental Organization
PTSD	Posttraumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
STD	Sexually Transmitted Disease
TIP	Trafficking in Persons
TVPA	Trafficking Victims Protection Act
U.S.	United States

## **SUMMARY**

Sex trafficking is often referred to as modern day slavery. In the Trafficking in Persons Report 2012, there are 20.9 million worldwide trafficking victims. There are estimated to be 244,000 U.S. children and youth at risk for domestic minor sex trafficking (DMST) and 100,000 to 300,000 DMST victims in the U.S. The detrimental effects of DMST include an array of psychological, behavioral and physical health conditions. An evident gap exists between the staggering number of youth trafficked in comparison to the limited number of U.S. rehabilitation centers for trafficking survivors. The purpose of this qualitative, descriptive research study was to provide a comprehensive description of services offered at rehabilitation centers for DMST survivors. An integrated model of Bronfenbrenner's ecological theory and Macy and Johns's framework for aftercare services to address sex trafficking survivors' needs was used to guide this research study. Using a semi-structured interview guide, five telephone interviews were conducted with two founders, two directors of social services, and one program manager. This study provided a fuller understanding of the range of services offered across these rehabilitation centers and identified how these services were addressing the immediate, ongoing and long-term needs of DMST survivors. Ultimately, this study has advanced science by laying the foundation for future studies to develop best practice guidelines and an integrated care management model for DMST survivors.

## I. SPECIFIC AIMS

The long-term goal of my research is to develop a comprehensive service delivery model for rehabilitation centers offering services to domestic minors of sex trafficking (DMST). Due to the underground nature of sex trafficking, the incidence and prevalence of DMST in America is grossly skewed. Clawson, Layne, and Small (2006) estimated that 397,502 females (0.227% of the total population of females in the United States) are at risk for sex trafficking in the United States. Females between the ages of 15-19 years old are at the greatest risk. Estes and Weiner (2001) found that the number of American children and youth at risk for DMST are estimated to be 244,000. The total population of females trafficked for sex in the United States was 29,876 (0.021% of the total population of females in the United States) with the highest percentage of females between the ages of 15 to 19 years old (Clawson, Layne, & Small, 2006). End Child Prostitution, Child Pornography, and the Trafficking of Children for Sexual Purposes (ECPAT, 1996) estimated that there are 100,000 to 300,000 DMST victims in the U.S. Trafficking Victims Protection Act (TVPA) of 2000 defined sex trafficking as “a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.” DMST is defined as the “commercial sexual abuse of children (under the age of 18) through buying, selling, or trading their sexual services” (Shared Hope International, 2007). Sex trafficking is often referred to as modern day slavery because of the “involuntary servitude, peonage and other forms of forced labor” that are associated with trafficking (Danailova-Trainor & Laczko, 2010; Trafficking Victims Protection Act [TVPA], 2000). The average age of entry into sex trafficking for females is 12-14 years old (with some girls as young as nine) and the average age of entry for males is 11-13 years old (Estes & Weiner, 2001; Omrod & Finkelhor, 2004).

To date, eight states throughout the country have passed Safe Harbor laws to protect the rights of minors by clearing their records of prostitution convictions that may have accrued while they were trafficked and referred them to aftercare services (N. Marquez, personal

communication, April 30, 2012). The purpose of these new laws is to increase the identification of trafficking victims and to appropriately refer them to social services. Ultimately, this will result in more referrals to rehabilitation centers and an increase in prosecution of traffickers (Illinois Safe Children Act, 2011). Despite the extent of victimization and the change in laws, research on rehabilitation services for this population is limited.

Research on sex trafficking has focused on the risk factors of DMST, the lived experience of DMST survivors and the complex needs of DMST survivors (Miller, Decker, Silverman, & Raj, 2007; Rafferty, 2008; Shigekane, 2007; Willis & Levy, 2002; Zimmerman et al., 2008). DMST survivors suffer from a combination of physical, behavioral and psychological conditions including, but not limited to, low self-esteem, posttraumatic stress disorder (PTSD), substance abuse, and/or sexually transmitted diseases (STDs) (Rafferty, 2008; Zimmerman et al., 2008). To the best of the researcher's knowledge, there are 14 rehabilitation centers providing services to DMST survivors in the U.S. This is an insufficient number of rehabilitation centers compared to the estimated number of minors at risk of being trafficked and those actually trafficked (Danailova-Trainor & Laczko, 2010; Smith, Vardaman, & Snow, 2009). Disturbingly, the lack of rehabilitation centers and services for DMST survivors has contributed to re-victimization and criminalization (Smith et al., 2009).

Macy and Johns (2011) conducted a systematic literature review to identify services recommended for DMST survivors. Based on their review, they developed a framework for services to address sex trafficking survivors' needs. Within their framework, they identified seven core services: basic necessities (e.g., food, water); secure, safe shelter and housing; physical health care; mental health care; legal and immigration advocacy; substance abuse services, and; job and life skills training (Macy & Johns, 2011). They categorized these core services into three domains including immediate, ongoing and long-term needs (Macy & Johns, 2011). See Appendix A for a model of Macy and Johns's (2011) framework for aftercare services to address sex trafficking survivors' needs. Clawson and Goldblatt-Grace (2007)

identified similar services (basic needs, mental health counseling/treatment, medical screening/routine care, life skills, and job training) supportive of Macy and Johns's (2011) seven core services. However, little is known about the services offered and the frequencies of the services offered across rehabilitation centers.

Guided by an integrated model of Bronfenbrenner's (1979) ecological theory and Macy and Johns's (2011) framework for continuum of aftercare services to address sex trafficking survivors' needs, this study assessed the services provided across 14 U.S. rehabilitation centers. A comprehensive literature review was conducted on this topic using the following databases: CINAHL, PubMed, JSTOR, Embase, PsycInfo, Social Service Abstracts, Sociological Abstracts, and Criminal Justice Abstracts. After reviewing an array of published articles and governmental reports, this was the first study of its kind to provide a comprehensive description of the services offered across rehabilitation centers for DMST survivors in the U.S. This study was the first step in reaching my long-term goal of developing a comprehensive service delivery model for rehabilitation centers offering services to DMST survivors.

The purpose of this qualitative, descriptive research study was to provide a comprehensive description of services offered at rehabilitation centers for DMST survivors. This study provided a fuller understanding of the range of services offered across these centers and identified if these services addressed the immediate, ongoing and long-term needs of DMST survivors (Smith et al., 2009). Data was collected through individual interviews with administrators at rehabilitation centers for DMST survivors.

The specific aims were to:

- (1) Describe services offered at rehabilitation centers for DMST survivors to address survivors' immediate, ongoing and long-term needs;
- (2) Provide the frequency of the seven core services across the rehabilitation centers;
- (3) Propose essentials and best practices for program directors and founders of rehabilitation centers for DMST survivors.

Increasing our knowledge of services provided at rehabilitation centers for DMST survivors will assist in defining core services critical for the protection and restoration of the health of sex trafficking survivors (Macy & Johns, 2011; Smith et al., 2009).

## II. LITERATURE REVIEW

### A. Significance

The psychological and behavioral outcomes of DMST survivors include lower self-esteem, loss of self-confidence, anxiety, panic attacks, depression, hopelessness, PTSD, substance abuse disorders, suicidal ideations, attachment disorders, mistrust of adults, antisocial behaviors, difficulty relating to others, developmental delays, language and cognitive difficulties, deficits in verbal and memory skills, poor academic performance, and grade retention (ECPAT, 2006; Rafferty, 2008; Raymond, Hughes, & Gomez, 2001; Shigekane, 2007; Twill, Green, & Traylor, 2010; Williamson, 2006; Zimmerman et al., 2008). The physical outcomes of DMST include complications from high-risk pregnancies and unsafe abortions, headaches, fatigue, dizziness, pain (e.g., back, stomach, pelvic), STDs, HIV/AIDS, and gynecological infections (Rafferty, 2008; Williamson, 2006; Zimmerman et al., 2008). Raphael and Shapiro (2002) found that girls trafficked before the age of 15 were found to have more health problems as adults than girls involved in the sex industry after the age of 15. Additionally, girls who were involved in the sex industry before the age of 18 were more likely to report having an STD and no HIV testing (Martin, Hearst, & Widome, 2010). These findings demonstrated a clear and present need for rehabilitative services for survivors exiting DMST situations (Family Violence Prevention Fund, 2005; Hotaling, Miller, & Trudeau, 2006; Kotrla, 2010).

### B. Conceptual Framework

Collaborative and coordinated service delivery models are recommended to address the numerous, significant needs of DMST survivors (Caliber, 2007). Macy and Johns's (2011) framework for a continuum of aftercare services to address sex trafficking survivors' changing needs incorporated seven core services within three domains: immediate, ongoing and long-term needs. This aftercare service delivery framework was selected because it was the first framework developed for rehabilitation centers offering services to sex trafficking survivors.

The seven core services included: basic necessities; secure, safe shelter and housing; physical health care; mental health care; legal and immigration advocacy; substance abuse services, and; job and life skills training. This framework was used to assess the level of services provided at U.S. rehabilitation centers for DMST survivors. Two of the seven core services (basic necessities; secure, safe shelter and housing) can be found within the domain of immediate needs (Macy & Johns, 2011). Once immediate needs are addressed and survivors become stabilized in a safe environment, establishing services to address their ongoing needs becomes a priority (Macy & Johns, 2011). Four of the seven core services (physical health care; mental health care; legal and immigration advocacy; substance abuse services) were found within the domain of ongoing needs (Macy & Johns, 2011). The last core services (job and life skills training) were found within the domain of long-term needs (Macy & Johns, 2011). A goal for all service providers is to move DMST survivors to a level of independence.

Macy and Johns's (2011) framework was integrated with Bronfenbrenner's (1979) ecological theory. See Appendix B for an integrated model of Macy and Johns's (2011) framework for aftercare services to address sex trafficking survivors' needs and Bronfenbrenner's (1979) ecological theory. Bronfenbrenner's (1979) theoretical framework was used in this study because it emphasized the relationship between individuals and their environment (Rafferty, 2008). Bronfenbrenner (1979) identified five environmental systems including microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem was represented by settings in which the individual lives including family, peers, church, or school (Bronfenbrenner, 1979). In this study, Macy and Johns's (2011) framework represented the microsystem including their peers and staff at the rehabilitation center. The mesosystem characterizes the relationship between the various agents in the microsystem (Bronfenbrenner, 1979). The exosystem refers to the broader community in which the DMST survivor lives. In this study, the exosystem included extended family, school, mass media, and neighborhoods (Bronfenbrenner, 1979). Macrosystem was the cultural context in which the

individual lived including social conditions, laws, history, culture, and economic systems (Bronfenbrenner, 1979). In this study, the macrosystem included recent changes to laws on DMST, an increase in social awareness of DMST and a decrease in funding related to the depressed economy. Chronosystem referred to patterns of environmental and transition across an individual's lifespan (Bronfenbrenner, 1979). These environmental systems were known to shape the development of individuals (Bronfenbrenner, 1979).

More research on service delivery models for rehabilitation centers are needed (Clawson & Goldblatt-Grace, 2007; Fong & Cardoso, 2010; Shigekane, 2007). The contribution of this study increased the knowledge and understanding of services offered to DMST survivors at rehabilitation centers allowing us to determine if survivors were receiving appropriate rehabilitative services to reintegrate back into society. Another contribution of this study was the expansion of core services offered at rehabilitation centers, which led to adaptations of a comprehensive service delivery model for rehabilitation centers serving DMST survivors.

### C. **Innovation**

This was the first study to integrate Bronfenbrenner's (1979) ecological theory and Macy and Johns's (2011) framework for aftercare services for sex trafficking survivors. Secondly, this research study was one of the first studies to provide a comprehensive description of services at rehabilitation centers for DMST survivors in the U.S.

### III. RESEARCH METHODOLOGY

#### A. **Design**

A qualitative description, nonexperimental research approach, was used to fulfill the purpose of this research study. The main purpose of this study was to describe services offered at U.S. rehabilitation centers for DMST survivors. Qualitative description fulfilled the aims of this study since it is considered the method of choice when straight descriptions of a phenomenon are desired (Sandelowski, 2000). Qualitative description allows the researcher to obtain a fuller description capturing all the elements of an event by targeting information-rich participants. It allowed the identification of Macy and Johns's (2011) seven core services across rehabilitation centers and the development of a descriptive summary of services provided at rehabilitation centers for DMST survivors. Therefore, contributing to the development of a more comprehensive database of best practices for the delivery of aftercare services.

#### B. **Setting and Sample**

The setting for this study included the 50 states within the U.S.

Purposeful, convenience sampling of founders, program directors and/or program managers of rehabilitation centers for DMST survivors was appropriate for this research study because of the importance of recruiting information-rich participants to provide detailed and insightful information about services offered at rehabilitation centers (Patton, 2002). These accounts assisted the researcher in obtaining a better understanding of this phenomenon.

The inclusion criteria for rehabilitation centers included: a) provided services exclusively to DMST survivors; b) actively housed DMST survivors; and, c) provided services to males, females, and transgender DMST survivors aged 11 or older. The exclusion criteria for rehabilitation centers included: a) runaway shelter for minors (DMST survivors housed with other non-DMST survivors); and, b) social service agency who provided services to DMST survivors without on-site housing. The rationale for excluding runaway shelters for minors and social service agencies without on-site housing was because trafficking survivors require

housing with a higher level of security and require more time-consuming and lengthy support compared to refugee and domestic violence survivors (Shigekane, 2007). The inclusion criteria for interviewees included: a) held the job title of founder, program director and/or program manager of a rehabilitation center; b) 21 or older; and, c) spoke English. The exclusion criteria for interviewees included: a) did not hold the job title of founder, program director or program manager of a rehabilitation center; b) 20 or younger; and, c) did not speak English. All participants of this study met the inclusion criteria.

A comprehensive, web-based search was conducted in August 2011 by the researcher resulting in the identification of 14 rehabilitation centers in the U.S. that appeared to meet the selection criterion for this study. Table I is a summary of the targeted sample in relation to how they met the inclusion and exclusion criteria for this study.

**TABLE I**  
SUMMARY OF TARGETED SAMPLE

	Inclusion			Exclusion			<i>n</i>
	Agreed	Refused	No response*	No center	Adults only	Other**	
Original	4	1	3	4	1	1	14
Additions	1	0	1	2	5	1	10
<b>Total</b>	<b>5</b>	<b>1</b>	<b>4</b>	<b>6</b>	<b>6</b>	<b>2</b>	<b>24</b>

\* Rehabilitation center met criteria, but no response to recruitment efforts.

\*\* Rehabilitation center failed to respond to recruitment efforts; researcher unsure if these centers met the inclusion criteria.

Of the 14 rehabilitation centers contacted, eight rehabilitation centers met the selection sample criterion, but only four agreed to participate, one declined to be interviewed, and three failed to respond. Of the remaining six rehabilitation centers contacted: four were found to have

no rehabilitation center related to a recent closure or delay in opening; one center only provided services to adults, and; one participant never responded. More information was later provided to the researcher from a participant, which led the researcher to contact an additional 10 rehabilitation centers. From this 10, two rehabilitation centers met the selection criterion; one participated in the study and the other one failed to respond. Of the remaining eight rehabilitation centers contacted: one offered only crisis housing and one housed DMST survivors with domestic violence survivors and runaway youth; five provided services to adults only, and; one failed to respond. Altogether 24 rehabilitation centers were contacted, 10 met the selection criterion; five participated in this study, four failed to respond, and one declined to be interviewed.

C. **Measures**

A semi-structured interview guide developed by the researcher was used to interview the founder, program director or program manager of a rehabilitation center for DMST survivors. See Appendix C for the interview guide. The interview guide was based on an integrated model of Bronfenbrenner's (1979) ecological theory and Macy and Johns's (2011) framework for a continuum of aftercare services to address sex trafficking survivors changing needs. The interview guide consisted of 39 questions. Two questions elicited information on demographics of the DMST survivors at the rehabilitation center and the origin of referrals to the rehabilitation center. Ten questions were related to the rehabilitation center, specifically its mission, vision, and philosophy; treatment model; board of directors; funding sources; geographic location; safety protocols; bed assignments; challenges and achievements, and; a question about neighborhood perception. Nine questions sought information about employees and staff development at the rehabilitation center including: quantity and type of employees; employee demographics; description and length of new employee orientation; description and frequency of ongoing staff development training; employee counseling services; employee turnover, and; employee satisfaction. Five questions addressed the immediate needs of DMST survivors, six

questions addressed the ongoing needs of DMST survivors, and three questions addressed the long-term needs of DMST survivors. Three questions elicited information on participants' follow-up after exiting their rehabilitation center. The final question on the interview guide asked if the participant had any additional information he/she would like to share about their rehabilitation center for DMST survivors.

D. **Procedure**

First, an updated web-based search was conducted to ensure rehabilitation centers still met the inclusion criteria for this study. This revised search was completed in collaboration with the Polaris Project, a national organization on human trafficking, to confirm the existence of rehabilitation centers for DMST survivors. After receiving approval from the University of Illinois at Chicago Institutional Review Board, an employee from each rehabilitation center holding the job title as founder, program director or program manager was approached via email to seek his/her interest for participating in this study. A cover letter along with a copy of the informed consent was included in the email sent to potential participants. If the potential participant responded with interest of participating in the study, then a date, time and interview method were arranged via email for the interview. For rehabilitation centers located outside the Midwest region of the U.S., web-based interviewing, Nefsis, was the first interview approach offered. This latter method required participants to have Internet access, a microphone and a webcam. If participants were located outside the Midwest and lacked technical capabilities for a web-based interview, then a telephone interview was offered. Web-based and telephone interviewing were selected as practical options related to the widespread, geographic locations of rehabilitation centers across the U.S. Telephone interviews were found to be as effective as face-to-face interviews in qualitative research (Hamilton & Bowers, 2006). For rehabilitation centers located in the Midwest, a face-to-face interview was the first interview approach offered followed by either a web-based or telephone interview. If two weeks passed after the original recruitment

email was sent, then the researcher called potential participants to determine their interest in participating in this study.

All of the participants preferred to be interviewed via the telephone because of its convenience and their previous unsuccessful attempts with web-based software. At the beginning of the interview, the researcher obtained undocumented informed consent from participants to participate in this study. During the interviews, the researcher requested documentation (e.g., annual report, training manuals, curricula) from participants, but only one participant provided requested documentation. Interviews were all digitally recorded; the shortest interview lasted one hour and nine minutes and the longest interview lasted one hour and fifty-two minutes. After the completion of the interview, a \$50 online donation was made through PayPal to the rehabilitation center for the participants' participation in the study.

#### E. **Data Analysis**

Creswell's (2009) criteria for qualitative data analysis were used. Creswell's (2009) six steps to qualitative data analysis included: 1) organizing and preparing data for analysis; 2) reading through all the data; 3) coding the data; 4) generating themes/categories for analysis; 5) providing representation of description/themes in the qualitative narrative; and, 6) interpreting the data. These six steps are considered both structured and flexible (Ulin, Robinson, & Tolley, 2005). The researcher was fully immersed in the data prior to the completion of data collection (Ulin et al., 2005). Glaser and Strauss's (1967) approach was selected as the preferred method to code data, which resulted in the development of a code list after data collection. The advantage of developing a code list after data collection included molding codes to fit the data collected, being more open-minded and being context-sensitive going into the analysis (Miles & Huberman, 1994). The original code list consisted of 28 codes. The code list was originally developed from the first interview, but later evolved as more data was collected and after receiving input from a committee member and a peer reviewer. The code list underwent six revisions with a final code list consisting of 27 codes. See Appendix D for a final version of the

code list. The transcripts from the interviews were uploaded to Atlas.ti, qualitative data analysis software, and coded accordingly. During data analysis, the researcher merged two codes together (challenges merged with barriers, success merged with outcomes, and retention strategies dissolved into two existing codes, staffing and program resources). Additionally, across-case analysis was conducted to identify the frequency of core services across the rehabilitation centers (Ayres, Kavanaugh, & Knafl, 2003). The researcher developed five matrices: a table of findings organized using the code list; a table of immediate, ongoing, and long-term needs organized by each rehabilitation center; a frequency table of Macy and Johns's seven core services organized by each rehabilitation center; a table of population demographics of those served at the rehabilitation center organized by each rehabilitation center, and; a table of demographics of the rehabilitation centers organized by each rehabilitation center. The researcher reviewed the matrices with two qualitative researchers. All data was stored as password-protected documents on an encrypted computer; data was also saved on an external hard drive as a back-up and stored in a fireproof, locked safe. All participants were assigned an identification number; these numbers were used to code all documents. Documentation retrieved from the rehabilitation centers was stored in a fireproof, locked safe. Data will be kept up to five years from the date it was collected, January and February 2012.

Lincoln and Guba's (1985) evaluative criteria for trustworthiness was used to establish credibility, dependability, confirmability, and transferability. Multiple independent coders, analysis by independent investigators, and inclusion of information about the researcher's background and professional training were all used to increase the dependability of qualitative findings (Ulin et al., 2005). Furthermore, an audit trail was maintained to ensure confirmability and thick, rich descriptions were provided to convey transferability of findings (Ulin et al., 2005).

## IV. RESULTS

The results of this study included the demographics of rehabilitation centers, the population demographics at rehabilitation centers, a description of other characteristics of rehabilitation centers, a description of services provided at rehabilitation centers to address the immediate, ongoing and long-term needs of DMST survivors, the frequency of core services provided at rehabilitation centers, and common practices across rehabilitation centers.

### A. Demographics of Rehabilitation Centers

The sample size consisted of five respondents from five separate rehabilitation centers, including two founders, two directors of social services, and one program manager. Demographics of the rehabilitation centers are displayed in Table II.

**TABLE II**  
DEMOGRAPHICS OF REHABILITATION CENTERS

<b>Demographics</b>	<b>n = 5</b>
Faith based	3
Urban setting	3
Length of establishment (years)	2 - 20
Housing	
House	3
Old Building	2
Capacity (# of beds)	5 - 48
Security	
Cameras on-site	4
Security gate	1
Shared bedrooms	3
Material resources	
On-site school	1
Drop-in center	1
Van	2
Recreational equipment	1
Additional buildings	3

Three rehabilitation centers were faith-based. Three rehabilitation centers were located in an urban setting and two rehabilitation centers were located in a rural setting. The average length of establishment was 7.2 years with a maximum of 20 years and a minimum of two years. The rehabilitation centers resided in houses, n =3, or older buildings, n=2. The number of beds across the five rehabilitation centers ranged from 5 to 48 with a total capacity of 90 beds. Three rehabilitation centers had never been at full capacity and two rehabilitation centers were commonly at full capacity with a waiting list. Four rehabilitation centers had cameras on-site and a security gate enclosed one rehabilitation center. At three rehabilitation centers, DMST survivors shared bedrooms based on length of stay and gender. The census was low at the other two rehabilitation centers, which provided the DMST survivors with their own private rooms. Material resources of these rehabilitation centers included: an on-site school, n=1; drop-in center, n =1; van, n=2; recreational equipment/area including a playground or basketball court, n=1, and/or; additional buildings, n=3.

#### B. **Population Demographics at Rehabilitation Centers**

Demographics of the DMST survivors receiving services at the five rehabilitation centers are displayed in Table III. The age range of DMST survivors served at these rehabilitation centers was between 11 and 20 years old. All participants provided services to females and two participants expanded their services to include males and transgender individuals. All participants provided services to U.S. DMST survivors; one participant provided services to international victims, three participants were open to providing services to international victims of DMST, and one participant provided services only to American DMST survivors. All participants acknowledged providing services to Caucasian, African American, and Latino DMST survivors; with African Americans being the predominate race of victims who sought services. The languages spoken by DMST survivors served at these rehabilitation centers were English and Spanish. Two participants accepted pregnant survivors, one participant did not accept pregnant survivors, and two participants never had a pregnant survivor and were unsure if services would be provided to them. None of the participants provided services to DMST survivors with children in their physical possession. The level of education of DMST survivors served at these

rehabilitation centers ranged from grammar school (as low as 3<sup>rd</sup> grade) to high school (as high as 10<sup>th</sup> grade). The length of time DMST survivors were trafficked ranged from six weeks to five years.

**TABLE III**  
POPULATION DEMOGRAPHICS AT REHABILITATION CENTERS

<b>Population Demographics</b>	<b>N = 5</b>
Age (years)	11 - 20
Gender	
Female	5
Male & transgender individual	2
Citizenship	
United States	5
International: Mexico	1
Race	
Caucasian	5
African American	5
Latino	5
Languages	
English	5
Spanish	5
Pregnant survivors	2
Survivors with children	0
Level of education (grade)	3 - 10
Length of time trafficked (months)	1.2 - 60

**C. Description of Other Characteristics of Rehabilitation Centers**

As shown in Table IV, other characteristics of the five rehabilitation centers included alumni involvement, barriers and challenges, board of directors, collaborative partners, employee orientation, institutional policies, mission, neighborhood perception and sentiment, ongoing staff training, objective outcomes, philosophy, policies related to youth, policies related to staff, program evaluation, program resources, referrals, schedule, staffing, treatment model, and vision.

Alumni involvement at the rehabilitation centers ranged from alumni having no direct contact with survivors in the program because current survivors did not identify with alumni, n=1, or had limited

contact with survivors as a result of poor outcomes, n=1, to alumni being strongly encouraged to be involved in programs as a staff member or volunteer, n=3.

**TABLE IV**  
OTHER CHARACTERISTICS OF THE FIVE REHABILITATION CENTERS

Rehabilitation Center	Alumni Involvement	Barriers & Challenges	Board of Directors	Collaborative Partners	Employee Orientation	Institutional Policies	Mission	Neighborhood Perception & Sentiment	Ongoing Staff Training	Objective Outcomes	Philosophy	Policies r/t Youth	Policies r/t Staff	Program Evaluation	Program Resources	Referrals	Schedule	Staffing	Treatment Model	Vision
1		X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	
2	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X
3	X	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X		X
4		X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	
5	X	X	X	X		X	X	X	X		X	X	X		X	X	X	X	X	
<b>Total (n)</b>	<b>3</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>1</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>2</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>2</b>

The barriers and challenges of operating a rehabilitation center for DMST survivors included funding, n=3, government regulations, n=5, staffing, n=5, and stigma, n=1. The limited amount of funds available prevented additional services from being provided, n=2, and limited the diversity of staff positions available (i.e., teachers, statisticians), n=2. Additionally, funders placed restrictions on the population eligible for receiving services at these centers, n=2. For instance, funders limited services to DMST survivors who were referred only under the status of homeless or runaway. Frequent staff turnover, n=3, related to employee burnout, n=2, or transfer to a new position after gaining experience, n=1, was another challenge. The direct staff position was noted to have the highest employee turnover

rate, n=1. Often times, these positions were transitional with employees holding this position for a few years to gain experience before moving into a higher position in the field, n=1. Also, the difficulty of finding appropriate, qualified staff to work in these positions were challenging, n=3. Individuals drawn to this field either had to have a genuine heart and/or a desire to work with this population. Having a culturally diverse staff, n=1, was yet another challenge. The majority of DMST survivors served at rehabilitation centers were African-American females and the majority of professionals and care providers at these centers were Caucasian.

The restrictions set by state government on group homes constrained the number of openings and closures of approximately four rehabilitation centers and affected the way services were provided at all five rehabilitation centers. Poor government oversight related to inconsistent state regulations of group homes, n=2, and lack of a uniformed, national tracking system for DMST survivors, n=1, were barriers to operating a rehabilitation center.

All five rehabilitation centers had a board of directors. The boards for each rehabilitation center included a diverse group of professionals (i.e., lawyers, social workers, police officers, etc.).

Collaborative partners were categorized into five fields for all rehabilitation centers: medical professionals (i.e., physicians, dentists, optometrists), mental health professionals (i.e., therapists, psychiatrists, psychologists, drug and alcohol counselors, social workers), law enforcement personnel (i.e., vice cops, local police officers, hospital security guards), educators (i.e., teachers), and legal professionals (i.e., attorneys, lawyers).

Employee orientation lasted anywhere from one week, n=2; multiple days, n=1; two weeks, n=1, and; unknown (no formal training), n=1. One participant provided the table of contents for their employee orientation, two additional participants discussed topics presented at their employee orientation, and two other participants did not conduct an intense employee orientation and did not provide a list topical areas covered. Topical areas included: commercial sexual exploitation of children (CSEC), n=3; safety, n=2, and; behavior management, n=3.

All participants constructed their institutional policies within two categories: governmental guidelines and medical needs. Institutional policies constructed from governmental guidelines included age of survivor and/or length of stay (i.e., stay until 18 or 21 years old, up to 24 months), n=5; admitting criteria (i.e., homeless, runaway youth), n=2, and; number of survivors housed at a rehabilitation center, n=5. Institutional policies developed to address medical needs included completing physical and psychiatric assessments upon admission, n=5; going to the hospital in the event of an emergency, n=5; never denying a survivor medical services when requested, n=1, and; admitting a DMST survivor to an inpatient substance abuse treatment program, n=3.

The mission statements for all five rehabilitation centers focused on empowering DMST survivors and engaging the community.

Three participants discussed how the neighborhood resisted a rehabilitation center of this kind being established in their neighborhood. One participant noted that the neighborhood was “unaware” of the rehabilitation center and one participant stated the neighborhood was “thrilled” about the rehabilitation center being in the community. All participants acknowledged that the safety of the community was uncompromised as a result of the establishment and in some cases the addition of the rehabilitation center led to neighborhood improvement, n=2.

Four participants held weekly staff meetings and one participant held monthly staff meetings where they discussed recent occurrences at the center and held micro-trainings. One participant included survivors in their staff meetings.

Only one participant collected objective outcomes on survivors who left the program for whatever reason (i.e., graduation, runaway, demographics, etc.). The four remaining participants had a non-systematic approach (i.e., mixing results with other services in their organization, anecdotal reporting) to data collection.

The philosophy for all five rehabilitation centers influenced daily operations. Common philosophical viewpoints found across the rehabilitation centers included:

1. Unconditional love, acceptance and ongoing support, n=3;

2. Creation of a family oriented environment, n=5;
3. Provision of structure to the DMST survivors' day, n=5;
4. Establishment of mentoring relationships, n=2;
5. Encouragement of survivors to contact the rehabilitation center during a crisis after discharge, n=4;
6. Emphasis on family involvement in the lives of DMST survivors, n=5;
7. Participation in formal education, n=5.

Philosophical viewpoints that differed across the five rehabilitation centers included:

1. Criteria on the age range and quantity of DMST survivors housed together at a rehabilitation center, n=3;
2. Discrepancy across the rehabilitation centers on the amount of freedom provided to DMST survivors ranged from very liberal to very restrictive. One participant was very liberal allowing DMST survivors to navigate public transportation to attend school, three participants were more conservative and drove DMST survivors to school, and one participant was very restrictive by not allowing DMST survivors to leave the rehabilitation center.

All participants agreed on the importance of structuring the survivors' time and did not entertain the idea of survivors having a large span of time alone. The two participants that accepted males and transgender individuals had policies on gender separation when assigning rooms. All participants expected DMST survivors to obey house rules. For example, house rules included completing assigned chores, obeying curfew, working towards individual treatment plan, dressing appropriately, and not placing others in danger. Four participants agreed they would allow survivors to re-enter the rehabilitation center multiple times, but their decision was affected by how the individual left the facility (i.e., destruction of property). One participant failed to discuss re-entry of DMST survivors to their rehabilitation center. A drug-free environment was promoted at all five rehabilitation centers. Three participants sent DMST survivors to an inpatient substance abuse detoxification and recovery program if they were found to be using drugs, one participant managed detoxification because of limited

substance abuse services in the area, and one participant failed to mention how they addressed DMST survivors who were using drugs. One participant restricted DMST survivors to only use the computer to search for information related to completing their academic assignments, while being supervised by a staff member. Another participant placed no restrictions on Internet use. The Internet usage among the remaining three participants was not discussed.

The policies related to staff included attendance and participation at staff meetings once a week, n=4 or once a month, n=1. Two participants always required at least two staff on-site, one participant did not list the quantity of staff on-site, but always had staff on-site around the clock, one participant always had one staff on-site with preset ratios of 1:8 during school and sleeping hours and 1:4 during wake and non-school hours, and one participant always had one staff on-site. The two other participants did not discuss the staffing ratios at their rehabilitation centers. The staff-to-survivor ratio differed across rehabilitation centers. One participant had a policy that staff was not allowed to be in a DMST survivors' bedroom at the same time as the survivor.

Two participants had external evaluations completed by their funders or licensing agency and one of these participants also conducted an informal, internal evaluation by collecting data through exit interviews, staff meetings and employee surveys. Two participants had not conducted an internal or external evaluation at the time of the interview, but were in the planning stages to conduct an evaluation. One participant demonstrated no interest in program evaluation.

All participants had a large quantity and array of volunteers serving at their rehabilitation center. Additionally, all participants received a diversity of funds ranging from private donors, n=5; local, n=1, and; federal government, n=4. Other program resources included individual and academic sponsorship, n=2, and material resources (i.e., van, additional buildings, Wii, computer, DVDs, new clothes), n=5. One participant provided their volunteers with written thank you notes from DMST survivors and held an annual volunteer recognition event.

All participants received referrals from a variety of sources including self, survivors' family members, law enforcement, community social service providers (i.e., shelters, non-governmental

organizations, group homes), Federal Bureau of Investigation (FBI), child protective services (CPS), and juvenile justice center probation department.

All participants stressed the importance of structure in the DMST survivors' daily schedule. Across the rehabilitation centers, it was common for survivors to be enrolled in school (public, private, online, general education development [GED] program) or work most of the day and attend workshops or programs in the evening. On the weekends, all participants planned recreational outings (i.e., attending museums, amusement parks), a time of relaxation (i.e., watching movies, cooking meals together), and family visits. Four participants provided family therapy during family visits and one participant provided DMST survivors with community passes to visit their family on the weekends.

Direct care staff composed the majority of staff with the highest employee turnover rate. The number of employees across the five rehabilitation centers ranged from 6 to 21. Five participants employed both full- and part-time staff. Two participants discussed the importance of having a diverse staff representing strong role models for survivors. Two participants recognized the importance of providing staff support (i.e., debriefing with a therapist, taking vacation time),  $n=1$ , and providing opportunities for staff to grow within the organization,  $n=1$ .

Four participants were able to articulate a treatment model including a trauma-informed, strengths-based, positive youth development, empowerment model with a status of change framework,  $n=1$ ; trauma-informed model,  $n=1$ ; strengths-based model and feminine theory,  $n=1$ , and; a social work model,  $n=1$ . One participant was unsure if their rehabilitation center used a particular treatment model.

Three participants did not have a formal vision statement at their rehabilitation center. The vision statements for the other two rehabilitation centers focused on eradicating CSEC and restoring the lives of children sexually exploited.

#### D. **Description of Services at Rehabilitation Centers**

The first aim was to describe services offered at rehabilitation centers for DMST survivors to address survivors' immediate, ongoing and long-term needs. Below is a description of services at

participating rehabilitation centers to meet the immediate, ongoing and long-term needs of DMST survivors:

1. **Immediate needs**

Four immediate needs (immediate safety, emergency shelter, basic necessities, and emergency medical care) identified by Macy and Johns (2011) were identified by participants from the rehabilitation centers. Language interpretation and crisis legal advocacy were included in Macy and Johns's (2011) framework, but were not identified as immediate needs by the participants. All participants identified immediate safety as an immediate need. One participant stated, "I think when they walk in the door their immediate need is to understand that they are protected and safe. So establishing a sense of safety and protection is important for these girls. That's one of the immediate needs." All participants provided emergency shelter at their rehabilitation centers for incoming DMST survivors. Three participants identified basic necessities as an immediate need, but all participants provided basic necessities for DMST survivors entering the rehabilitation center. One participant stated, "We try to make sure that all immediate needs, you know, food, clothing if they need it, shower, if they want it, and then rest is the first options for them." All participants identified emergency medical care as an immediate need of a DMST survivor. One participant reported, "Health care is the first thing that is addressed." Macy and Johns (2011) identified comprehensive and coordinated case management throughout every phase of addressing DMST survivors' needs. All participants provided some level of initial case management in the form of conducting a biopsychosocial assessment and developing a service plan based on the survivors' needs identified from the assessment. One participant stated, "Well, within 72 hours there's a needs and service plan that's done."

Participants identified additional immediate needs not identified by Macy and Johns (2011): emergency mental health care, emergency substance abuse services, initial family involvement, and educational re-entry. Four participants identified emergency mental health care as an immediate need. One participant stated,

We set up appointments with the psychologist, you know, and then the psychologist determines...You know, and we set-up an appointment with the doctor. The psychologist makes recommendations whether or not they think the child needs to be on medication. If the child needs to be on medication then we set up an appointment with the psychiatrist and, you know, so you're talking about a week or two trying to get all that coordinated.

All five participants identified emergency substance abuse services as an immediate need. One participant stated,

If a child comes in and says that I've used cocaine, I've used marijuana or what have you, we have a drug and alcohol assessment done, then from that assessment we determine how deep the problem is. If the child needs to be in inpatient therapy for substance abuse then that's something that they need to go through first before they come back to our program.

Three participants encouraged initial family involvement upon a survivor's entry into the rehabilitation center. One participant stated,

We know in congregate care that family involvement is the number one predictor of resiliency and so if they don't have any family I will shake that tree and find an aunt in New York that's willing to just talk to her once a week.

Two participants provided educational re-entry services. One participant stated, "School and kind of getting back into school and figuring out what an educational goal looks like and what you're interested in and what you want to do...I would say those are kind of the critical pieces." In summary, the immediate needs identified by participants were immediate safety, emergency shelter, basic necessities, emergency medical care, emergency mental health care, emergency substance abuse services, initial case management, initial family involvement, and educational re-entry.

## 2. **Ongoing needs**

Five ongoing needs (physical health care, mental health care, substance abuse services, safety services, and legal advocacy) identified by Macy and Johns (2011) were reported by participants from the rehabilitation centers. Transitional housing, immigration advocacy, and language

services were included in Macy and Johns's (2011) framework, but were not identified as ongoing needs by the participants. All participants provided ongoing physical health care. One participant stated, "So that's kind of it on a sort of week-to-week basis besides, you know, every now and then doctor's appointments and there's medication appointments." All participants provided ongoing mental health care. One participant stated, "You know, I run two of the groups a week. Another therapist runs groups another day of the week and the caregivers, the direct care staff facilitate two of the other groups." One participant identified ongoing substance abuse services and reported, "...depending on kind of what you're dealing with, right, there might be like a substance abuse group that's mandatory or something." All participants provided safety services through camera and/or door security systems. Four participants identified legal advocacy as an ongoing need. One participant stated, "She had an attorney that was appointed, you know by the feds or whoever the attorney was appointed by and we collaborated with that attorney to be able to put that particular perpetrator behind bars." All rehabilitation centers engaged in case management. One participant stated,

And in that service plan there are various goals and various service plans that they have to go by before they can be discharged...So we look at every individual, individualized treatment planning and see, you know, what each individual needs and take it from there.

Moreover, two participants identified religious practices (i.e., praying before meals and attending worship services) as another ongoing need not identified by Macy and Johns (2011). In summary, the ongoing needs identified by the rehabilitation centers were physical health care, mental health care, substance abuse services, safety services, legal advocacy, case management, and religious practices.

### 3. **Long-term needs**

Three long-term needs (life skills training, job skills training and long-term housing) identified by Macy and Johns (2011) were reported by participants from the rehabilitation centers. The participants did not mention language skills, which was originally included in Macy and Johns's (2011) framework. All participants identified life skills training as a key service provided at their rehabilitation centers. Examples of life skills highlighted throughout the interviews were building healthy relationships

with peers, grocery shopping, navigating public transportation, cooking, and building a support network among service providers. Two participants mentioned following an independent living curriculum at their rehabilitation center. Three participants identified job skills training as a service provided at their rehabilitation center. Two participants mentioned DMST survivors were enrolled in a GED/trade school program including certified nursing assistant or cosmetology. Creating resumes, looking for employment, role-playing for job interviews, and participating in a vocational training program were provided at the rehabilitation centers. All participants discussed long-term housing upon the DMST survivor leaving the rehabilitation center. One participant stated, “We’ve gone through periods where we’ve housed individuals for a couple of months at a time...always trying to get them into a more secure, stable permanent housing.” All participants engaged in case management either by assisting DMST survivors in finding a job, locating housing or applying for college.

Furthermore, participants identified two long-term needs not identified by Macy and Johns (2011): family reunification and higher education. All participants provided family reunification, including supervised and unsupervised visitations, family counseling, and re-establishment of family connections. All participants discussed the importance of being involved in a GED program or alternative high school. Additionally, all participants encouraged DMST survivors to enroll in higher education and provided information and assistance to apply for available college scholarships. In summary, the long-term needs that were identified included life skills training, job skills training, long-term housing, case management, family reunification, and higher education.

#### E. **Frequency of Core Services at Rehabilitation Centers**

As shown in Table V, seven core services identified by Macy and Johns (2011) to address sex trafficking survivors’ needs were provided internally or externally by all participants. However, Macy and Johns’s seventh core service, job and life skills training, was divided into two separate core services resulting in eight core services.

Three out of five participants provided all eight core services at their rehabilitation centers. The core service, job and life skills training, was divided in this section because not all participants provided

job and life skills training at their rehabilitation center and participants reported these services separately. Additionally, immigration advocacy was removed from legal advocacy, since participants did not identify it as a service provided at their rehabilitation center. All participants internally provided basic necessities, secure, safe shelter and housing, mental health care, and life skills. All participants externally provided physical health care services through collaborative partnerships with primary care providers and local hospitals. One participant provided internal legal services (e.g, lawyer on-site), while the legal services at the three remaining rehabilitation centers were provided externally (e.g., state appointed attorney, outside law firm). Substance abuse services were provided either externally through an inpatient, hospital substance abuse detoxification program, n = 3, or internally through a substance abuse group, n=1, or on-site detoxification, n=1. Two participants provided jobs skills training by externally connecting DMST survivors to a vocational training program (e.g., cosmetology, certified nursing assistant) in the community and one participant internally assisted DMST survivors with developing computer skills, writing resumes, and role playing interviews.

**TABLE V**  
EIGHT CORE SERVICES TO ADDRESS DMST SURVIVORS' NEEDS

Rehabilitation Center	1. Basic Necessities	2. Secure, Safe Shelter, and Housing	3. Physical Health Care	4. Mental Health Care	5. Legal Advocacy	6. Substance Abuse Services	7. Job Skills Training	8. Life Skills Training	Total (n) Core Services
1	X	X	X	X	X	X	X	X	8
2	X	X	X	X	X	X	X	X	8
3	X	X	X	X	X	X		X	7
4	X	X	X	X	X	X	X	X	8
5	X	X	X	X		X		X	6
<b>Total (n) Centers</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>5</b>	<b>3</b>	<b>5</b>	<b>37</b>

F. **Common Practices Across Rehabilitation Centers**

The original plan for this study was for all participants from rehabilitation centers to provide objective outcome data. However, only one participant provided objective outcome data from their rehabilitation center, which made it difficult to propose essentials and best practices for rehabilitation centers servicing DMST survivors. Therefore, common practices were identified through the inclusion of characteristics represented in four or more rehabilitation centers, as shown in Table VI. The characteristics excluded were alumni involvement, objective outcomes, program evaluation, and vision.

**TABLE VI**  
COMMON CHARACTERISTICS ACROSS REHABILITATION CENTERS

Rehabilitation Center	Barriers & Challenges	Board of Directors	Collaborative Partners	Employee Orientation	Institutional Policies	Mission	Neighborhood Perception & Sentiment	Ongoing Staff Training	Philosophy	Policies r/t Youth	Policies r/t Staff	Program Resources	Referrals	Schedule	Staffing	Treatment Model
1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
4	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
<b>Total (n) Centers</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>5</b>	<b>4</b>

Also, common practices were identified through the inclusion of services to meet immediate, ongoing, and long-term needs of DMST survivors represented in four or more rehabilitation centers. See Appendix E for an adapted model of Macy and Johns's framework.

## V. DISCUSSION

### A. Common Practices Across Rehabilitation Centers

A discussion of common practices across four or more participating rehabilitation centers will be discussed. These common practices were categorized as organizational structure, staffing, daily operations, and services to meet DMST survivors' needs. Even though, a description of common practices across the rehabilitation centers will be provided, this is no indication that these practices are equivalent to best practices.

#### 1. Organizational structure

The individual foci of the rehabilitation centers' mission statements complimented Macy and Johns's (2011) aftercare service delivery framework by addressing the needs of DMST survivors and empowering DMST survivors to develop into their full potential. The community foci of their mission statements complimented Bronfenbrenner's (1979) ecological theory by engaging the community, transforming the communities' public perception, and changing the systems and policies around the commercial sexual exploitation of children (CSEC). All rehabilitation centers had a board of directors to guide and keep them centered on carrying out their mission.

Clawson and Goldblatt-Grace (2007) recommended designing programs to provide trauma-informed services; however, the effectiveness of trauma-informed services has not been evaluated with this population (Macy & Johns, 2011). Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) define trauma-informed organizations as organizations that have a better understanding of the vulnerabilities and triggers of trauma survivors, so they can provide services that are more supportive and avoid re-victimization. Shigekane (2007) acknowledged that an understanding of trauma and trauma-informed programs are essential to designing effective treatment programs for DMST survivors. In this study, two participants based their programs on a trauma-informed model and two other participants based their programs on a non-trauma informed model.

All participants established institutional policies either based on government regulations of the rehabilitation center or the medical needs of the survivors. The availability of governmental funds is

crucial for the existence of rehabilitation centers, but these funds create their own limitations for providing services to DMST survivors. All participants discussed the affect of government regulations on program operations. Two participants discussed how funders placed restrictions on the population eligible for services at their rehabilitation centers. For instance, funders limited services to DMST survivors who were referred only under the status of homeless or runaway. One participant discussed how they allocated one bed for any DMST survivor indifferent from funders' eligibility criteria for services. Chen, Garrett, and Waldrop (2009) recommended the government administer fewer, larger grants in order to diminish the bureaucratic burden and afford an opportunity to advance sustainable systems and structures permitting practitioners to concentrate on program outcomes. Even though there are limitations to receiving government funding, the existence of these rehabilitation centers would not be possible without their financial support. Short-term, fixed funding was not recommended because it did not meet the long-term needs of children (Asquith & Turner, 2008). Asquith and Turner (2008) stated, "This is an area that requires financial commitment and long-term programming" (p. 24). Ultimately, continuous, long-term funding or a combination of short- and long-term funding was recommended to meet the needs of DMST survivors (Asquith & Turner, 2008).

Participants developed policies related to addressing the needs of DMST survivors at their rehabilitation centers. Policies related to medical needs were a common finding among the rehabilitation centers. All participants completed a comprehensive assessment of survivors' physical and mental health needs upon admission. This assessment is imperative to the survivors' road to recovery. Zimmerman et al. (2008) studied women and adolescents who sought services after exiting sex trafficking. Zimmerman et al. (2008) found severe, concurrent physical and mental health symptoms among newly trafficked women suggesting the immediate delivery of treatment services to DMST survivors. The exact instrument participants used to assess the physical and mental health needs of the DMST survivors was unknown, but the use of a validated tool for this population is encouraged. To the researcher's knowledge, there has only been one validated tool used to assess

psychiatric disorders among trafficked women, the Structured Clinical Interview for DSM-IV (Ostrovski et al., 2011).

## 2. **Staffing**

All participants identified staffing as a challenge to operating a rehabilitation center for DMST survivors. Staff found working with the sex trafficked population was more difficult than working with any other vulnerable group (Kliner & Stroud, 2012). Staff frequently described burnout and other adverse effects on their psychological and physical health leading them to leave their positions (Kliner & Stroud, 2012). Two participants identified frequent staff turnover related to employee burnout. Additionally, one participant recognized the direct care staff position as having the most frequent turnover. Kliner and Stroud (2012) emphasized the importance of providing better training to equip staff with tools to handle the challenges of working with this vulnerable population. This recommendation was made based on the finding that staff reported feeling under supported and under trained by their organizations (Kliner & Stroud, 2012). Moreover, all participants employed full- and part-time staff. Employing part-time staff may assist in employee retention, but could be viewed as a barrier for DMST survivors to build trust with staff.

Four participants discussed new employee orientation lasting anywhere from one week, n=2; multiple days, n=1, to; two weeks, n=1, at their rehabilitation center. One participant provided a table of contents for their new employee training. Five participants emphasized the importance of weekly or monthly ongoing staff meetings and training. Further research on the effectiveness of new employee orientation and ongoing employee training on staff retention at rehabilitation centers for DMST survivors is recommended. Pierce (2012) found that one of the major lessons learned about working with trafficking individuals was the importance of practicing intensive self-care. Staff working with this population is exposed to secondary trauma. Pierce (2012) stressed the importance of weekly staff meetings to discuss challenges, to support one another, and to work together to resolve any problems. Further research is needed on employee's lived experience working with DMST survivors. It is important to appropriately train staff to protect DMST survivors from any further harm (Asquith &

Turner, 2008). Additionally, finding staff with relevant skills and expertise is key to the success of recovery and reintegration programs (Asquith & Turner, 2008). Asquith and Turner (2008) identified that minors need consistency and continuity to support them through their recovery process, which has proven to provide better outcomes. It is important to attract well-qualified, skilled and experienced staff to work with DMST survivors (Asquith & Turner, 2008).

All participants emphasized the importance of collaborative partnerships (individuals or entities providing professional services). Additionally, volunteers (individuals who gave of their time without using their professional skills) were an undeniable contribution to program operations. These collaborative partnerships were inclusive of medical professionals (i.e., physicians, dentists, optometrists), mental health professionals (i.e., therapists, psychiatrists, psychologists, drug and alcohol counselors, social workers), law enforcement personnel (i.e., vice cops, local police officers, hospital security guards), educators (i.e., teachers), and legal professionals (i.e., attorneys, lawyers). Building collaborative partnerships is one way to utilize current community resources and provide consistent services to DMST survivors at a low cost to the rehabilitation center (Chen et al., 2012). With the current state of the economy, it is unrealistic and unwise to think that an array of services for DMST survivors can be provided by one provider. A collaborative system of care for survivors allows for long-term and more sustainable solutions in order to benefit both the individual and the community.

### 3. **Daily operations**

All participants identified receiving referrals from a variety of sources including self, survivors' family members, law enforcement personnel, community social service providers (i.e., shelters, mental health centers), FBI, CPS, or juvenile justice probation department. Unfortunately, nurses were not identified as a referral source. Nurses play a critical role in encountering and identifying DMST victims and intervening by referring them to a rehabilitation center for DMST survivors (Sabella, 2011). Nurses need to be educated on how to identify a DMST victim and how to refer a DMST victim to a rehabilitation center.

Another area recommended for further exploration is the interagency relationship

between rehabilitation centers. As mentioned earlier, the number of beds across the rehabilitation centers ranged from 5 to 48 with a total capacity of 90 beds. Three rehabilitation centers had never been at full capacity and two rehabilitation centers were commonly at full capacity with a waiting list. A rationale behind this finding may be related to the geographic location of the DMST survivors. For example, one rehabilitation center's referral source was heavy on local referrals from families; however, this rehabilitation center had opening beds. More research is needed to examine type of referrals received (local versus out-of-state) and type of referrals either denied services at a rehabilitation center or transferred to another rehabilitation center. This data would provide a better understanding of the collaborative partnerships between providers at various rehabilitation centers for DMST survivors.

All participants acknowledged that the safety of the neighborhood did not decrease with the addition of the rehabilitation center. In some cases, the establishment of a rehabilitation center led to neighborhood improvement. Often times, individuals in the neighborhood focus on reducing the problem of trafficking in their community instead of being part of the solution (Hughes, 2004; Clawson & Goldblatt-Grace, 2007). When involving the community in the planning stages of building a rehabilitation center, Williamson and Baker (2008) experienced a positive outcome. The Salvation Army in Chicago experienced the same outcome when they developed a task force in 2005 to combat CSEC. The development of a rehabilitation center in Chicago was an initiative from this task force. Individuals in the community may be willing to get involved in combating sex trafficking, but may become resistant to the idea of a rehabilitation center being established in their neighborhood related to safety and stigma. However, this idea appears to be counteracted when individuals in the community are involved in the planning stages of developing a rehabilitation center. More research is needed on the perception and outcome measures of neighborhoods with a rehabilitation center for DMST survivors.

All participants accepted private donations and diversified their funding sources at their rehabilitation centers. The challenge of limited funds to sustain these rehabilitation centers was an expected finding. In 2008, the annual individual grant budget for the Office to Monitor and

Combat Trafficking in the U.S. was roughly \$153,000 (Chen et al., 2009). In 2011, there was a decrease in federal funding with non-governmental organizations (NGOs) reporting, “victim funding levels were inadequate to provide comprehensive long-term victim care and key legal services” (U.S. Department of State, 2012, p. 360). All participants were found to diversify their funding entities related to the insufficient funds from each entity. According to two participants, the limited amount of funds prevented additional services from being provided and limited the diversification of staff. All participants collected private donations and recognized the importance of these donations to the development and operation of their rehabilitation center. In order to provide ongoing, comprehensive services to DMST survivors, more governmental funding is needed.

While similar services were provided at the rehabilitation centers, the founders’ philosophy heavily influenced the daily operations of the rehabilitation centers. Thomas Watson Jr., former Chief Executive Officer (CEO) of International Business Machines Corporation (IBM), (2003) stated, “...the basic philosophy, spirit and drive of an organization have far more to do with its relative achievements than do technological or economic resources, organizational structure, innovation and timing. All these things weigh heavily in success” (p. 5). In this study, the participant who presented with the strongest philosophical viewpoints was associated with the longest operating rehabilitation center. Further research is needed on the impact of leadership philosophy and the success of rehabilitation centers for DMST survivors. Common philosophical viewpoints found across the rehabilitation centers included: creation of a family oriented environment, n=5; provision of structure to the DMST survivors’ day, n=5; encouragement of survivors to contact the rehabilitation center during a crisis after discharge, n=4; emphasis on family involvement in the lives of DMST survivors, n=5, and; participation in formal education, n=5.

Often times, DMST victims lack family support related to either being orphans, runaways, homeless, and/or having family members who collaborated with their trafficker (Clawson, Dutch,

Solomon, & Goldblatt-Grace, 2009). However, all participants recognized the importance of family involvement to a survivor's recovery and provided supportive services (e.g., family therapy) to encourage the development of healthy family relationships. Clawson and Goldblatt-Grace (2007) recognized the need for survivors to develop healthy relationships with their peers, adults and family members. All participants emphasized the importance of creating a healthy family oriented environment with unconditional love, acceptance and ongoing support. To encourage family reunification, one participant went as far as flying family members to meet with DMST survivors at their rehabilitation center.

All participants stressed the importance of structure in the DMST survivors' daily schedule. Across all five rehabilitation centers, it was common for survivors to be enrolled in school (public, private, online, or GED program) or work most of the day. In the evenings, DMST survivors attended workshops or programs. All participants encouraged DMST survivors to receive an education. Further research is needed to explore various methods of re-entry into education after exiting sex trafficking (Kotrla, 2010). Additionally, all participants discussed the importance of survivors enrolling in a GED program. More research is needed to explore stigma associated with obtaining a GED degree in comparison to a high school diploma. On the weekends, all participants organized recreational outings (i.e., attending museums, amusement parks), a time of relaxation (i.e., watching movies, cooking meals together), and family visits at their rehabilitation centers. Four participants provided family therapy during family visits and one participant provided DMST survivors' with community passes to visit their family on the weekends. Ultimately, a schedule may decrease the anxiety of DMST survivors when they first come to a rehabilitation center providing them with predictability to their day. Additionally, structure may provide DMST survivors with a sense of normalcy and lower anxiety by allowing them to feel in control of planning his/her day and knowing what tomorrow will bring. A schedule may also enable DMST survivors to strive toward meeting their goals allowing a DMST survivor to gain control over his/her life.

Four participants encouraged DMST survivors to contact them during a crisis after discharge. One participant spoke of how years had passed and DMST survivors still called and provided updates on their whereabouts. Relapse from sex trafficking is a part of the recovery. Four participants agreed they would allow survivors to re-enter their rehabilitation center multiple times, but their decision to accept a DMST survivor back was based upon how they initially left (i.e., property damage, safety violation). Further research is needed to determine the frequency of relapse amongst DMST survivors. Dalla (2006) conducted a study on adult women exiting street-level prostitution; it was unknown how many of these women were originally trafficked as minors. At the time of follow-up, Dalla (2006) found that over 50% of the women returned to street prostitution. More research is needed on the long-term outcomes of DMST survivors who receive services at a rehabilitation center.

According to the researcher, one of the most interesting findings from this study was the discrepancy among rehabilitation centers on the amount of freedom, ranging from very liberal to very restrictive, DMST survivors were given. One participant was very liberal allowing DMST survivors to navigate public transportation to attend school, three participants were more conservative and drove DMST survivors to school, and one participant was very restrictive not allowing DMST survivors to leave the rehabilitation center. The varying restrictions placed on the DMST survivors appeared to be related to their safety. Some participants created a restricted environment related to their own fears of traffickers pursuing survivors after their exit. All participants protected the safety of their survivors either through alarm systems and/or cameras positioned inside and outside the premises and through their partnerships with local law enforcement. The U.S. has been increasing their “legal sophistication in the investigation, prosecution, and conviction of traffickers; and strengthened federal coordination efforts to improve identification of cases at the federal level” (U.S. Department of State, 2012). As more states pass new legislation to shift the prosecution from victims to traffickers (e.g., johns and pimps), they are less likely to be patrolling rehabilitation centers prying on survivors.

All participants discussed the importance of survivors obeying house rules. House rules consisted of maintaining a drug-free environment, completing assigned chores, obeying curfew, working towards individual treatment plans, dressing appropriately, and maintaining a safe atmosphere. The establishment of these rules fosters independence and empowers DMST survivors to become healthy, productive citizens in the community.

Program evaluation is a valuable resource to improving the quality and expanding the services of an organization, but is often times left undone due to a lack of resources (e.g., time, staff). This was evident finding in this study with two participants having external evaluations completed by their funders or licensing agency and one of these participants also conducting an informal, internal evaluation. Program evaluation is a way to objectively document the strengths of an organization (Royse, Thyer, Padgett, & Logan 2001). In general, program evaluation is extremely useful when requesting funds to further support program operations and/or embark upon new developments within an organization. Objective data can favorably influence funders to support organizations. As mentioned previously, all participants received funds from private donors. Additionally, published results from a program evaluation promote transparency within the organization. Further program evaluation research should be conducted on rehabilitation centers for DMST survivors to determine if there is necessary, high quality, cost-effective services being provided.

#### 4. **Services to meet DMST survivors' needs**

A holistic approach to address the physical, psychological, and emotional needs of DMST survivors is necessary (Mayhew & Mossman, 2007). Throughout the years, several researchers have recommended an array of services to be provided to sex trafficking victims. Willis and Levy (2002) emphasized the need for sustainable medical and psychological support, education, and vocational training after exiting a trafficking situation. Williamson (2006) emphasized the need for case management, safe and long-term housing, education, vocational training, medication management, trauma treatment, all under the care of qualified, educated, and empathetic staff. Additionally, Spear (2004) identified an expansive range of resources

needed for rehabilitating trafficking survivors including medical care, education, substance detoxification, counseling, job skills, and residence. Busch-Armendariz, Nsonwu, and Heffron (2011) conducted a qualitative study on adult women exiting trafficking identifying five long-term needs of these women including safety, medical health, emotional and psychological health, financial stability, and social and familial equilibrium. Most recently, recommendations on steps to reinstate psychological well-being were published in the 2012 Trafficking in Persons (TIP) Report including ensuring survivors' safety, soliciting the support of health providers' knowledge in trauma-centered care, providing collaborative therapies, creating an environment that fosters empowerment, assessing for medical conditions and mental illness, providing unconditional support, supporting social and family reunification, rebuilding identity, and re-establishing skill sets and self-esteem (U.S., Department of the State, 2012). These recommended services were similarly represented in Macy and Johns's (2011) framework for a continuum of aftercare services to address sex trafficking survivors.

In this study, Macy and Johns's (2011) framework for aftercare services for sex trafficking survivors' changing needs was used as a guide to identify services that should be provided to DMST survivors compared to services that are actually provided to DMST survivors. The immediate needs provided across all participating rehabilitation centers included immediate safety, emergency shelter, basic necessities, emergency medical care, and initial case management. In addition to those services, the immediate needs provided across four out of five participating rehabilitation centers were emergency mental health care and emergency substance abuse services. The ongoing needs provided across all participating rehabilitation centers included physical health care, mental health care, safety services (i.e., cameras, security systems), and case management. In addition to those services, an ongoing need provided across four out of five participating rehabilitation centers was legal advocacy. The long-term needs provided across all participating rehabilitation centers included life skills training, long-term housing, case management, family reunification, and higher education.

Three participants provided all eight core services recognized by Macy and Johns (2011)

including: basic necessities; secure, safe shelter and housing; physical health care; mental health care; legal advocacy; substance abuse services, job skills training, and; life skills training at their rehabilitation centers. Job skills training is an area that is in need of further development. Recognition that not all services can be provided internally is key and the use of external services involving an array of community providers is encouraged. This is an area where volunteers could easily fulfill this service need by assisting DMST survivors in creating a resume, teaching them how to search for employment and role-playing for interviews. Further research is needed to explore difficulties DMST survivors have in finding a job related to a criminal history of felony. All rehabilitation centers identified family reunification and higher education as key services provided at their rehabilitation centers. Further research is needed on the expansion of core services to include family involvement and education.

B. **Framework**

Macy and Johns (2011) conducted an extensive literature review for the purpose of developing a framework for a continuum of aftercare services to address international sex trafficking survivors' changing needs. Their framework was used in this study as a guide to discuss the services provided at U.S. rehabilitation centers for DMST survivors. To the researcher's knowledge, this is the only framework that exists for providing aftercare services to sex trafficking survivors. The researcher was aware of the international focus of this framework, but given the statistics that 14,500 to 17,500 individuals are trafficked annually into the U.S., the researcher thought there would be a greater number of international victims served at these rehabilitation centers and would fit nicely with this study (U.S. Department of State, 2006). However, only one participant spoke of services provided to a few international victims since the existence of their rehabilitation center. Three participants were open to providing services to international DMST victims, but had not provided services to international victims at the time of the interview. Further research is also needed to explore where the majority of international victims are receiving aftercare services and if they are receiving comprehensive aftercare

services like those offered at the participating rehabilitation centers. This is why these services (language interpretation, crisis legal advocacy, immigration advocacy, language services, and language skills) were not utilized across these rehabilitation centers. Macy and Johns (2011) discusses the importance of creating a continuum of aftercare services. This study advanced science by adapting Macy and Johns's framework through the inclusion of additional services and removal of other services resulting in the Twigg aftercare services for domestic minors of sex trafficking model (see Appendix E). In this study, participants not only spoke of the emergency medical care, as identified by Macy and Johns (2011) as an immediate need, but they also spoke of emergency mental health care and emergency substance abuse services as immediate needs. Therefore, substance abuse services were seen by all participants as more of an immediate need than an ongoing need. Furthermore, educational re-entry, higher education, initial family involvement, and family reunification were additional service areas identified by the participants. However, only higher education and family reunification were identified as common practices. Further research is needed on the inclusion of initial family involvement and educational re-entry as services to address DMST survivors' immediate needs. Moreover, there were three faith-based organizations in this study. Further research is needed on the incorporation and impact of religious practices into services provided at rehabilitation centers for DMST survivors. Also, further research comparing the effectiveness of faith-based and secular rehabilitation centers for DMST victims in the U.S. is needed.

Macy and Johns's (2011) framework was integrated with Bronfenbrenner's (1979) ecological theory. Since the environment instead of the individual was the focus of this study, there were no findings to comment on the microsystem and mesosystem. The exosystem relates to the broader community in which the DMST survivor lived including extended family, mass media, place of employment, neighborhood, legal services, social welfare services, and health care services. In this study, participants discussed the initial resistance from individuals in the neighborhood related to the establishment of a rehabilitation center for DMST survivors. Other participants spoke of the

improvement within the neighborhood related to the establishment of the rehabilitation center. The macrosystem contains the attitudes and ideologies, values, laws and customs around the topic of sex trafficking. A finding from this study relative to the macrosystem layer was the impact of the depressed economy and changes in political leadership. These two things alone impacted the funding stream toward aftercare services, which affects the recovery of DMST survivors. Furthermore, the increased media coverage on the topic of sex trafficking involving underage sex advertisements on Backpage and Craigslist, in addition to, FBI sting operations leading to the prosecution of sex traffickers across the country are additional examples found within the macrosystem layer. In 2012, there was a great movement in the anti-trafficking legislation including the composition of 344 bills with 69 of those bills becoming laws in the U.S. (B. Vanderhoof, personal communication, June 29, 2012). The macrosystem like all these contexts is ever-changing. In this study, the chronosystem represented life transitions that took place in the lives of DMST survivors. Examples included relapse back to the “life”, moving in with family, moving into their own apartment, or going to college. The integration of these two frameworks provided a holistic view of how environment affects the quality and quantity of services provided to DMST survivors.

### C. **Limitations**

This study was an initial step in understanding the actual services provided at rehabilitation centers for DMST services. Even though the sample size for this study was small, it was adequate for a qualitative study. The sample size for this study represented 50% of known rehabilitation centers, as defined in the inclusion criteria. A limitation of this study was the novice interviewing skills of the qualitative researcher. During data analysis, the researcher identified additional opportunities for further probing in the interviews. The inability to observe the natural settings of the rehabilitation centers was another limitation of this study. Another limitation of this study was the use of only one interviewing method, telephone interviews. The researcher originally planned to collect data using three different interviewing methods: face-to-face, telephone and Nefsis. Hamilton and Bowers (2006) found telephone interviews were comparative in the quality of data collected to face-to-face interviews.

However, the researcher questions this finding since some of the participants were noticeably distracted (i.e., typing, phone calls, dog chocking) during the interview. Future research should compare the quality of data collected using various interviewing methods. Moreover, only one participant was forthcoming about their outcomes, which was a major limitation of this study. Triangulation would have contributed to ensuring quality data. Additionally, objective outcome data would have added to the richness of the data and reflected the complexity of providing rehabilitative services to DMST survivors. Also, it would have provided the researcher with an opportunity to reflect on best practices for rehabilitation centers. A limitation of this research design, qualitative description, is the lack of drawing causal inferences. More rigorous studies are needed to make causal inferences. Lastly, another drawback to qualitative research was subjectivity. However, maintaining the properties of qualitative description diminished this limitation.

The identification of information-rich participants was a strength of this study. The participants selected for this study were the best informants to answer the research question. Also, the researcher was fortunate to have a “gatekeeper” as part of the sample (Illingworth, 2001). This participant assisted the researcher in recruiting additional participants for the study. Another strength of this study was its cost effectiveness, since all interviews were conducted via telephone.

#### D. **Implications**

##### 1. **Practice**

This study provided insight into the services that are actually being provided to DMST survivors. There is a range of implications for practice that can be drawn from this study. Founders and/or program managers at rehabilitation centers can determine if they are providing the common services that meet DMST survivors’ needs by comparing the findings from this study to the actual services they are providing at their rehabilitation center. For instance, there were two rehabilitation centers in this study that did not provide job skills training. Job skills training was identified as a core service to meet the long-term needs of sex trafficking survivors (Macy & Johns, 2011). This service can easily be provided through the development of community connections, whether it comes in the form of

volunteers assisting DMST survivors to create a resume or a community organization offering a free workshop on resume building or role playing job interviews. This latter statement segues nicely into the next implication for practice. In the climate of a depressed economy and insufficient allocation of funds to support aftercare services for DMST survivors, communities need to come together to provide comprehensive services to address the immediate, ongoing and long-term needs of DMST survivors. Further research needs to explore the dynamics of collaborative relationships amongst rehabilitation centers for DMST survivors. Founders and/or program managers at rehabilitation centers should consider expanding and strengthening their collaborative partnerships with other community agencies, in addition to other rehabilitation centers across the U.S. Further research is needed to explore the dynamics of collaborative partnerships among rehabilitation centers for DMST survivors. Additionally, rehabilitation centers should develop programs that are trauma-informed.

Furthermore, nurses working in the emergency room, primary care clinic, or school have a pivotal role in identifying and assisting DMST victims in exiting a trafficking situation and connecting them with aftercare services (Goldblatt-Grace, Starck, Potenza, Kenney, & Sheetz, 2012). Nurses are in a key position to develop collaborative partnerships among community providers to provide the recommended services identified through this study. Nurses are also in a reputable position to advocate for the needs of DMST victims. Only eight states across the country have recognized CSEC as victims rather than criminals (N. Marquez, personal communication, April 30, 2012). Nurses can advocate for the passage of new legislative to identify these children as victims in need of aftercare services. Also, nurses are in a position to shift the perceptions of health care providers on the treatment of commercially sexually exploited children and bring awareness to the needs of sexually exploited children.

## 2. **Research**

Based on new findings from this study, further research on the development of a framework for aftercare services to address sex trafficking survivors' needs is warranted. The development of the Twigg aftercare services for domestic minors of sex trafficking model is only

the beginning to understanding the services needed to address the immediate, ongoing and long-term needs of DMST survivors in the U.S. The next step would be to evaluate the effectiveness of these rehabilitation centers that provide the recommended services to determine if these services meet the needs of DMST survivors. By determining the effectiveness of these services in meeting the needs of the survivors, researchers will be able to identify best practices for rehabilitation centers. Effectiveness of services provided at these rehabilitation centers can be determined by conducting experimental studies such as, longitudinal prospective and retrospective studies to determine the outcome of DMST survivors and the impact of these services on their recovery. This idea was supported by Laczko (2005):

To really understand the long-term impact of trafficking there is a need for more investigation into the experiences of survivors and the extent to which they are able to integrate or reintegrate into their communities and recover both physically and mentally from their ordeal (p. 9).

Also, more research is needed to focus on exploring different models for providing aftercare services to DMST survivors. One may consider conducting a comparative analysis between two different types of organization (faith-based versus secular providers) using the same model or between two different models (rehabilitation centers versus host families with community support) in order to determine the most sustainable and effective model for meeting the needs of DMST survivors.

Further exploration is needed to focus on where international sex trafficking victims are predominately receiving aftercare services and how these services compare to services provided through rehabilitation centers. Additionally, further research is needed to explore why some rehabilitation centers are not operating at full capacity and the relapse rate among DMST survivors. An area that has been untouched is the perception of the neighborhood after the development of a rehabilitation center. More research is needed on the demographics of staff working with DMST survivors and the rate of employee burnout. Also, more research is needed

to explore the effectiveness of new employee orientation and ongoing employee training and how this relates to staff retention. More research is needed to explore the lived experience of staff working with DMST survivors. These are all ways to study employee retention at rehabilitation centers for DMST survivors. Additionally, more research is needed to explore the various methods of re-entry for DMST survivors after exiting a trafficking situation. More research is needed to explore the lived experience of DMST survivors in regards to re-entry to public school and associated barriers. More program evaluation research is needed to explore the various levels of restrictions placed upon DMST survivors. Further research is needed to study the impact of leadership philosophy on the success of rehabilitation centers for DMST survivors.

A recommendation listed in the TIP 2012 is to improve data collection and analysis of human trafficking cases (U.S. Department of State, 2012). Through the development of systems for data collection, further research is needed to focus on the representation of DMST survivors seeking treatment at these rehabilitation centers (Laczko, 2005). These findings could result in tailoring interventions to meet the population needs of DMST survivors. The researcher supports this recommendation given only one participant generated objective outcome data.

#### E. **Conclusion**

This study provided a fuller understanding of the range of services offered across five U.S. rehabilitation centers and identified how these services addressed the immediate, ongoing and long-term needs of DMST survivors, as identified by Macy and Johns (2011). The two major scientific advancements of this study were the refinement and expansion of Macy and Johns's (2011) core services to address survivors' needs and the adaptation of Macy and Johns's (2011) framework to create the Twigg aftercare services for domestic minors of sex trafficking model (see Appendix E). Overall, our understanding of aftercare services for DMST survivors

remains limited. In the end, it will take a collective and coordinated effort among practitioners and researchers to expand our knowledge on aftercare services for DMST survivors in order to impact the care we provide to this vulnerable population.

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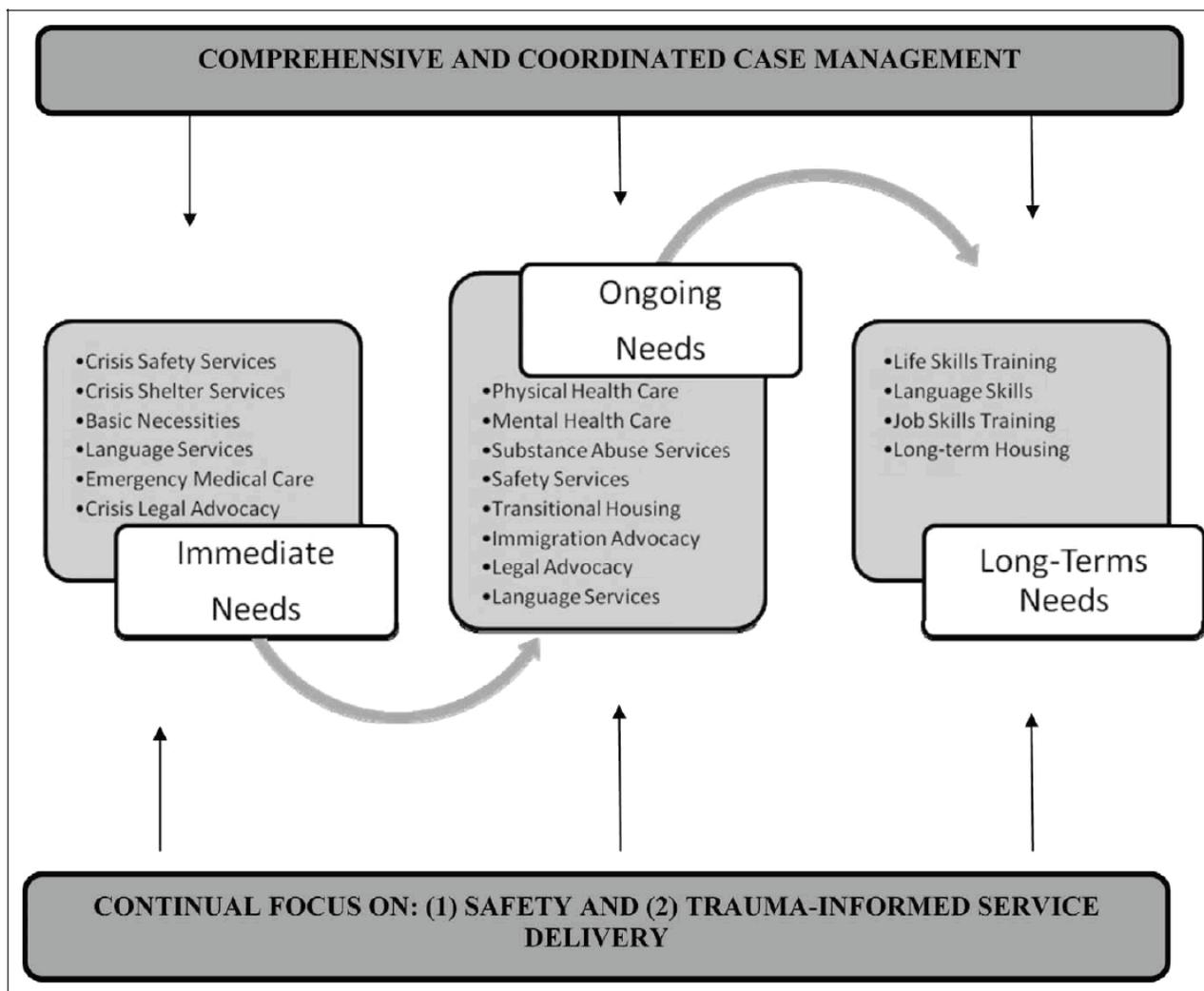
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## APPENDICES

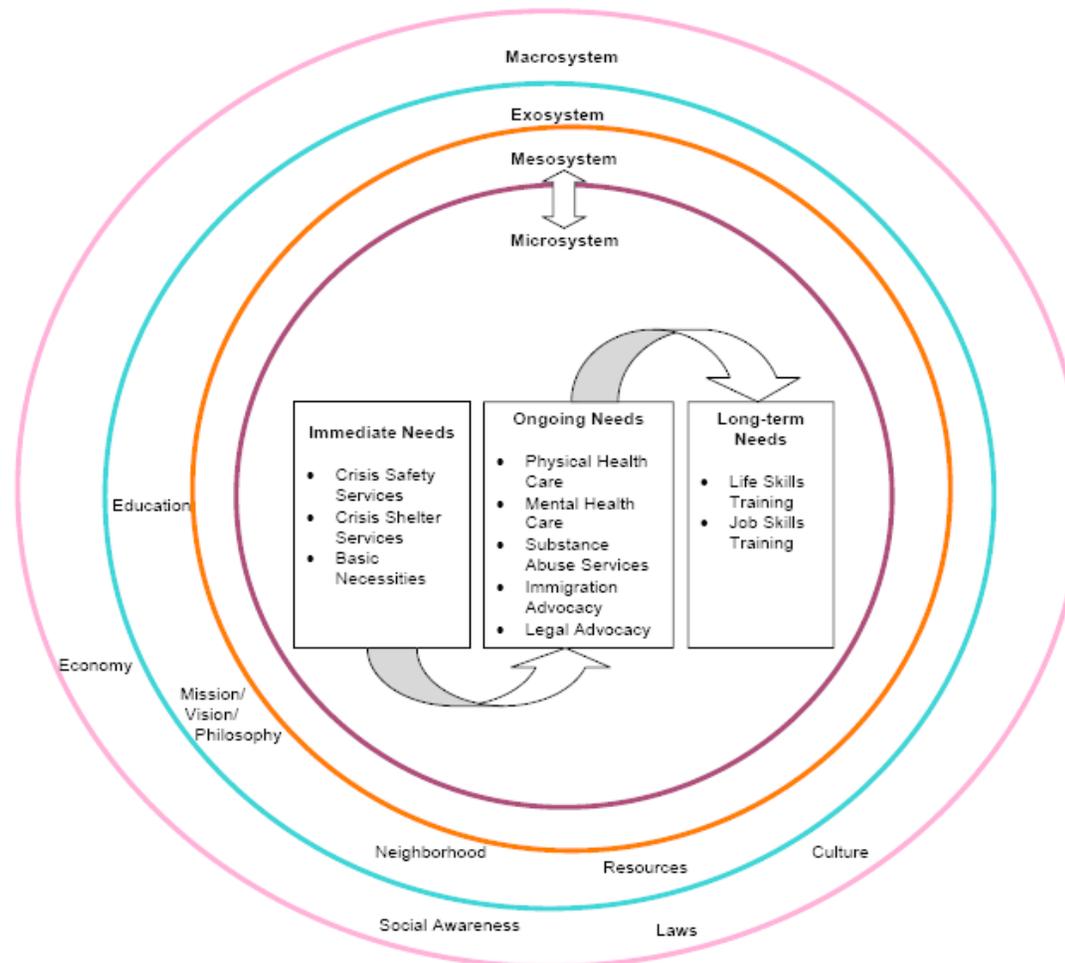
### APPENDIX A

Macy and Johns's framework for aftercare services to address sex trafficking survivors' needs.<sup>13</sup>



## APPENDIX B

A framework for aftercare services to address sex trafficking survivors' needs within Bronfenbrenner's ecological theory.<sup>13;15</sup>



## APPENDIX C

### Semi-Structured Interview Guide

#### I. Introduction (~ 1 minute)

A. Today, I am here to gather more information about the components of your rehabilitation program for domestic minors of sex trafficking. The Victims of Trafficking and Violence Protection Act of 2000 defines sex trafficking as “a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.” The purpose of this research study is to gain a better understanding of the services your rehabilitation center provides to domestic minors of sex trafficking.

#### II. Description of population served at the rehabilitation center (~ 8 minutes)

*I would first like to ask you about the population served at your rehabilitation center.*

A. Describe the population your rehabilitation center serves.

*Probe:* Age, males, females, transgender, ethnicity, race, country of origin, level of education, length of time trafficked, languages spoken?

B. How are survivors referred to your rehabilitation center?

*Probe:* Who refers survivors to your center?

*Probe:* How do you receive referrals?

*Probe:* What percentages of referrals are received from social services, law enforcement, etc.?

*Probe:* What percentage of survivors voluntarily enters your rehabilitation program? Court mandated?

#### III. Rehabilitation Center (~ 30 minutes)

A. What are the mission, vision and philosophy of your rehabilitation center?

B. Describe the treatment model your center uses.

*Probe:* Why did you select this model for your center?

C. Does the center have an advisory board?

*Probe:* How many members are on the board?

*Probe:* Describe the selection process for board members.

D. Describe funding sources for your center and provide the percentage allocation of this funding source to your overall budget.

*Probe:* Private donors?

*Probe:* Grant monies from governmental entities?

*Probe:* Grant monies from private organizations?

*Probe:* Other sources of funding?

E. How did you select the location for your facility?

*Probe:* Why did you select this area?

F. Describe the safety protocols your center has implemented.

*Probe:* Security alarm system?

*Probe:* Assistance from law enforcement?

G. How are beds assigned?

*Probe:* By age?

H. Describe the neighborhood's response to this type of center.

*Probe:* List challenges your center has faced by being in this neighborhood.

I. Describe other challenges your center has faced.

*Probe:* Limited funding?

J. Describe achievements of your center.

*Probe:* Awards?

### APPENICIX C (continued)

#### IV. Employees & Staff Development (~ 30 minutes)

A. On average, how many employees work at the center?

*Probe:* Administrators?

*Probe:* Administrative support?

*Probe:* Clinicians (nurses, doctors, social workers, therapists, psychiatrists)?

*Probe:* Educators?

*Probe:* Support staff?

*Probe:* Volunteers?

*Probe:* Security?

B. Describe your employees' level of education, type of license(s) and certification(s).

C. What is the employee ratio of males to females?

D. Describe your training program for new employees.

*Probe:* What topics do you cover in new employee training?

E. What is the length of your new employee-training program?

F. Describe ongoing staff development training. How frequently is ongoing training provided?

G. Describe the support services available to employees when working with a challenging survivor.

*Probe:* Emotional support?

H. What is the rate of employee turnover? Which position had the most employee turnover within the past two years? Describe potential reasons for employee turnover and what action steps the center has taken to reduce turnover.

I. How is employee satisfaction measured? What were the results of the last employee satisfaction survey? What actions were taken to improve employee satisfaction?

#### V. Immediate Needs (~ 10 minutes)

A. Define immediate needs of sex trafficking survivors.

B. How is your center addressing the survivors' immediate needs?

*Probe:* What type of services, care or resources does your organization offer to meet a survivor's immediate need for basic necessities? Immediate safety? Emergency shelter? Language interpretation? Emergency medical care? Crisis legal advocacy?

C. How long does it take to meet the survivor's immediate needs? (Ask participant how long it takes to meet each specific need mentioned in the previous question.)

*Probe:* Does the amount of time it takes to meet the survivors' immediate needs vary based on survivor's age? Length of time trafficked? Immigration status?

D. Describe the collaborative relationships your center has with health care providers and local area hospitals for providing emergency medical and mental health care.

E. Describe your organization's policy for determining the immigration status of a survivor.

#### VI. Ongoing Needs (~ 20 minutes)

A. Define ongoing needs of sex trafficking survivors.

B. How is your center addressing the ongoing needs of sex trafficking survivors?

*Probe:* What type of services, care or resources does your center offer to meet a survivor's ongoing need for physical health care? Mental health care? Substance abuse? Safety? Transitional housing? Immigration advocacy? Legal advocacy? Language services?

C. How do survivors receive formal education?

### APPENDIX C (continued)

*Probe:* School on-site?

*Probe:* Volunteer tutors from area schools?

D. Describe the collaborative relationships your center has with medical and mental health providers for providing medical management and ongoing therapy.

E. Describe the progression of survivors through your rehabilitation program.

*Probe:* Describe a typical day of a survivor living in your facility.

*Probe:* How is a survivor's day structured?

*Probe:* Describe your center's policy for reuniting survivors with family members.

*Probe:* Describe trends (movement of detectable changes) you have observed as survivors progress or withdrawal from your rehabilitation program.

*Probe:* Based on your observations, list contributing factors to a survivor's progression through your program.

*Probe:* Provide examples (e.g., curfew) of "house" rules at this center and the consequences of breaking "house" rules (e.g., no weekend pass for a month).

F. How many times can a survivor seek treatment at your rehabilitation center?

#### VII. Long-Term Needs (~ 5 minutes)

A. Define long-term needs of sex trafficking survivors.

B. How is your center addressing the long-term needs of sex trafficking survivors?

*Probe:* What type of services, care or resources does your center offer to meet a survivor's long-term need for building life skills? Language skills? Job training? Permanent housing?

*Probe:* Describe challenges your center faces with reintegrating survivors back into society.

C. How do you assist survivors in meeting their personal goals?

#### VIII. Follow-up (~ 5 minutes)

A. How does your center define success?

B. How does your center measure success?

*Probe:* List variables your center collects after a survivor leaves the rehabilitation center. Number of survivors who attend college? Number of survivors who abuse substances? Number of survivors who re-enter the sex industry?

*Probe:* What is the rate of survivors returning to your rehabilitation center?

*Probe:* How often do you follow-up with survivors?

*Probe:* Do you measure survivor satisfaction of your program and/or facility? What are the collective results of your survivor satisfaction survey? What actions has your center taken to improve survivor satisfaction with your program and/or facility?

*Probe:* Describe alumni involvement within your center. Peer mentoring? Raise community awareness about sex trafficking?

C. Has your program undergone an internal and/or external evaluation since its existence?

*Probe:* When was your program last evaluated?

*Probe:* How often is your program evaluated?

*Probe:* What were the results of your last evaluation?

*Probe:* How have these results changed your service delivery today?

**APPENDIX C (continued)**

IX. Closing (~ 1 minute)

A. Is there anything else you would like to share about your program?

## APPENDIX D

## Code List

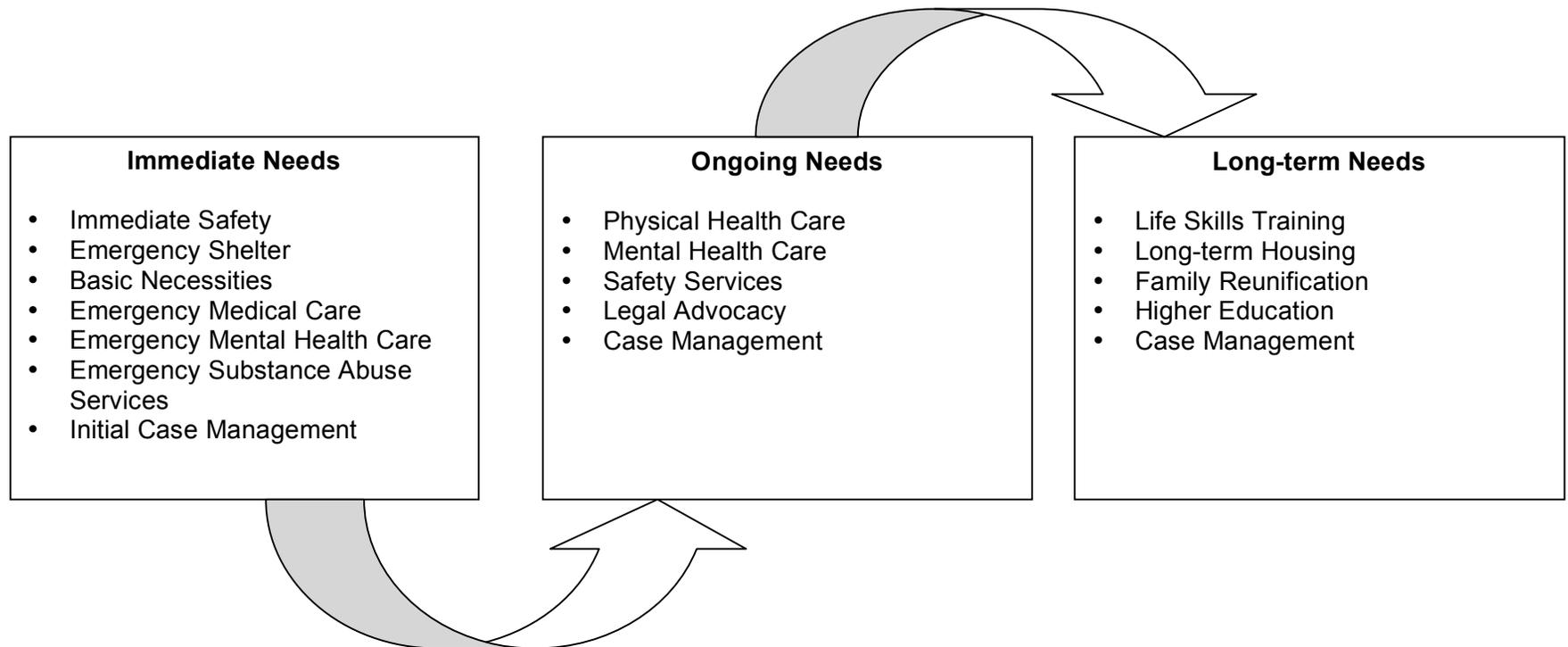
<b>Code</b>	<b>Definition</b>
<b>Facility demographics</b>	Any description of the long-term residential facility (i.e., number of years established, security).
<b>Population demographics</b>	Any description of the population receiving services at the long-term residential facility.
<b>Referral</b>	Any individual or entity currently sending survivors to the long-term residential facility.
<b>Treatment Model</b>	The name of a conceptual framework used to represent the long-term residential facility.
<b>Geographic Location</b>	The setting of the long-term residential facility.
<b>Institutional Policies</b>	Rules and regulations (written or unwritten) that directly or indirectly effect the daily operations of the long-term residential facility (i.e., house rules).
<b>Policies related to staff</b>	Rules and regulations (written or unwritten) pertaining to staff.
<b>Policies related to youth</b>	Rules and regulations (written or unwritten) pertaining to youth living in the long-term residential facility.
<b>Barriers</b>	Obstacles preventing services from being provided within the long-term residential facility.
<b>Challenges</b>	Obstacles overcome without delaying services within the long-term residential facility.
<b>Neighborhood Perception &amp; Sentiment</b>	The neighborhood's response to the long-term residential facility.
<b>Staffing</b>	Employees (not volunteers) of the long-term residential facility (i.e., characteristics).
<b>Collaborative Partners</b>	Any individual or entity providing professional services (e.g., volunteer physician who is providing medical services) to survivors at the long-term residential facility.
<b>Retention Strategies</b>	Ways to retain employees and volunteers.
<b>Employee Orientation</b>	Mandated training for new employees.
<b>Employee Evaluation</b>	Methods used to assess employees' performance.
<b>Ongoing Staff Training</b>	Mandated training (after orientation) or meetings of an employee at a long-term residential facility.
<b>Immediate Needs</b>	Includes (a) immediate safety, (b) emergency shelter, (c) basic necessities, (d) language interpretation, (e) emergency medical care, (f) crisis legal advocacy (Macy & Johns), and (g) initial family involvement.
<b>Schedule</b>	How survivors' time is organized along with a rationale.
<b>Ongoing Needs</b>	Includes (a) physical health, (b) mental health, (c) substance abuse problems, (d) safety, (e) transitional housing, (f) immigration, (g) legal issues, (h) language needs (e.g., interpretation and translation (Macy & Johns)), and (i) spiritual needs.
<b>Program Evaluation</b>	Methods used to assess the effectiveness of services provided at the facility.

**APPENDIX D (continued)**

<b>Code</b>	<b>Definition</b>
<b>Long-term Needs</b>	Includes (a) life skills, (b) language skills, (c) education and job training, (d) permanent housing, (e) family reunification, and (f) repatriation (Macy & Johns).
<b>Outcomes</b>	Objective results during or after transition from the long-term residential facility.
<b>Alumni Involvement</b>	An individual's involvement in a program after completion.
<b>Program Resources</b>	People (i.e., volunteers who give their time without using their professional services) or things (i.e., money) needed to operate a program.
<b>Mission</b>	A measurable objective of an organization.
<b>Vision</b>	A thought or concept an organization strives to achieve.
<b>Philosophy</b>	The basic beliefs or attitudes of an individual or an organization.
<b>Success</b>	A favorable outcome of a survivor from the perspective of the respondent (e.g., survivor does not engage in illegal activity).
<b>Board of Directors</b>	A body of elected or appointed members that act upon the best interest of the organization.

**APPENDIX E**

## Twigg Aftercare Services for Domestic Minors of Sex Trafficking Model



## VITA

**Naomi Mae Twigg, MSN, RN**

### **EDUCATION**

University of Illinois at Chicago	Ph.D. candidate	2012
University of Illinois at Chicago	M.S.N.	2008
Millersville University	B.S.N.	2004
Harrisburg Area Community College	A.D.N	2003

### **PROFESSIONAL EXPERIENCE**

2011 - present	Senior Research Specialist, University of Illinois at Chicago, College of Nursing, Chicago, Illinois.
2008 - 2011	Visiting Research Specialist, University of Illinois at Chicago, College of Nursing, Chicago, Illinois.
2008 - 2009	Visiting Clinical Instructor, University of Illinois at Chicago, College of Nursing, Chicago, Illinois.
2007 - 2008	Teaching Assistant for Dr. Judith McDevitt, University of Illinois at Chicago, College of Nursing, Chicago, Illinois.
2007	Staff Nurse, Northwestern Memorial Hospital, Transplant Unit, Chicago, Illinois.
2006 - 2009	Agency Nurse, Medical Staffing Network, Medical-Surgical Unit, Warrenville, Illinois.
2003 - 2006	Staff Nurse, Lancaster General Hospital, Medical-Surgical Unit, Lancaster, Pennsylvania.

### **HONORS and AWARDS**

2012	Sigma Theta Tau International Honor Society Alpha Lambda Chapter Research Award
2012	College of Nursing PhD Student Research Award
2011	Chancellor's Student Service Leadership Award
2011	Sutton's Who's Who in Academia
2011	The Honor Society of Phi Kappa Phi Inductee
2010	Telluride Patient Safety Scholar
2009	Sigma Theta Tau International Honor Society of Nursing Inductee
2008	Master's Recognition Award
2008	Summa cum laude Graduate
2004	Magna cum laude Graduate
2003	Outstanding Compassionate Nurse Award

2003 Phi Theta Kappa Alpha Nu Omega graduate

## **RESEARCH**

Twigg, N.M. (2008). *Gender inequalities and Guatemalan female sex workers susceptibility to HIV* (Master's thesis, University of Illinois at Chicago).

## **PRESENTATIONS**

Twigg, N.M. (2010, October). *The health of female sex workers' children*. Poster session presented at the International Association of Forensic Nurses scientific assembly. Pittsburgh, PA.

Twigg, N.M. (2009, April). *Synchronous facilitation of NONPF competencies in population-focused interventions*. Poster session presented at the National Organization of Nurse Practitioner Faculties annual meeting. Portland, OR.

## **MANUSCRIPTS IN PROCESS**

*Gender inequalities and Guatemalan female sex workers susceptibility to HIV*. Healthcare for Women International.

*The health of female sex workers' children*. The Journal of Child & Adolescent Trauma.

*Concept analysis of female sex worker*. Women and Criminal Justice.

*The prevention of commercial sexual exploitation of children using the Spectrum of Prevention*. American Psychological Association.

## **PROFESSIONAL ACTIVITIES**

### **Professional Organizations:**

2011 - present	Institute for Healthcare Improvement
2011 - present	The Honor Society of Phi Kappa Phi
2009 - present	Sigma Theta Tau International Honor Society of Nursing
2008 - present	Global Health Council
2008 - present	American Public Health Association
2008 - present	University of Illinois Alumni Association
2004 - present	Millersville University Alumni Association

## **PROFESSIONAL SERVICE**

2011 - 2012	President, Institute for Healthcare Improvement Open Chapter School, University of Illinois at Chicago.
2011 - 2012	Immediate Past President, Graduate Student Nurses Organization, University of Illinois at Chicago.
2010 - 2011	President, Graduate Student Organization, University of Illinois at Chicago.
2009 - 2010	Vice President, Graduate Student Organization, University of Illinois at Chicago.

2009 - 2010 Senate Student Representative, Graduate Student Organization,  
University of Illinois at Chicago.  
2007 - 2008 Health Professional Student Council Representative, Graduate  
Student Organization, University of Illinois at Chicago.  
2006 - 2007 Secretary, President, Graduate Student Organization, University of  
Illinois at Chicago.

### **COMMUNITY SERVICE**

2010 Volunteer Registered Nurse, Cusco, Peru.  
2009 - 2012 Youth Group Leader, Rogers Park Community Church.  
2006 Volunteer Registered Nurse, Owerri, Nigeria.  
2006 Volunteer Registered Nurse, Zacapa, Guatemala.  
2005 Volunteer Registered Nurse. Bethel, India.

### **TEACHING EXPERIENCE**

2008 Health, Environment, and Systems  
2009 Population Focused Interventions in Primary Care