IMPROVING RURAL MENTAL HEALTH CARE IN NORTH DAKOTA FOR SURVIVORS OF HUMAN TRAFFICKING

Erin R. Hagen M.Ed. LPCC-S

PREPARED FOR THE NDHTTF Fargo, North Dakota

Executive Summary

In the Fall of 2017, the North Dakota Human Trafficking Task Force (NDHTTF) contracted with a non-affiliated mental health professional to (a) assess existing services and models for adult human trafficking clients in North Dakota, (b) formulate an assessment plan to evaluate effectiveness of these mental health services based on current literature and field interviews, and (c) offer recommendations to better serve human trafficking clients in a largely rural state. Currently, mental health services are provided to human trafficking survivors across North Dakota in a variety of settings, including state public institutions, addiction treatment centers, private practices, violence intervention agencies, family service centers, etc.

NDHTTF Overview

NDHTTF was established in 2015 with the following mission: "The North Dakota Human Trafficking Task Force is a statewide, multidisciplinary collaboration of law enforcement, service providers, and prosecution established to work in a victim-centered manner to prevent, detect, disrupt, and dismantle human trafficking through coordinated, comprehensive services and efficient investigation and prosecution."

The NDHTTF has identified the following as primary goals and objectives:

Goal 1: Support diverse and accessible programming to sustain long-term independence for survivors of labor and sex trafficking.
Objectives:

- Increase number of clients transitioning to long-term independence
- Develop innovative, culturally appropriate approaches to serving victims
- Identify and provide more accessible and affordable treatment options/facilities
- Identify labor trafficking and enhance services provided for labor trafficking victims

Goal 2: Implement effective evaluation systems to secure multiple streams of funding and ensure data-driven equitable policies.
Objectives:

- Adapt data collection system to ensure accuracy for reporting and interpretation
- Secure sustainable funding utilizing reliable data

Goal 3: Collaborative and efficient team
Objectives:

- Identify resources and plan to provide service and investigation in rural and tribal areas
- Establish, or maintain MDT meetings
- Conduct outreach operations with key community partners

Goal 4: Justice for victims through offender prosecution and accountability.
Objectives:

- Increase, and track, number of successful prosecutions
- Consistent charging and sentencing within judicial system
- Train judicial system

Goal 5: Increased awareness, understanding, and prevention through education.
Objectives:

- Provide prioritized education and outreach to communities and sectors, based on data
- Conduct outreach operations with key community partners

Project Overview

The project objectives were informed by the following stakeholder concerns gathered at NDHTTF victim service provider subcommittee meeting, regarding unmet or inconsistently met mental health needs of survivors:

- Inconsistent contact by service providers (investigators, prosecutors, direct care service providers) with survivors with mental health issues.
- Inconsistent mental health care for survivors to minimize disruptions to meeting basic needs.
- Inadequate investigation and prosecution of trafficking cases for survivors with unmet mental health needs, which makes prosecution difficult since there is generally a lack of physical evidence. It is much more important to have a victim as a witness to prosecute in sex trafficking cases as there is typically no other physical evidence. This is similar to sexual assault cases where an estimated 3.4% of sexual assault cases result in conviction of the perpetrator (RAINN)
- Inadequate and often inaccessible network of clinicians trained to effectively work with Human Trafficking survivors presenting with distinct mental health issues.
- Inadequate continuation of mental health services, which challenges the expectations of mental health providers for continuation of services. Therefore, measuring outcomes was difficult or impossible because of movement of the individuals, and transfer of knowledge between service providers was impossible due to confidentiality confines.
- Ineffective communication procedures among inter-agency and client/provider relationships, which may be influenced, in part, by triangulating dynamics.

Currently, there are no models to address the challenges of rural areas for human trafficking service provision in the literature, or in available intervention models. Therefore, the focus of this project was to (a) assess existing access to services for adult human trafficking clients in North Dakota, (b) evaluate effectiveness of mental health services based on current literature and field interviews, and (c) make recommendations to better serve clients in a largely rural state.

Performance Objectives and Major Accomplishments

The table below presents the goals, performance objectives, and major accomplishments for the project. For those wishing more information on literature or assessments, refer to the bibliographic references in Appendix A and assessment references in Appendix B.

Table 1. Goals, Performance Objectives, and Major Accomplishments

Goal	Performance Objective	Major Accomplishment	Recommendations
Evaluate service provision based on current literature	Literature review	a. Topic 1: mental health service provision	Mental health services are seen as crucial to the overall health of trafficking survivors. *Sustainable funding is necessary to increase access to mental health services for survivors and competencies for providers.
		b. Topic 2: available assessment tools and service models See appendix B	There are several available assessment tools. Outcome research is necessary for general implementation.
		c. Topic 3: services in rural communities for human trafficking survivors	Barriers for rural service delivery should be addressed on a programmatic level. Education should be provided directly and continuously to rural service providers.
Assess existing services	Consultation with human trafficking experts	Consultation with task force sub-committee members	Identification of key informants is a critical step- utilization of the established regional multi-disciplinary teams to regionally resource
		Consultation with local experts	*Development of a treatment collaborative that would maintain a provider list for ease of referral and would connect providers to

Goal	Performance Objective	Major Accomplishment	Recommendations
			education, research, and case consultation. Funding is needed to implement and maintain this operation.
		Consultation with national experts	Ongoing
	Consultation with licensed professional therapeutic providers	Facilitated focus groups in eight of nine key MDT committee locales of the state with local therapy providers. (One MDT location was not included due to that region not having therapeutic providers in region, rather, they are served as an outreach region by one of the larger regions.)	See detailed regional considerations in appendix C. *Provider concerns could be addressed by increasing public awareness and provider training, developing flexible and accessible programmatic policies, and generating support (professional and financial) from administrators, legislators, and colleagues.
		Identification of preferred provider network	*Public access to this network should be established via state website which would allow access for clients, advocates, and other task force stakeholders.

***For full recommendations see recommendations section in the body of the report**

Major Accomplishment 1: Literature Review

Topic 1: Mental Health Service Provision

Human trafficking is a term used to identify the phenomenon of persons that are sold or traded with the use of force or coercion for goods, services or money (TVPA, 2000). Two distinct subcategories of human trafficking are sex trafficking and labor trafficking. Labor trafficking victims are forced or coerced into providing services with little or no compensation including housekeeping, dealing drugs, restaurant service, etc. Sex trafficking is specific to individuals who are forced or coerced to provide sexual acts. These "persons" are typically identified as two distinct subgroups (a) homeless persons trafficked to meet survival needs (shelter, food, addiction, transportation) or (b) persons in a relationship with their perpetrator (partner, parent, or authority figure) who is emotionally or physically coercive and facilitates the sale of sex acts (Gibbs et al., 2015; Hardy, Compton, & McPhatter, 2013). While the broader category of human trafficking which includes both labor and sex trafficking is included in this report, the major focus of inquiry is on sex trafficking.

The NDHTTF has collected data for the past two years and reports serving 158 victims/survivors of human trafficking in some capacity. These numbers do not represent the actual prevalence in our state as comprehensive data is not reported from all stakeholders at this time. There are limited statistics on the prevalence of human trafficking locally, nationally, or globally, given the highly criminal and covert nature of the phenomenon (Chung, 2009). Studies provide support for how the psychological effects of isolation by perpetrator or conditions keep victims involved with trafficking (Aron et al., 2006). Moreover, trafficking survivors are facing a multitude of issues and trafficking is often seen as a "solution" to the more crucial problems they face (Gibbs et al., 2015).

The most commonly cited age of entry into trafficking is 12-14 years old, with some sources noting children as young as 10 years old being trafficked, with women and children being the most vulnerable to trafficking recruitment (Shigekane, 2007; Yakushko, 2009). Information published by the Polaris Project disputes the accuracy of this statistic and calls for research with both juvenile and adult participants that will provide more accurate information. Recent research has established the vulnerability of LGBTQ individuals to being trafficked (Covenant House, 2013). Mental health professionals will come into contact with a spectrum of survivors from considering or very recently exiting "the life", to multiple years out with chronic functional impairment. Service models will need to be flexible to fit these stages. Adult survivors will have a higher likelihood of delays in social, emotional, or occupational development if entry into trafficking occurred in adolescence or if they experienced childhood abuse.

A core component of the phenomenon of human trafficking is that many are either unable or unwilling to self-identify their experience as human trafficking victims (Aron, Zweig, & Newmark, 2006). This can be due to varying reasons: developmental naivete, lack of education, language barriers, cultural barriers, and shame/guilt about their experiences or how others perceive them. Survivors also vary in how they perceive their experiences, which impacts their situational and victim identities. Perkins & Ruiz (2017) found that of 40 minor participants

interviewed in a correctional facility, only 17.5% of their sample identified as a victim of sex trafficking. The remainder of the participants identified personal choice (survival sex, or sex for trade) or some level of secondary gain (Perkins & Ruiz, 2016). Human trafficking survivors are psychologically at risk due to traffickers' grooming behaviors. Grooming is the process of systematically desensitizing and normalizing abusive behavior, creating decreased awareness in victims (Miller-Perrin & Wurtele, 2017).

The literature on the mental health effects from trafficking include depression, anxiety, and post-traumatic stress disorder (PTSD). In a 2016 study on the mental health effects of trafficking, Oram et al. (2016), reported that 78% of women and 40% of men involved in human trafficking reported high levels of depression, anxiety, or PTSD with suicidal ideation, demonstrating the importance of attending to survivors. Abas et al., (2013) suggested that treatment is likely to be complicated by the existence of predisposing, precipitating, and maintaining factors such as early childhood trauma or emotional/social developmental issues, as well as mistrust, fear and shame (Contreras, Kallivayalil, & Herman, 2017).

Treating survivors is complicated by the complexity and multiplicity of issues they present. Thus, fidelity of treatment with human trafficking survivors must take into consideration complex trauma, poverty, the dynamics of early adverse childhood experiences or childhood trauma, and the relational consequences of shame, mistrust, and fear (Aron, Zweig, & Newmark, 2006; Chung, 2009; & Contreras, Kallivayalil, & Herman, 2017). Mental health professionals may need to focus their efforts on relationship building and maintaining trust, with adequate repair of inevitable ruptures, while attending to many core functions of their treatment plan including safety planning, risk reduction, emotion regulation, job/life skills, trauma symptom reduction, intrapersonal empowerment, interpersonal support, and community reintegration (Schmidt, 2014). Advocacy for appropriate services for survivors needs to occur simultaneously at multiple levels: therapeutically, programmatically, and systemically.

Topic 2: Available Assessment Tools and Service Models

Screening and assessment tools- See Appendix B

Quick screens can be used in identifying high risk clients in a crisis-focused setting (i.e., after a recover op (raid) to triage). Appropriate assessment should occur over a longer period of time in a collaborative relationship with the client (Hopper, 2017)

Service models- See Appendix D

Providers must be able to adapt conventional counseling systems to meet survivor needs. This will include the adjustment of (a) agency policies (fee for service, attendance policies, period of sobriety policies, legal history policies) (b) provider expectations of behavior (sobriety, language, therapeutic pace) (c) therapeutic models (models are typically adapted from evidence-based trauma counseling models). Always, the goal is to create models and interventions that heal interpersonal damage-skills for PTSD amelioration will not be effectively received outside of safety in the relationship and environment.

Topic 3: Services in Rural Communities for Human Trafficking Survivors

There is currently very limited empirical research that addresses rural mental health provision with complex trauma victims or provides a model for service delivery. Breen & Drew (2012) outlined characteristics of rural culture impacting mental health services that include: valuing safety and resisting outsiders, a family-first mentality which may delay and stigmatize accessing outside help, and resistance to urban values and strategies which means existing urban models cannot be simply replicated. Rural victims more commonly identify their traffickers as family members (Cole & Sprang, 2014; Perkins & Ruiz, 2017). Emphasis on privacy and self-sufficiency provides an additional layer of barriers for connecting survivors to mental health care. Cole and Sprang (2014) found that rural area clinicians are found to have less education, less ability to accurately identify victims, and less resources to provide adequate intervention than clinicians in more urban areas. Rural counselors will succeed when adapting to the cultural rules of rural health, one of which is adaptation to a generalist model and highly collaborative work with local medical providers (Bischoff et al., 2014; Breen & Drew, 2012). Training for providers should be repeated often, available on-site, and integrated into program training (Cole & Sprang, 2014).

Recommendations: Literature

Competencies will increase with training and direct service specific to human trafficking victims. Areas of training should include the following:

- Points of entry into trafficking
- Indicators of trafficking involvement
- Risk factors for involvement
- Trauma-informed practice
- Referral protocol (agency driven)
- Mandated reporting for children and adults
- Evidence-based trauma treatment models
- Male victims
- LGBTQ victims
  (Cole & Sprang, 2014; Middleton, Gattis, Frey, & Roe-Sepowitz, 2018)

Theoretical recommendations: (1.) Trauma-informed: conceptualizes and intervenes with client in light of their trauma experiences. (2.) Feminist: focuses on intervening with factors and systems that oppress the individual, values client autonomy and self-determination, works toward empowerment of the client.

Therapeutic models recommendations: identified through literature, consultation, and field interviews. All of the following are models developed for use by licensed mental health professionals and that require training from a certified training program.

- Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
- Non-verbal somatic-based therapies
- Interpersonal therapy
- Motivational interviewing (MI)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Prolonged Exposure (PE)

Major Accomplishment 2: Consultation

This effort is ongoing.

NDHTTF-Victim Service Provider Sub-committee: committee members made recommendations to speak with specific individuals and organizations (locally and nationally) known to hold expertise and/or experience in effective service provision to human trafficking survivors. These individuals informed collaborative networks for the undertaking of the focus groups that took place across the state.

Local & National Experts: Experts were identified by affluence in the field of human trafficking research, training, practice, or advocacy. They were queried on suggestions about provision of mental health service to human trafficking survivors and provision within the barriers of rural areas.

Echoing the concerns that led to the current project, Dr. Elizabeth Hopper of the Justice Research Institute stated that "Mental health service provision is an extremely important aspect of comprehensive services, because it impacts survivors' ability to make use of all of the other services offered. Important considerations include (but are not limited to): access (including logistical barriers, emotional barriers, matched services such as linguistic match), trauma-informed care, culturally sensitive care, risk and level of care needed, client-therapist match, etc." (Hopper, 2018)

Major themes included:

Collaboration

- Practitioners must work in collaboration to provide effective services. Examples of necessary collaboration are with substance abuse treatment programs or with non-clinical professionals (in school or residential facilities) that can assist in facilitating telehealth sessions (if available and appropriate).
- Telehealth is not indicated without thorough attention to providing in-person safeguards given the numerous risks to client safety, but it is thought to be suitable for providing basic needs/support with the supplemental facilitation of a trained in-person liaison. It is contraindicated for deeper trauma work.

Trauma Competence

- Practitioners serving human trafficking survivors must be experienced and highly skilled given the breadth of challenges offered. This will include mastery of basic counseling skills and motivation enhancement. Qualified practitioners should be experienced with *complex trauma. Unskilled (lacking training or experience) practitioners should not be providing services to human trafficking survivors and should refer to a qualified provider.
- Skilled practitioners should take into consideration the client's range of needs and consider professional areas of competence in assessing appropriateness for providing treatment vs. need for referral.
- Skilled practitioners must have a significant base of knowledge in *neurological basis of trauma treatment supported by current research.

- Practitioners must use a model or therapeutic strategy that is adequate and flexible enough to address the breadth of treatment issues. *Trauma training certifications will support interest and experience working with survivors.

*See Glossary of Terms in Appendix D

- Practitioners are best served by closely attending to how the client is identifying their problems or goals. If a client identifies their core issue as domestic violence, the well-matched practitioner should have established expertise in domestic violence treatment.

Barrier Reduction

- Ideally services for survivors should be free or low cost as finances are a common barrier for survivors.
- Ideally practitioner trainings should be free and geographically available as barriers to practitioners should also be considered.

Major Accomplishment 3: Regional Focus Groups with Service Providers

Focus groups were held in Eight of Nine key multi-disciplinary committee regions across North Dakota, which provided information in multiple areas (1.) unique regional considerations *See Appendix C (2.) Available and qualified service providers *See Appendix E (3.) Provider concerns/barriers (4.) Available regional resources (5.) Missing information (6.) Areas for improvement (7.) Necessary or desired support. All practitioners experienced or interested in serving human trafficking survivors in the state of North Dakota were invited to attend the focus group in their region. Contact information was accessed through a state mental health information website and by word of mouth. Key informants identified by the task force sub-committee members were contacted directly to be invited. Special consideration was taken to honor rural cultural dynamics by locating a collaborator in each region. The collaborators acted as key informants to mental health professionals in the region, to spread the invitation and garner attention and interest in the focus group, and to act as an insider to deepen the discussion of focus group material. Collaborators were initially identified from the human service centers (public agencies acting as a catch-all level of mental health care) in all regions of the state. For regions in which the human service centers declined participation (3 of 8) alternative collaborators were identified by contacting key informants in each region.

Major themes identified:

- Many attendees (practitioners) in more rural/remote areas were transplants to the region and had previous experience working with human trafficking survivors in an urban area. This may indicate that practitioners in North Dakota are hesitant to participate in this field due to inexperience or perhaps lack of knowledge about human trafficking dynamics/prevalence.
- All regions had unique needs and considerations. Practitioners acted as valuable sources of information about the state of mental health care in their respective regions.

- Most attendees expressed gratitude for the ability to have a conversation about trafficking. This may indicate that training and improvement to systems is either past due or timely.
- Many practitioners expressed confusion about identification and language. An example of this is the terms trafficking vs. prostitution. "Prostituted" is another term for trafficked.
- Across the state, public entities are noticing barriers to the ethical and effective treatment of trafficking survivors as they move to an "open-access" system which serves clients with group therapy. Practitioners are concerned about group therapy being contraindicated for this population, which has some anecdotal support in the literature on human trafficking but is a more well-known issue in trauma-informed practice.
- There is adequate interest to serve human trafficking survivors in a specialty capacity. However, it is crucial that all generalist counselors have enough information for appropriate identification and referral.
- Attendees expressed support for referrals to target appropriate provider over available agency.

Recommendations: Consultation

Based on consultation from local and national experts in the human trafficking field as well as focus groups with involved state providers the following actions are recommended:

1. Development of a state-wide clinical training on human trafficking service provision that includes, but is not limited to:
   - GEMS (Girls Educational and Mentoring Services) training
   - Effective engagement strategies: Motivational Interviewing or Transtheoretical Model
   - Information on complex trauma treatment
   - EMDR- evidence based model, frequently acknowledged by survivors and counselors as a strong treatment option, most suitable for survivors who have adequate resources for support and stabilization.
   - Prolonged Exposure- evidence based model- no empirical or conceptual literature exists for use of this model with human trafficking survivors but has strong support in field of psychology for trauma treatment with military veterans.
   - TF-CBT- Keystone model (Adapted for Human Trafficking Clients)- Multiple clinicians in ND trained in this model. Empirical outcome research would establish effectiveness.

     *see glossary of terms for further explanation of training and treatment models
2. Data collection
   - Outcome research on provider services in the areas of
     - Engagement
     - Client satisfaction
     - Functional improvements of survivors

3. The creation of an adult complex trauma treatment collaborative. Treatment collaboratives can function as a system of providers that can receive support and consultation on cases that demand high resources. Adult human trafficking survivors as well as others with complex mental health issues are underserved and practitioners to these populations require supportive resources to prevent burnout and decreased efficacy.
    - Modeled after TCTY (Treatment Collaborative for Traumatized Youth), which is managed by Neuropsychiatric Research Institute
    - Supports constant access to literature, training, and staffing/supervision for providers
    - Would require an administrator for maintenance

4. Use of the preferred provider list created through this project. The "preferred provider list" identifies licensed practicing providers that have qualities recognized by the literature as important to ethical and effective services for human trafficking survivors
    a. experience as a clinician
    b. training on human trafficking dynamics
    c. multicultural competence
    d. a relational therapeutic framework
    e. training in an evidence-based trauma treatment model
5. Further exploration of rural mental health options
    a. Consultation with Veterans Administration on safe and acceptable telehealth services to individuals with PTSD. results

Next Steps

A proposed second phase of this project based on information gathered includes the following:

1. Development of training(s) for mental health professionals across the state. Deliverables include: outline of training objectives and outcomes, as well as provider minimum competencies, training curriculum, and a regional training strategy, addressing accessibility to continuing education in rural areas.
2. Development of a treatment collaborative for mental health professionals specializing in treatment of human trafficking clients. Deliverables include: treatment collaborative website used as a central base for resources, information, referral, and consultation. Schedule for ongoing and consistent training and consultation for providers across the state.
3. Data Collection (outcome research) on existing services to trafficking survivors at key service organizations or with preferred providers. Deliverables include: measurement of client satisfaction, survivor access to appropriate service, survivor functional mental health improvements, and provider effectiveness.
4. Expanding local collaborative options for accessible survivor services within regions of the state (Hospitals, Clinics, private practice agencies, Schools, etc.). Deliverables include: collaborative network contracts for provision of services.

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Appendix A

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Appendix B

Screening and Assessment References

Trauma-Informed Psychological Assessment of Human Trafficking Survivors

Hopper, 2017

This assessment is best fit for mental health professionals, direct service providers, and advocates that are engaged in therapeutic or long-term service delivery. This assessment is indicated to provide a whole-picture of survivor needs.

Trafficking Victim Identification tool (TVIT) Screening for Human Trafficking

Vera Institute of Justice, June 2014

A quick screen tool (16 items) designed for law enforcement officers and direct service providers to identify potential victims and make appropriate referral. Not indicated for long-term therapeutic conceptualization.

Child Welfare Trauma Referral Tool: Child Welfare Trauma Training Toolkit

March 2008 The National Child Traumatic Stress Network www.NCTSN.org

This measure is designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. It is to be completed by the child welfare worker through record review and key informants (i.e., natural parent, foster parent, child therapist, school-aged children or adolescents if appropriate, and other significant individuals in the child's life).

Child Trafficking Rapid Screening Instrument (RST):

Baskin, D., Sommers, I., & Kaufka Walts, K. (2014). Center for the Human Rights of Children, Loyola University, Chicago.

A quick screen inventory to be utilized with minor victims. Developed for rapid identification of potential victims that indicate baseline legal elements of a trafficking case. Not indicated for long-term therapeutic conceptualization.

North Dakota Human Trafficking Rapid Indicator Tool- Minor/Youth

A 10-item rapid screening inventory designed for any direct service professional to identify minors who meet criteria for trafficking victimization for the purpose of referral to appropriate agencies. Not indicated for long-term therapeutic conceptualization.

Appendix C

Unique regional considerations

Bismarck (3 total participants in attendance- 1 mental health clinician, 2 case managers)
Of note:
It was obvious in this group that the leadership is not adequate in this community to address the issue of trafficking. Another mechanism must be utilized to establish the relevance of human trafficking before adequate recommendations can be made.

- Community dialogue around human trafficking is limited- participants expressed skepticism about prevalence
- Area is rich with trauma-trained clinicians
- Proximity to state penitentiary- More people that are drug addicted or have sexual offending behavior

Asking for:

- Data that indicates prevalence of trafficking
- Community and provider dialogue around human trafficking services

Devils Lake (7 total participants in attendance- 7 mental health and addiction clinicians)
Of note:

- Trafficking activity is highly related to survival needs
- Familial trafficking is common
- Cultural desensitization to survival sex or labor trade is a critical treatment issue
- Disjointed jurisdictional issues cause complexity that providers may not know how to navigate
- Community or Public care options are very limited
- Public services are seen as exclusionary- clients cannot meet criteria for assistance
- Access to resources is limited for several reasons
    - Abject poverty
    - No public transportation
    - Very limited housing and sheltering
    - High rates of addiction
    - Unmet addiction and mental health needs- services are overloaded and understaffed

Asking for:

- Training that addresses human trafficking content knowledge, clinical skills, and assessment
- Research on clinical treatment
- Community collaboration
- Specialized services/agency that includes vocational rehabilitation, job training, child care, transportation, and therapy

Dickinson (1 total participant in attendance- human trafficking advocate)
Of note:

- Mental health providers are limited in quantity and accessibility in this area
- Local college attracts international students whose vast acculturation needs go unmet and creates vulnerability to being trafficked
- Influx of drugs with oil boom
- Nearly impossible for rural clients to be served due to provider shortage and lack of services
- Hard for victims to come forward due to cultural climate
- Agency policy restrictions limit accessibility for survivors (e.g., period of sobriety)

Asking for:

- Trained mental health professionals
- Networks to access services
- Human service center transparency in policy and resources
- Top down change- leaders placing mental health care as a priority
- Transportation for rural areas
- Professional resources such as training and collaborative networks

Fargo (~20 total participants in attendance- mental health and addiction clinicians, administrators, human trafficking advocates, and justice system workers)
Of note:

- Area is rich with trauma-trained clinicians and education opportunities
- Focus may be working out glitches in policy and protocol to improve services
- Rich environment for research, specialized training, and collaborative agency work. Specific to human trafficking-this so far does not exist
- Area has host homes available for trafficked clients
- Trainings on human trafficking have been provided to 4500 people (statewide)
- Although considered an urban area in North Dakota, trafficking pimps know each other as well as women and girls that have been trafficked which creates fear for accessing services
- Victims are not expressing their perception of safety within systems
- Not enough safe and affordable housing options
- Barriers may be more emotional and programmatic than physical in this region

Asking for:

- Training on assessment and screening, early identification, ethics, and boundaries
- Collaborative networks
- Research on human trafficking competencies
- Drop-in agency for basic needs

Grand Forks (3 total participants in attendance- 2 mental health and addiction clinicians, 1 juvenile justice worker)
Of note:

- Area rich with resources and opportunities for education

- Interventions with Law Enforcement seems to have deterred human trafficking but also limiting service provider exposure to survivors. Concern that victims are intimidated to connect with law enforcement or service providers
- Establishment of host home for trafficking clients is seen as a positive sign that the community is open to improving/expanding services to trafficked clients.
- Community has resources for advocacy e.g., legal services for labor trafficking, Sexual Assault Response Team
- Housing options are expensive and public housing has an extensive waitlist
- Lack of mental health providers- many have a waitlist to be seen
- Many agencies and therapists are seen as unwilling to work with trafficking clients

Asking for:

- Provider training that includes, screening, assessment, intervention, ethics, and boundaries
- Research on therapeutic interventions
- Collaborative networks for providers/agencies

Jamestown (7 total participants in attendance- 7 mental health and addiction clinicians)
Of note:

- Mental health is not seen as collaborative in the area (e.g., public and private)
- Community buy-in to dialogue about mental health is extremely limited
- Penitentiary and state hospital discharge into the community creating concentrated populations of transient individuals and those with addictions and sex offending history
- Not adequate staff to cover rural outreach area
- Area funding cuts in juvenile services which limits access to schools and quiets conversation around trafficking
- LGBTQ population are not being served- too scared to enter systems that have been unwelcoming in the past
- No homeless support services exist
- No safe detox option- as the state hospital is not seen as an appropriate option for survivors

Asking for:

- Training on clinical treatment of survivors, clinical assessment, and reporting.
- Public awareness and community buy-in
- Community organization- a community forum
- Edits to agency policy that allow for accessibility and flexibility in service to survivors

Minot (4 total participants in attendance- 4 mental health clinicians)

- Lack of mental health services- this may be due to a "bootstrap mentality" of a conservative region
- Trafficking movement may be peripheral to the city as there is not public transportation to rural areas
- Bus lines run infrequently
- Public resources are seen as unsafe for survivors to utilize
- Area is not viewed as an open community

- School policies are seen as underdeveloped and unsupportive of intervention with adolescents
- Described as a "split" community made up of transplants that have stayed and locals which do not mix
    - Survivors are not able to "fit in" causing systemic marginalization
- Hotel industry boomed after the flood
    - This reduces accountability- no background check
    - Hotels are not invested in intervening with trafficking

Asking for:

- Training on broader and deeper knowledge of intervention with trafficking survivors, and treatment model
- Referral network for working within competency level and access to advocates and trafficking specific information
- Professional initiatives for specialization in trafficking intervention

Williston (2 total participants in attendance- 1 mental health clinician, 1 human trafficking advocate 2 additional participants provided feedback by phone)

- Mental health and addiction services are slowly gaining in availability
- Oil boom drives housing prices and discourages mental health professionals from moving to the area
- High population of men and transient oil workers
- Partners of oil workers moving to the region present with depression due to unmet social/emotional needs caused by a lack of community opportunities, later disclosing trafficking experiences
- No emergency services- hospital does not directly serve emergency mental health or addiction needs
- The jail is used as a holding unit for acute mental health and chemical dependency cases
- Statistical figures from law enforcement regarding numbers of drug arrests and domestic violence are not decreasing despite the decrease in numbers of oil workers and population overall
- Telehealth is primary means of psychiatric care, telehealth is not indicated for human trafficking
- Providers see human trafficking referral process as undeveloped
- Trafficking survivors are not being adequately served in public agencies as agency policy dictates referral out for acute cases

Asking for:

- Training on interventions, psychoeducation materials, assessment/identification tools, working with complex trauma, rapport building skills with trafficking survivors
- Public education that encourages acknowledgement of trafficking as a local problem
- Education for teens to prevent sexual exploitation
- A more refined referral process
- A funding source for mental health intervention

Appendix D

Glossary of Terms

Complex Trauma: A term coined by the work of Judith Herman (1992). Refers to a person who has experienced repeated trauma rather than a singular incident. Clinical presentation of complex trauma involves layered or complex effects of the spectrum of trauma symptoms (intrusive thoughts or images, avoidance of trauma reminders, hypervigilance- being overly aware of surroundings based on fear, and dissociation-feeling unreal or out of body).

Evidence-Based: a term to indicate that a treatment model has undergone a number of research-based trials to indicate the consistency and effectiveness of the model for the treatment of, in this case, PTSD.

Eye Movement Desensitization and Reprocessing (EMDR): An evidence-based model developed by Francine Shapiro for adults experiencing PTSD or other mental health diagnoses. Utilizes eye movement during exposure to traumatic imagery to decrease distress, increase insight, and develop positive associative beliefs.

Girls Education and Mentoring Services (GEMS): A human trafficking advocacy and intervention agency based out of New York City. GEMS training is a curriculum-based training that advises the ethical and trauma-informed treatment of survivors. Several certified GEMS trainers are available in North Dakota.

LGBTQ: Lesbian, Gay, Bisexual, Transgender, & Queer individuals are more at risk of victimization and are underserved in terms of intervention and support. LGBTQ individuals may be severely underserved in conservative and rural areas due to political non-affiliation with human rights social services.

Motivational Interviewing (MI): A therapeutic approach designed to reduce ambivalence and enhance motivation for behavior change. This therapeutic method is endorsed as a therapeutic style that is appropriate for human trafficking survivors by several trafficking experts.

Neurological Basis of Trauma: This is sometimes referred to as the fight or flight response which is an activation of the brain component- the amygdala. Traumatic events are known to create a unique activation of the brain which aids in survival but also has long-term effects in terms of impairment of emotion regulation, memory, and arousal regulation. Providers must be fully aware of the research on neurological components of trauma in order to treat a traumatized client.

Post-Traumatic Stress Disorder (PTSD): Clinical diagnosis defined in the Diagnostic and Statistical Manual-V (the primary reference for clinical mental health diagnosis) as the effects of

direct or witnessing exposure to death, serious injury, or sexual violence. Effects are characterized by symptoms in the following four categories: (1) intruding or unwanted memories in sleep or wake states experienced in thoughts or sensations, (2) avoidance of thoughts, people, places, or experiences associated with the trauma, (3) dominant negative mood, thoughts, or feelings connected to the event, and (4) increased arousal or fear response in wake (focusing, clarity, hypervigilant) and sleep (insomnia, sleep disturbance) states

Prolonged Exposure (PE): An evidence-based treatment model developed by Edna Foa. This treatment is focused on gradual exposure to trauma-related images, thoughts, and situations. This treatment model is regarded highly within the field of psychology.

Transtheoretical Model of Change: A therapeutic model defining stages of readiness for behavior change. Used frequently in addiction and mental health services as a way of conceptualizing the client's current status and designing appropriate treatment interventions. Stages of change include: pre-contemplation, contemplation, preparation, action, maintenance, and relapse.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): An evidence-based model for treatment of PTSD. TF-CBT is recommended standard treatment for trauma exposure in children. This model is multi-component and includes education for child and caregiver, relaxation and emotion regulation, coping, exposure to and development of the client's trauma narrative, and relapse prevention.

TF-CBT Keystone Model: An adapted model of TF-CBT for human trafficking survivors developed by Kelly Kinnish. Dr. Kinnish provided information regarding the model and emphasized the importance of a slower pace and additional resource development (multi-provider team, additional support),

Trauma-Informed Practice: An umbrella term for therapeutic practice where practitioners consider the impact of trauma on emotions, thoughts, and behaviors, have adequate knowledge and competency in the signs, symptoms, and treatments of traumatized people, and takes steps to avoid re-traumatization of clients.

Appendix E

Preferred Providers (by region)

*****This list is not considered exhaustive and has potential for further development through the development of a collaborative network

*****Due to the nature of professional movement, providers are listed by name and their agency may or may not be listed and may or may not be accurate at the time of publication. Please make attempts at accessing each provider by name and community.

*Providers are identified as preferred based on meeting all of the following criteria: direct or secondary involvement with informing the current project, 3+ years of therapeutic and/or direct service experience, direct experience with human trafficking survivors, demonstrated ethical understanding of the complexity of human trafficking survivors and interest in specialization with human trafficking survivors.

Bismarck:

Alayna Semchenko
DeCoteau Trauma

Devils Lake:

Marci Kligmann
Lake Region Human Service Center
Jocelyn Soderstrom
Blooming Prairie Assessment and Therapy Center
Jamie Boe
Lake Region Human Service Center
Christine Bushy
The Village Family Service Center

Dickinson:

Brenda Erie
Therapy Solutions
Natalie Tangen
Therapy Solutions

Fargo:

Mary Uong Kaale
The Village Family Service Center
Kirsten Husebye
The Rape and Abuse Crisis Center

Rachel Gronbach
The Rape and Abuse Crisis Center
Melissa Longtine
The Rape and Abuse Crisis Center

Grand Forks:

Therese Hugg
Community Violence Intervention Center

Jamestown:

Chelsea Modlin
South Central Human Service Center
Courtney Reinarts
South Central Human Service Center
Jennifer Nitshcke
Sharon Raugutt
Redemption Psychotherapy Services PLLC

Minot:

Connie Tyler
Community Medical Services
Maggie Bohannon
The Village Family Service Center

Williston:

Heidi Danks
Three Affiliated Tribes Victims Services
Theresa Scully
Selah Counseling