UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK

PARI: PREVENTION OF ADOLESCENT RISKS INITIATIVE

# Human Trafficking Training Series for Mental Health Professionals

## A Technical Report of the Development, Implementation & Evaluation

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# Acknowledgements

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The authors would like to acknowledge and thank our partners for their efforts to support this study. We are grateful to the training participants. Without the assistance and support from numerous state agencies and victim services providers, we would not have been able to conduct this training and evaluation. These partners include: the Maryland Human Trafficking Task Force, Anchored Hope Therapy, Araminta Freedom Initiative, the Maryland Network Against Domestic Violence, Sungate Foundation and TurnAround, Inc. We would also like to acknowledge the expertise and guidance of our survivor leaders and trainers which included: Chelsea Haverly, Elisabet Martinez, Iona Rudisill, Roxie Farrow, Shamere McKenzie, and Thomas Stack. This report was prepared by the University of Maryland, School of Social Work's Prevention of Adolescent Risks Initiative (PARI) in collaboration with Caroline Harmon-Darrow (Rutgers University) and Chelsea Haverly (Anchored Hope Therapy). Additional thanks to PARI staff past and present, Neil Mallon, Rochon Steward, Amelia Rubenstein, and Sharon Henry who were instrumental in supporting the training development and implementation.

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# Executive Summary

# Program Summary

This technical report encompasses the development, implementation, and evaluation of the Human Trafficking Training for Mental Health Professionals. This was one of several trainings developed as a part of the unified training strategy for professionals which includes victim-centered and trauma-informed best practices for handling human trafficking cases involving children and youth under the DOJ funded Maryland Human Trafficking Initiative FY2019. The complete logic model for this initiative is shown below in Figure 1. This training model was unique in that it leveraged the knowledge and expertise of those in both state and local government, victim services organizations and survivor leaders.

In the short-term, the training was designed to improve the capacity of mental health professionals throughout the state of Maryland to provide services tailored to the unique needs of human trafficking victims. In the long run, it continues to serve as a vehicle for effective collaboration between the clinicians and victim services organizations who serve child, adolescent, and young adult victims. This report describes the development process, provides an overview of the curriculum, and examines the data collected for the effectiveness of the initial pilot and implementation phases of the training offered between September 2020 and September 2022.

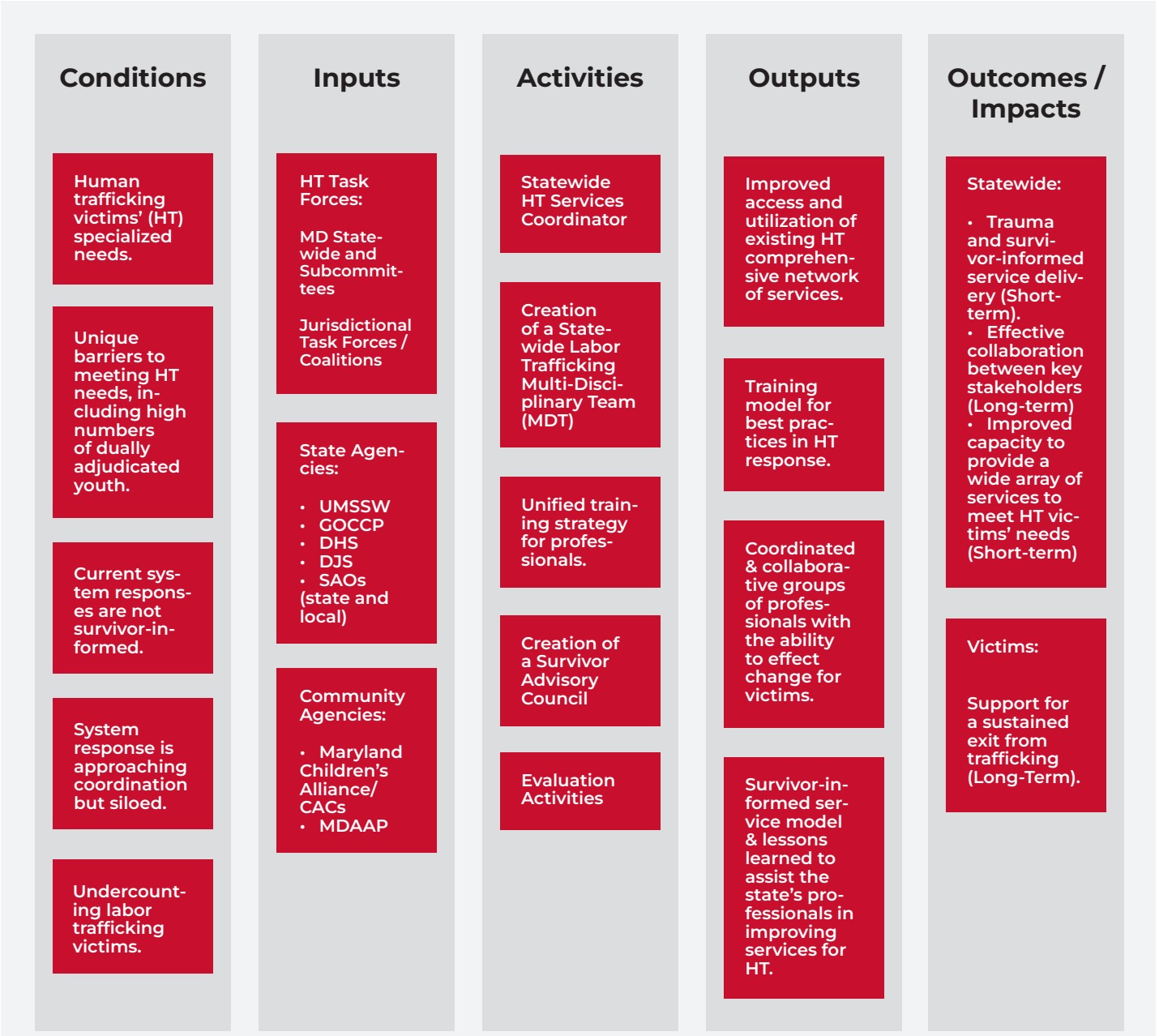


Figure 1 - Logic Model of the Maryland Human Trafficking Initiative FY2019

# Conclusions / Recommendations

The findings can be used to develop the evidence base for establishing survivor-informed, coordinated service response for human trafficking victims, especially child, adolescent, and young adult victims. It is hoped that the lessons learned from developing and implementing this training may be helpful with strategic decision-making for successful replication and adaptation of evidence-based programs when training mental health clinicians working with this vulnerable population.

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# The Report

# Statement of the Problem

Maryland has increasingly documented a significant problem of sex and labor trafficking of children and youth. A complicated mix of geographic and socioeconomic factors contribute to this crime, from Maryland's midpoint location on the Eastern Seaboard and access to I-95, to large numbers of vulnerable youth and unaccompanied minors. While data on the scope of child trafficking is fragmented, several key sources of data have been established to help estimate the size of the problem.

In 2012, Maryland family law was amended to add "prostitution of a child" and "human trafficking" as forms of sexual abuse. Since that change, Maryland's child welfare agency, the Department of Human Services (DHS), added an identifier to the child welfare database to record and track maltreatment cases of suspected child sex trafficking (CST). Between June 2013 and July 2022, 931 reports of suspected child sex trafficking were reported to and screened in by Child Protective Services (CPS) units in Maryland's 24 local Departments of Social Services (LDSSs). At least 318 of these cases were confirmed as human trafficking (marked as "indicated").

# Prevention of Adolescent Risks Initiative (PARI)

PARI is a standalone research unit led by Nadine Finigan-Carr, PhD at the University of Maryland Baltimore's School of Social Work. PARI focuses on adolescent risks by promoting healthy practices during adolescence and taking steps to better protect young people from health risks; critical for the prevention of health problems into adulthood, especially those from vulnerable populations.

PARI partners with various teams across Maryland to improve human trafficking victim identification through the creation and statewide implementation of resources and multidisciplinary teams to address sex and labor trafficking of children and youth. Our work is in partnership with the Maryland Human Trafficking Task Force, the Governor's Office of Crime Youth and Victim Services (GOCYVS), the Maryland Department of Human Resources (DHS - the child welfare agency), the Maryland Department of Juvenile Services (DJS), and the U.S. Attorney's Office. Numerous project partners include the University of Maryland SAFE Center, Healthy Teen Network, TurnAround, Inc., and the Baltimore Child Abuse Center, as well as a network of survivors of human trafficking and child sexual abuse.

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# Task Forces and Coalitions

In 2007, the United States Attorney's Office, the Attorney General of Maryland, and the State's Attorney for Baltimore City formed the Maryland Human Trafficking Task Force (MHTTF), a multidisciplinary team of agencies and organizations committed to a victim-centered approach in addressing human trafficking in Maryland.

Maryland identified two primary challenges in the fight against human trafficking – victim identification and service response. The MHTTF has focused on training first responders and the public on the signs  of the crime and its victims. Once these victims were identified, agencies and organizations were expected

to provide services for victims with a coordinated, victim-centered and trauma-informed response.

The MHTTF has created a well-functioning tool for advancing the work to address trafficking within the child welfare population: the Victim Services Subcommittee. This subcommittee collaborates with members of the Law Enforcement, Public Awareness/Training and Legislative Subcommittees to craft an informed community of service providers in Maryland to identify and respond to the needs of all trafficking victims with a victim-centered response while simultaneously supporting investigations and prosecutions of traffickers.

In addition to the work of the MHTTF which operates statewide, local task forces and coalitions have been established in Baltimore City, Baltimore County, Prince George's County, Anne Arundel County, Howard County, Frederick County, Washington County, Cecil County, Montgomery County, and the Eastern Shore. These county-level task forces gather local stakeholders, address case challenges, disseminate key information from the MHTTF and draft protocols and policies tailored to the specific needs of their jurisdiction. Each group focuses on having a diverse and multi-disciplinary set of participants and the Baltimore City Human Trafficking Collaborative, Anne Arundel County Human Trafficking Collaborative, and Prince George's and Montgomery County Human Trafficking Task Forces recreated the structure of the MHTTF to include subcommittees for victim services, public awareness, and law enforcement.

# Need for Mental Health Clinician Training

Over the past decade, survivor networks, referral listservs, and working groups have been formulated to weave and connect survivors to skilled therapists

with specialized knowledge and trauma training. In 2016, the Maryland Human Trafficking Task Force identified a gap in survivor care which led to the development of this training. Specifically, it was designed in response to the following questions: Where do we refer the identified survivors to longer term therapy? What type of therapy is right? Who are the trauma-informed/trauma-specific referrals?

Many stakeholders indicated that there was a need for training beyond awareness workshops to better respond to the needs of both those at risk for trafficking as well as trafficking victims. Mental health service providers specifically have benefited from trauma-informed, victim-centered training from the MHTTF with funding that PARI has received from DOJ OVC since 2016. These trainings utilize a trauma-informed, victim centered framework that prioritizes developmentally appropriate and culturally sensitive work with victims.

# Training Intervention Description

There is a growing need for specialized mental health treatment approaches for survivors of human trafficking. These approaches must center survivor voices and equip providers to treat the unique sequelae of complex trauma experiences. For years, state and federal training efforts have  centered professional training on equipping providers and law enforcement with identifying victims of human trafficking. Identification training is crucial to the anti-trafficking movement. In addition to these efforts, we must also provide training on what happens beyond identification. Through coordinated and collaborative partnerships across the state of Maryland, survivor leaders, mental health clinicians, and survivor serving organizations have established standards of survivor centered, trauma-specific, mental health therapeutic treatment. The standards of care include a therapeutic approach that focuses on Response, Engagement, and Invention throughout a three-part training series.

The Response, Engagement, and Intervention (REI) © training series is a synchronous training curriculum that builds from foundational knowledge to advanced knowledge of human trafficking to support mental health clinicians in not just responding to the needs of survivors, but on how to align with and empower survivors to guide their own healing (Figure 1). An integral part of this training and treatment modality is understanding the need for clinicians to work within cross agency collaborative partnerships to support survivor care. Survivor integration into the community includes a network of wraparound services. Collaborative partnerships with law enforcement, advocacy groups, shelter-based organizations, long term therapy providers, and survivor leadership are crucial to building a supportive network for survivors. These wrap-around services and collaborative responses are necessary to ensure safety, minimize re-traumatization, and prevent survivors from returning to trafficking situations (colloquially known for some survivors of sex trafficking as the life).

The guiding principles of REI treatment for survivors starts with the foundations of trauma-informed care including safety, trustworthiness and transparency, peer support, collaboration, empowerment, and humility and responsiveness. Beyond the foundations of trauma-informed care in level 101 of this training, REI treatment focuses on trauma-responsive programming in level 201, incorporating survivor voice, community-focused collaborations, and sustainable service provision by providers to mitigate burnout. This training program places a strong emphasis on both survivor and clinician self-care and mutual respect. Throughout each training level, the need for survivors to feel seen, heard, and treated as an equal in the therapy process is highlighted. Power and control dynamics, which are key to traffickers' manipulation of victims, are discussed, processed, and worked through experientially throughout the training both in terms of recruitment tactics and therapeutic alliance. The use of harm reduction as a tool and framework for alliance building is highlighted as well. Harm reduction is an especially important tool for those in high-risk situations who may not always

be able to mitigate the safety risks. Key components to the 101-training component of this model include approaching trauma-informed care through any and all interactions between survivors and systems including law enforcement. During the training, facilitators provide participants with collaborative knowledge to work with survivors, including recruitment and grooming tactics such as trauma bonding. For example, the "Bottom Girl Phenomenon" presented by Shamere Mckenzie, survivor leader and trainer, takes participants into the mind of the bottom girl[1] and highlights the psychological framework for this survivor and how the dynamics of the bottom girl are historically and experientially relevant to work with survivors.

The 201-training component of this curriculum dives into the role and stance of the therapist and the important role the therapist has in ensuring mutual respect and alliance is valued first and foremost in building rapport with a survivor. The therapist is tasked with redistributing power in the therapeutic relationship to support the survivor in guiding the process of therapy vs. the therapist guiding the healing process. Dynamics of race, privilege, and power are discussed openly in the therapeutic relationship and are approached by the therapist to invite conversations that are central to identity formation, trafficking and recruitment, and post-traumatic growth and resilience. Unpacking past therapy experiences, prior contact with systems, and other experiences with helping professionals, both negative and positive, help support rapport building from a "lessons learned" perspective. Sometimes, finding out what was not helpful for a survivor can guide what may be helpful looking ahead. Another central therapeutic tool introduced in level 201 and expanded in the 301 level of training is the use of harm reduction as a framework for alliance building, compassionate care, and risk reduction.

[1] A bottom girl is a victim appointed by the trafficker to recruit, train and watch over new victims, enforce rules, and inflict punishments. See Appendix B for a brief glossary of trafficking terms taught during the training.

The REI treatment approach is considered a trauma-specific empowerment model. The 301-training component supports survivors to guide their own process for healing and for the therapist to offer trauma-specific modalities for therapy that include evidence-based and evidence-supported modalities that integrate brain-based and body-focused interventions. It focuses on the need for survivor empowerment and focuses on post-traumatic growth which showcases the inherent strengths of each survivor vs. survivors being defined by their trauma or adverse experiences. A common question asked by participants in the training is "how do we get survivors to identify as being a victim?" The short answer in this curriculum is that we do not. We do not need someone to self-identify as a victim in order to heal or access services. In many ways, survivor work is challenging the misconception that talking about each traumatic event is necessary for healing. It is not.

This third training level also deepens the need to support therapists in doing their own therapeutic work around attachment wounds, parts work, and body-oriented experiential processing. Therapists have the power to cause harm when their own nervous systems are triggered or dysregulated working with complex trauma survivors (Briere & Lanktree, 2011). It is important for therapists to work to be attuned to their own biases, privilege, power, and emotional triggers. It is also important that providers be engaging in regular supervision and self-care in order to ethically and collaboratively provide trauma-informed care. The details of the Human Trafficking Clinician Collaborative, a consultation group for clinicians working with survivors is detailed later in this report. In addition, countertransference and transference within the therapeutic alliance is revisited in the 301 training. It is highlighted that the trafficking experience is deeply connected to attachment trauma.  Therapists must  be aware of attachment patterns within themselves and others in order to support attachment healing and repair with survivors.

# Design/Partners

This training series is a unique pairing of partnerships across the state. The Maryland Human Trafficking Task Force, Victim Services Sub-Committee has a mental health working group that has been meeting since 2014 on the development of training curriculum for professionals in the community. Key partners include survivor leaders, legal advocacy agencies, survivor serving agencies, private practice therapists, non-profit/non-government community advocates, and state and federal agencies including law enforcement. The main goals of the Mental Health Training Work Group was to identify three types of stakeholders (trauma therapists who had extensive experience working with survivors; law enforcement partners with extensive experience investigating and supporting survivors; and, survivor leaders with experience presenting human trafficking content to professionals); and, to increase the capacity of our state to serve survivors with their mental health therapy needs. At the time, task force partners were struggling to connect survivors to short and long term specialized mental health care.

Originally, this training series was hosted in person across the state, in areas to ensure that providers were located in both urban and rural areas. Training locations included the Baltimore metropolitan area, the Eastern shore, Southern, and Western Maryland. During the height of the Covid-19 pandemic, this training series moved from in person instruction to fully virtual. Now, providers across the state can choose to participate regardless of their regional location. Each training is hosted and supported by PARI and MHTTF Partners. Continuing Education Units are provided by the Maryland Network Against Domestic Violence to ensure that units of education are supporting continuation of licensure requirements for clinicians across the state.

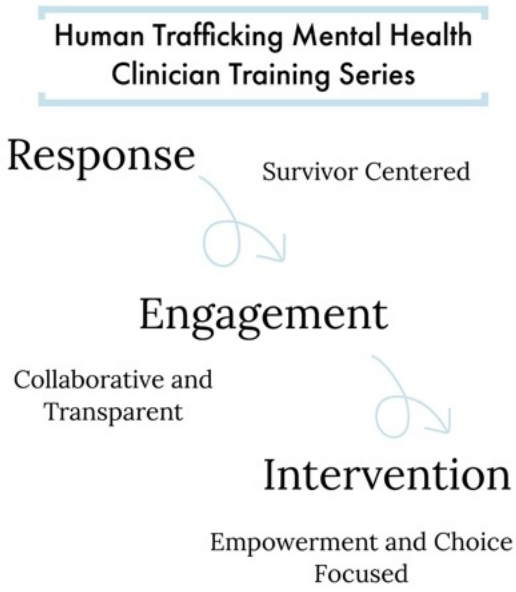


Figure 2 - Response, Engagement, Intervention (REI) Model ©

# Trainees and Eligibility

In the development of this training program, the mental health working group identified the need for prerequisite standards of education and licensure to clarify the purpose and goal of this training series. This training equips direct mental health service providers with specialized training to work with survivors. It also invites providers to be part of an ongoing collaborative as referral sources and to receive continued peer-support in this work. Delineating this training program from other community human trafficking training was important to ensure that trauma therapists, not just case managers or advocates, were being trained to support survivors. Due to the complexities of human trafficking case management, the need for a network of trauma-specific providers is critical to providing supportive wrap-around services survivors need. Following a standard of care, with prerequisites for higher levels of specialized training, is in line with other curricula in the field of mental health therapy. The foundational goal of outlining prerequisite

education, practice, and licensure is to ensure that those providing direct therapeutic services are skilled, supervised, and board certified to provide direct service. Careful attention was made to ensure that the prerequisites did not exclude a group of providers who were already providing direct service, but who may not have the licensure or years of practice criteria. Accessibility of the information to those in a direct mental health service provision role was discussed regularly by the training committee to ensure that we were not creating additional barriers.

### Training Prerequisites

Participants are required to be Licensed Clinicians (e.g. LMSW, LCSW-C, LGPC, LCPC, etc.) with a minimum of three years of experience practicing in a clinical capacity (including internships).

Participants who are licensed clinicians, with less than three-years of clinical experience (under supervision) and currently working in a Rape Crisis, domestic/intimate partner violence or Anti-Trafficking organizations are eligible to attend.

## Trainers

The trainers were comprised of mental health clinicians, victim services professionals, and survivor leaders. All were required to have training experience and be knowledgeable about human trafficking.

**Roxie Farrow** is the Executive Director and Founder of The Exodus Project. She is co-chair of the Maryland Survivor Network, a membership group providing support and professional and leadership development for human trafficking survivors participating in anti-trafficking efforts in the state. She is also a survivor leader consultant for the University of Maryland Support, Advocacy, Freedom, and Empowerment (SAFE) Center for Human Trafficking Survivors, serving on the Human Trafficking Clinicians Collaborative and the Human Trafficking Survivors' Council. The Exodus Project, a human trafficking advocacy and awareness organization that focuses on educating community leaders and youth in the DC metro area. Roxie trains in levels 101 and 301.

**Chelsea Haverly, LCSW-C**, is a TF-CBT and IFS-Level I certified provider and a Victim Assistance Specialist VAS-III for the State of Maryland. Her work with survivors, through referrals from the state Task Force, developed the REI model for collaborative care. She has been an active member of the Maryland Human Trafficking Task Force, Victim Service Subcommittee for over 10 years. Chelsea is a subject matter expert in the neuroscience of trauma and traumatic bonding. She consults with agencies and providers across the country on trauma-specific interventions and programming for survivors of complex trauma and also trauma-informed business practices. She works in private practice currently. Chelsea trains in levels 201 and 301.

**Elisabet Martinez, LCSW-C, LICSW** is a clinical supervisor and a recent lead trauma therapist at TurnAround Inc. TurnAround is an anti-trafficking organization in Baltimore City. Elisabeth is highly experienced working with survivors of both sex and labor trafficking. She has worked in victim services for over a decade. Elizabeth trains in levels 201 and 301.

**Shamere McKenzie,** who is the Chief Executive Officer of Sun Gate Foundation. Shamere is a survivor leader and co-chair of the Maryland Human

Trafficking Task Force. She is "The voice of those who are still enslaved; those who perished while enslaved; and the voice for those who are free but don't have the courage to speak." She is a subject matter expert consultant with Fox Valley Technical College Amber Alert TTA; a member of the National Survivor Network and the Survivor Leadership Institute; a mentor to survivors of sex trafficking and an international speaker; traveling to other countries to speak to both the general population and to work with governments to spread awareness about human trafficking. Shamere is a part of the More than a Survivor: "More than my Story Campaign". Shamere trains in levels 101 and 301 in this training Curriculum.

**Iona Rudisill** is the Clinical Director of Survivor Services at Araminta Freedom Initiative. She is a Certified National Victim's Advocate for victims of child abuse. Iona is an expert in forensic interviewing and its national and international protocols. As a member and certified trainer of the Maryland Human Trafficking Task Force (MHTTF) she has trained and developed standards of care for minor survivors of trafficking. Iona has co-chaired the MHTTF Victim Services Subcommittee. Iona trains in level 101.

**Thomas Stack** is a Law Enforcement Consultant and an active member of the Maryland Human Trafficking Task Force. Tom is the Anti- Human Trafficking and Sexual Assault Response Manager at City of Baltimore. Tom is an active member of the Maryland Human Trafficking Task Victim Service and Law Enforcement Committee. Tom trains in level 101.

## Human Trafficking 101 Overview:

This training highlights the dynamics and elements of human trafficking by (1) providing a scope of the crime through an explanation of laws, vulnerabilities, and processes; (2) bringing understanding to how law enforcement engages with victims and traffickers as well as how they collaborate with partners through their

investigative modalities and operating procedures; (3) highlighting the importance of complex trauma by discussing the effects of trauma bonding and necessity for specialized service provisions; and (4) providing understanding of the different types of victimology.

## Human Trafficking 201 Overview:

This is an advanced clinical training meant for direct service providers who attended 101 and are likely to come in direct clinical contact with survivors of human trafficking. Participants of this training are meant to understand and identify mental health risks associated with trafficking and barriers to treatment for survivors; understand neurobiology of trauma and how it relates to treatment expectations; understand how traumatic bonding impacts the therapeutic alliance and ability to form and maintain new and healthy relationships; understand how abuse and impact of poly-victimization for survivors of trafficking impacts their ability to engage in mental health therapy; learn trauma-informed interventions to address safety, build rapport, manage emotional dysregulation, build skills and process grief; and acknowledge the role of self-care, system collaboration and transparency of decision-making in mental health with survivors.

## Human Trafficking 301 Overview:

This is an advanced clinical training meant for participants who completed 101 and 201. Participants of this training expect a combination of didactic teaching, experiential learning, role-play case examples and videos. The session focuses on the importance of knowledge of the brain and how complex trauma exposures, such as human trafficking can complicate the brain's ability to engage in traditional therapy modules. Presentation includes new information on neuroscience as it applies to survivors of complex trauma and ways that a therapist can pass "the therapist test" to continue working with survivors of trafficking. Participants will

be able to build rapport and maintain an alliance using motivational interviewing (MI) strategies; differentiate a bottom-up approach vs. top down approach to clinical work; identify what body-based interventions are; understand the role of micro-expressions in therapeutic work; and identify different "parts of self" as it relates to dissociation and post-traumatic growth. In an effort to encourage clear communication with participants this message was communicated- "please note, this is a highly interactive training that will require providers to participate in role plays and to be reflective and vulnerable."

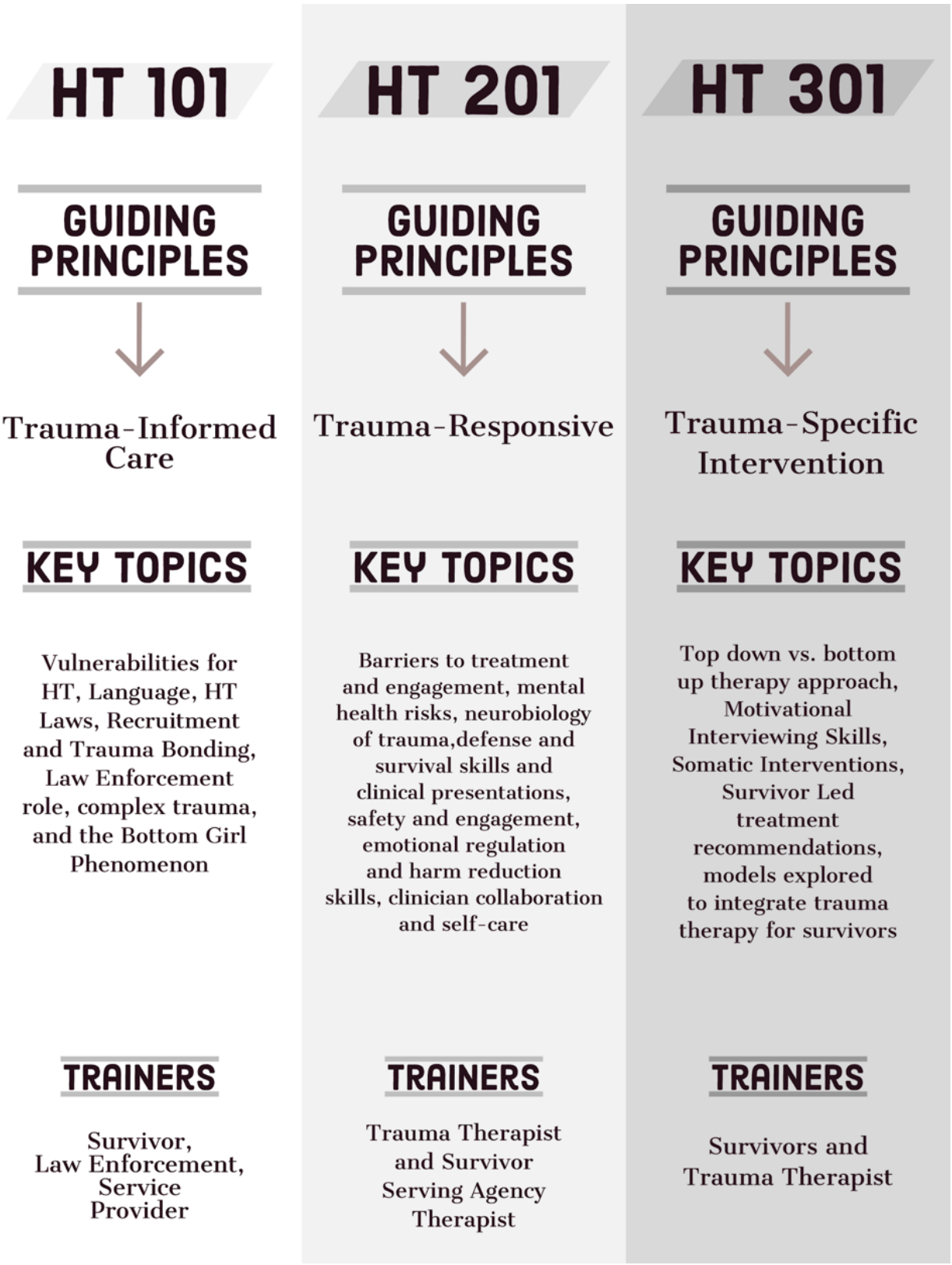


Figure 3 - Overview of REI Training Series ©

# Human Trafficking Clinician Collaborative

The purpose of the Human Trafficking Clinician Collaborative (HTCC) was to establish and create a sustainable, collaborative, trauma-informed group of therapists across the state of Maryland. The need for longer term services for survivors of human trafficking was conducted in a collaborative needs assessment by the Maryland Human Trafficking Task Force, Victim Service Subcommittee. In 2017, there was a growing number of shelter-based and case management programs looking to connect survivors to longer term trauma therapy support. The mission of the HTCC continues to be a commitment to collaborative community care for survivors through an established network of trauma providers. This network of providers continues to seek consultation with other providers and task force leaders to best meet the clinical needs of survivors of human trafficking.

Providers are eligible to join the HTCC once participants complete the 101 and 201 training levels. Structurally, the collaborative meets bi-monthly and is supported by survivor leadership partnerships. It facilitates what's called a warm referral to trained providers in a process meant to limit barriers to accessing specialized services. If a task force member is working with a survivor with a need for trauma therapy, they email the HTCC to be connected to a provider (HTCC@anchoredhopetherapy.com). Eligible providers are contacted to see who is available to see the survivor. The survivor is then connected directly to the provider to facilitate the next steps for therapy.

# The HTCC operates under the below Guiding Principles:

## Be Respectful of Self and Others

The practice of adopting a trauma-informed and healing approach to clinical work with survivors of trafficking involves navigating complex systems, collaborating with other providers, and engaging in self/community care practices for sustainability. Participants acknowledge that this work is hard; and, it is necessary to be respectful of self-led boundaries and the boundaries and capacities of others.

## Respect Everyone's Privacy

Participants acknowledge the need for mutual trust. Authentic and expressive discussions make groups great but may also be sensitive and private and include confidential information. What is shared in the group should stay in the group. If a problem or concern arises connected to a group member or survivor, address this issue directly with the person and or group administrators. The group also acknowledges that sharing clinical obstacles and client experiences must be done with permission to prevent further exploitation of their experience. The group will engage in group consultation that is confidential and only information relevant to the consultation will be shared.

## Consultation and Collaboration Happens Here

The HTCC supports the sharing of resources, discussions, consultations and connections. While this group aims to protect participants' privacy and will protect client privacy, this collaboration group is not a confidential and privileged communication space. Therefore, supervision and other in-depth clinical concerns should be addressed in a formal supervision setting. No client names and identifiable information should be used in consultation with other providers in this

group.

## Honor Brave Space

This is a BRAVE space-not a “safe” space. Dr. Jama Shelton once said “safe spaces are not enough to change the world.” We will address areas of struggle, while centering the needs of survivors of trafficking in complex systems of oppression, racism, transphobia, sexism, fat phobia and any other -ism/-phobia that we are actively working to dismantle. The intersectionality of social issues and survivor issues will be acknowledged ongoing. The HTCC acknowledges the need and cultivation of the “awkward space” to call someone into ‘going deeper’ on an issue when intersectionality is not fully acknowledged. It is necessary work to challenge ourselves and each other to do better and think differently. It is also important to acknowledge white body supremacy and the need to name privilege and power in the helping profession to challenge saviorism tendencies when they arise.

# Lessons Learned By Trainers

This training series began pre-pandemic when in-person training was the only method used to disseminate the curriculum. Adjusting materials and discussion to fit an online platform became important in the Spring of 2020. Experiential learning through role play and small group discussion was challenging via a virtual platform. The positive side of the virtual platform is the ability to have providers from all over the state attend regardless of distance. Creating a hybrid training model would be helpful to consider, especially with the goal of applying a hybrid approach to levels 201 and 301 as these trainings become more experiential for integration of learning.

In a post training work group, trainers discussed the need to provide an

acknowledgment in each section of the training. This acknowledgement would include "what will you get and what are we asking of you today" slide to invite participants to receive the information in a collaborative way. Key areas for growth and further exploration are also the need for expanded content on labor trafficking with specific examples and not just sex trafficking examples. The language used tends to be largely heteronormative and future training should include increased focus on the use of non-binary language and case examples representative of trans and non-binary survivors of trafficking.

Since the beginning of this training series, one of the most common questions trainers have received is "how do we get survivors to identify as being a victim?" There are several layers of tension amongst those in the anti-trafficking, harm reduction, advocacy, and therapy space around identification of survivors and what needs to happen to support and protect survivors. Some survivors do not identify as a "survivor" or a "victim". Some identify as a "sex worker" and some do not identify the same way depending on their experiences both pre-and post-trafficking. It is important to acknowledge this tension in the field because there is no "right way" to be a survivor and/or victim of trafficking.

Harm reduction policies and decriminalization policies continue to have a major impact in the anti-trafficking movement. Concerns around the safety of sex workers and the rights of sex workers is at the forefront of many policy advocate's minds along with ensuring the rights and safety of children. Part of this layered tension includes a disconnect between the federal definition of trafficking outlining that any minor, who engages in a commercial sex act, is a victim of human trafficking and some empowerment model programs supporting body liberation and choice as key factors to consider in identifying a victim of trafficking. This tension between "choice" and "recruitment" and "survival-based decision making" are important areas for continued exploration in this field. It is important that providers and advocates explore their reactions to the idea of someone choosing

sex-work, being recruited, recruiting others, feminist liberation theory, minor sex workers, harm reduction policies and decriminalization policies. It is also important to consider the deeper and nuanced neuroscience of choice and safety that is emerging in the field (Dolcos & Denkova, 2014).

Survivor leader Rebeka Charleston and Expert Trainer Chris Wilson, PsyD provide a fantastic overview of "threat mapping" in our brains in neurobiology training through the Being Trauma Informed Training Series[2]. They provide excellent knowledge on how our survival circuitry impacts our attachment and choice patterns. Traumatic decision making and survival-based decision making are important to learn and understand when we are looking at someone's "choice" to engage in sex work or recruitment behavior and decision making. Further research and training in this field should explore where choice, survival, trauma, pain, discomfort, socio-economic factors, and attachment patterns intersect.

There is no such thing as a single issue or single determinant factor that makes someone "choose" or be "recruited" into trafficking. Cognitive dissonance, familiarity, safety, and chronic states of chaos are all additional factors that are also part of the layered tension of someone self-identifying as a victim of trafficking. The polarizations and black and white thinking that can keep advocates and providers stuck in silos of policies and practices needs to be recognized. It is imperative that trauma therapy providers again explore their own relationships and attachments with these issues and be able to hold space for a survivor to not identify in one specific way to access services. Providers must also expand knowledge and practice skills in using and implementing harm-reduction with survivors of trafficking. Harm reduction, as a therapeutic framework, has great potential to leverage relationship building and risk management in a compassionate and non-judgmental way.

[2] Being Trauma Informed Virtual Training Academy - https://bti.thinkific.com/

We must broaden our idea of what a survivor is and what they look like. They do not need to identify as a survivor or victim to access services, they should explore their relationship with choice, autonomy, survival-based decision making to explore and deepen their own understanding of their experience. After all, it is their understanding and integration of their own life experience and story that is the most important goal of therapeutic work.

# Program Evaluation and Monitoring

## Evaluation Methods

## Sample

Respondents were participants who completed the Human Trafficking Training for Mental Health Providers 101, 201 & 301 sessions described above, offered in eighteen sessions (six each of 101, 201, and 301) between September 2020 and September 2022. The training series was offered on a strictly cumulative basis, meaning that completion of each level was a pre-requisite for the next level. Therefore 201 sessions had slightly fewer trainees complete them than 101 sessions, and so on. The 201 evaluation survey respondents therefore duplicate the 101 respondents, so summary statistics only draw from the 101-level pre-tests. Of the 153 attendees at the 101 training, 149 filled out pre-training surveys, for a response rate of 97%. It was not possible to calculate a response rate for the 201 training series due to data tracking errors with the sign-in sheets, but 109 trainees completed pre-tests. Of the 89 trained at level 301, 88 responded to pre-training surveys, for a response rate of 99%.

## Procedure

Online evaluation surveys were provided via a link to all training participants before and immediately after each training session, with time for filling out the pre- and post-training surveys at the beginning and end of each training session.

## Measures

The Human Trafficking Awareness Survey is a 27-item questionnaire originally utilized nationally by the United States Children's Bureau Fromknecht & Ingoldsby, 2020). The pre-training survey asked training participants to answer five demographic and work history questions, including an open-ended question "what is your gender?" that was re-coded into a binary male and female (having received one transgender response). Race and ethnicity included African American, American Indian/Alaska Native, Asian/Pacific Islander, Caucasian, Hispanic/Latino(a), and other (write in). Analyses were limited to the Caucasian and African American respondents, since no other group comprised two or more percent of the sample. Tenure was measured in years and months. Current position listed 26 choices, ranging from caseworker to judge to foster parent. Knowledge and self-efficacy questions were identical in both the pre-and post-test surveys (See results Tables 2-4 for complete items).

## Analysis

Frequencies and descriptive statistics related to participant characteristics such as demographics and tenure were tabulated using only the 101 training pre-tests, since the training sessions were cumulative. Internal reliability for the knowledge and self-efficacy scales were calculated for each training level. Dependent samples T-tests were conducted in SPSS (IBM, 2022) to identify the

statistical significance of the change in knowledge and self-efficacy on an item and sum level from pre-training test to post-training test for each level.

# Evaluation Results

## Summary Statistics

Participants were mostly women, with 91% of respondents typing “female” or “woman,” two people writing in “nonbinary” or “enby,” and 7% writing “man” or “male.” About half (54%) of participants marked “Caucasian” on the pre-101 survey, with 26.2% marking African American and 8% “Hispanic/Latino.” Five participants marked Asian/Pacific Islander, and three marked “Other” race.

Respondents were moderately experienced on average, with a mean of nine and a half years in the field. Current positions were mostly marked as “Mental Health Provider”, with 74 of 130 respondents in that category, which was the target audience for whom the training was designed. There were six administrators responding to the 101 pre-test, 27 marking other direct service roles such as school counselor or case manager, and 22 marking “other.”

**Table 1 Summary Statistics for 101 Training Evaluation Respondents**

| Variable Name | N | Freq. | Percent | Range | Mean (SD) |
|---|---|---|---|---|---|
| **Gender** | | | | | |
| Male | 149 | 11 | 7.4 | | |
| Female | 149 | 136 | 91.3 | | |
| Nonbinary | 149 | 2 | 1.3 | | |
| **Race** | | | | | |
| African American | 149 | 39 | 26.2 | | |
| American Indian/Alaska Native | 149 | 0 | 0.0 | | |
| Asian / Pacific Islander | 149 | 5 | 3.4 | | |
| Caucasian | 149 | 81 | 54.4 | | |
| Hispanic/Latino | 149 | 12 | 8.1 | | |
| Other | 149 | 3 | 2.0 | | |
| Years in the field | 114 | | | 0-40 | 9.56 (8.35) |
| **Current Position** | | | | | |
| Local-Level Child Welfare Supervisor or Administrator | 130 | 6 | 4.6 | | |
| Caseworker | 130 | 9 | 6.9 | | |
| Child Protective Investigator | 130 | 4 | 3.1 | | |
| School Based Counselor | 130 | 3 | 2.3 | | |

| Variable Name | N | Freq. | Percent | Range | Mean (SD) |
|---|---|---|---|---|---|
| Victim Advocate | 130 | 6 | 4.6 | | |
| Mental Health Provider | 130 | 74 | 56.9 | | |
| Trafficking Treatment Provider | 130 | 2 | 1.5 | | |
| Shelter/Housing Provider | 130 | 3 | 2.3 | | |
| Other | 130 | 22 | 16.9 | | |
| | | | | | |
| **Mean Knowledge Pre-Training** | 132 | | | 0-10 | 5.66 (1.88) |
| **Mean Knowledge Post-Training** | 113 | | | 0-10 | 8.33 (0.99) |
| **Change in Mean Knowledge** | | | | | 2.67 |
| **Mean Self-Efficacy Pre-Training** | 131 | | | 0-10 | 5.53 (2.09) |
| **Mean Self-Efficacy Post-Training** | 111 | | | 0-10 | 7.99 (1.23) |
| **Change in Mean Self-efficacy** | | | | | 2.46 |

# Knowledge and Change in Knowledge

Prior to the 101 training, there was a broad range of human trafficking knowledge levels, and the areas in which participants came with the least self-reported knowledge were government definitions of trafficking, trafficking-related terminology, ways to engage with trafficked youth, and the victimization and dynamics of the bottom girl. Participants arrived with higher self-reported knowledge about reporting requirements, complex trauma, and factors that put youth at risk for trafficking. A change in self-reported knowledge was shown for every knowledge item, and the differences in means were statistically significant for every item, indicating improved knowledge in each area. Items with the most improvement in self-reported knowledge were the same items about which participants arrived with little knowledge: definitions, terminology, engagement with survivors, and victimization of the bottom girl.

For the 201 training, pre-test results show that trainees self-reported the least knowledge about the clinical presentation of survivors and the most knowledge about self-care strategies for clinicians. Overall self-reported pre-training knowledge was greater for the learning objectives of the 201 training than for the 101 training. As with the 101-curriculum training, change in self-reported knowledge was shown for every item, and the differences in means were statistically significant for every item, indicating improved knowledge in each area. Items with the most improvement in self-reported knowledge were the clinical presentation of survivors, treatment considerations and rapport-building strategies for survivors of trafficking, and trauma processing for survivors.

With the 301 training, trainees self-reported higher knowledge levels about motivational interviewing strategies, and lower levels of self-reported knowledge about a “bottom-up” or “top down” approach to therapy is, body-based interventions for survivors, how micro-expressions are used in therapeutic work,

dissociation and parts work, how to identify a "part" and its purpose, how to work with "parts" towards integration, and how to incorporate post-traumatic growth in therapy and assessment. As with the first two curricula, a change was seen with every knowledge item, and the differences in means were statistically significant for every item, indicating improved knowledge in each area. Change in knowledge during the 301 training was highest for how to incorporate post-traumatic growth in therapy and assessment and defining bottom-up and top-down approaches to therapy.

## Self-efficacy and Change in Self-efficacy

Attendees of the 101 training began with levels of self-efficacy that were somewhat lower than their self-reported knowledge. Modest change in self-efficacy was similar for all three items: applying trauma informed practices when working with victims of trafficking and those at high risk, engaging in proactive activities to assess and identify youth at risk of trafficking, and responding appropriately when victims of human trafficking are identified. Participants in the 201 training sessions arrived with higher levels of both self-reported knowledge and self-efficacy, and experienced less change in self-efficacy during the training than did the 101 participants. Confidence or self-efficacy improved most related to identifying types of trafficking and its red flags, while self-efficacy improved least for the item related to effective supervision. For those continuing with the 301 training, motivational interviewing was the most comfortable before the training began, and utilizing "parts-work" to manage, assess and treat dissociation with survivors was the area they were least self-confident about. Trainees experienced the least improvement in the areas of comfort with self-care, and harm reduction techniques. Attendees experienced the most improvement in their confidence with utilization of "parts-work" to manage, assess and treat dissociation with survivors.

**Table 2. 101 Training: Knowledge and Self-efficacy Item Responses with Pre-post Change T-tests**

- **Cronbach's alpha .932 for Knowledge**
- **Cronbach's alpha .913 for Self-efficacy**

| Item | Pre-test Mean n = 131 | Post-test Mean n = 111 | Change | *t* | *p* |
|---|---|---|---|---|---|
| ***What is your levael of knowledge about the items below?*** | | | | | |
| The federal and state definitions of sex trafficking | 5.03 | 7.85 | +2.82 | -11.95 | <.001 |
| Factors that put youth at risk of sex trafficking | 6.37 | 8.26 | +1.89 | -9.85 | <.001 |
| Ways to engage with sex trafficked youth | 5.02 | 7.82 | +2.80 | -12.22 | <.001 |
| Mandated reporting requirements for youth victims of trafficking | 6.64 | 8.75 | +2.11 | -8.79 | <.001 |
| Strategies used to recruit youth into sex trafficking | 5.84 | 8.47 | +2.63 | -11.81 | <.001 |
| Terminology related to sex trafficking (e.g., commercially sexually exploited youth, prostitution, pimp, etc.) | 5.27 | 8.36 | +3.09 | -13.28 | <.001 |
| Complex trauma and trauma bonds and the impact on survivors of human trafficking | 6.24 | 8.49 | +2.25 | -10.55 | <.001 |
| The victimization and dynamics of the "bottom girl" | 4.88 | 8.58 | +3.70 | -14.37 | <.001 |
| **Mean of all knowledge items above** | **5.66** | **8.33** | **+2.67** | **-14.20** | **<.001** |

| Item | Pre-test Mean n = 131 | Post-test Mean n = 111 | Change | *t* | *p* |
|---|---|---|---|---|---|
| ***With your current level of experience, how comfortable do you feel about your ability to:*** | | | | | |
| Apply trauma informed practices when working with victims of trafficking and those at high risk | 5.78 | 8.02 | +2.24 | -9.60 | <.001 |
| Engage in proactive activities to assess and identify youth at risk of trafficking | 5.27 | 7.86 | +2.59 | -11.12 | <.001 |
| Respond appropriately when victims of human trafficking are identified | 5.55 | 8.07 | +2.27 | -10.76 | <.001 |
| **Mean of all self-efficacy items above** | **5.53** | **7.99** | **+2.46** | **-11.34** | **<.001** |

**Table 3. 201 Training: Knowledge and Self-efficacy Item Responses with Pre-post Change T-tests**

- **Cronbach's alpha .959 for knowledge scale**
- **Cronbach's alpha .955 for self-efficacy scale**

| Item | Pre-test Mean n = 109 | Post-test Mean n = 80 | Change | *t* | *p* |
|---|---|---|---|---|---|
| ***What is your levael of knowledge about the items below?*** | | | | | |
| The red flags for identifying a survivor of trafficking | 6.21 | 8.13 | +1.92 | -9.92 | <.001 |
| Clinical presentation of survivors | 5.82 | 8.09 | +2.27 | -10.16 | <.001 |
| Types of trafficking (i.e., survival sex, pimp-controlled trafficking, gang-controlled trafficking, non-pimp-controlled trafficking, familial trafficking) | 6.62 | 8.39 | +1.77 | -8.04 | <.001 |
| The formation/perpetuation of trauma bonding | 6.59 | 8.23 | +1.64 | -7.35 | <.001 |
| Tangible Needs of Survivors | 6.39 | 8.29 | +1.90 | -8.68 | <.001 |
| Complex Trauma and the Brain | 6.76 | 8.24 | +1.48 | -6.80 | <.001 |
| Treatment considerations and rapport building strategies for survivors of trafficking | 6.25 | 8.34 | +2.09 | -9.37 | <.001 |
| Role of toxic stress and brain development | 6.54 | 8.20 | +1.66 | -7.47 | <.001 |
| Stages of change in recovery and healing | 6.88 | 8.29 | +1.65 | -6.64 | <.001 |

| Item | Pre-test Mean n = 109 | Post-test Mean n = 80 | Change | *t* | *p* |
|---|---|---|---|---|---|
| Trauma processing for survivors | 6.54 | 8.19 | +2.22 | -7.62 | <.001 |
| Self-care strategies for clinicians | 7.38 | 8.71 | +1.33 | -6.20 | <.001 |
| Ethical collaboration among providers in working with survivors | 6.50 | 8.43 | +1.93 | -8.77 | <.001 |
| **Mean of all knowledge items above** | **6.54** | **8.29** | **+1.75** | **-9.98** | **<.001** |
| ***With your current level of experience, how comfortable do you feel about your ability to:*** | | | | | |
| Identify types of human trafficking including red flags for human trafficking | 6.28 | 8.11 | +1.83 | -8.38 | <.001 |
| Apply trauma informed practices when working with survivors of trafficking in mental health therapy | 6.36 | 8.11 | +1.75 | -7.51 | <.001 |
| Engage in evidence-based treatment modalities to support the reduction of trauma symptoms for survivors | 6.32 | 8.06 | +1.74 | -7.69 | <.001 |

| Item | Pre-test Mean n = 109 | Post-test Mean n = 80 | Change | *t* | *p* |
|---|---|---|---|---|---|
| Respond appropriately when victims of human trafficking are identified (e.g. rapport, non-judgmental stance, mandated reporting, relationship building) | 6.92 | 8.54 | +1.62 | -7.12 | <.001 |
| Apply brain-based science and research on how trauma impacts brain development and treatment planning | 6.25 | 7.97 | +1.72 | -7.19 | <.001 |
| Demonstrate skills needed to successfully reduce symptoms of trauma and maintain positive rapport with survivors | 6.66 | 8.23 | +1.57 | -7.18 | <.001 |
| Effectively use supervision and case consultation to sustain self-care in working with high risk/survivor populations | 7.11 | 8.59 | +1.48 | -6.28 | <.001 |
| **Mean of all self-efficacy items above** | **6.56** | **8.23** | **+1.67** | **-8.50** | **<.001** |

**Table 4. 301 Training: Knowledge and Self-efficacy Item Responses with Pre-post Change T-tests**

- **Cronbach's alpha .950 for knowledge scale**
- **Cronbach's alpha .942 for self-efficacy scale**

| Item | Pre-test Mean n = 88 | Post-test Mean n = 58 | Change | *t* | *p* |
|---|---|---|---|---|---|
| ***What is your levael of knowledge about the items below?*** | | | | | |
| Techniques to build rapport using Motivational Interviewing | 6.91 | 8.02 | +1.11 | -5.46 | <.001 |
| Techniques to maintain alliance using Motivational Interviewing | 6.81 | 7.90 | +1.09 | -5.15 | <.001 |
| What a "bottom-up" approach to therapy is | 5.60 | 8.12 | +2.52 | -8.34 | <.001 |
| What a "top down" approach to therapy is | 5.58 | 8.04 | +2.46 | -8.13 | <.001 |
| What are body-based interventions for survivors | 5.89 | 8.12 | +2.23 | -7.33 | <.001 |
| How micro-expressions are used in therapeutic work | 5.51 | 7.97 | +2.46 | -8.28 | <.001 |
| Dissociation and Parts Work | 5.85 | 7.86 | +2.06 | -6.86 | <.001 |
| How to identify a "part" and its purpose | 5.67 | 7.73 | +2.06 | -6.67 | <.001 |
| How to work with "parts" towards integration | 5.35 | 7.67 | +2.32 | -7.68 | <.001 |
| How to incorporate post-traumatic growth in therapy and assessment | 5.39 | 7.98 | +2.59 | -7.35 | <.001 |

| Item | Pre-test Mean n = 88 | Post-test Mean n = 58 | Change | *t* | *p* |
|---|---|---|---|---|---|
| **Mean of knowledge items above** | **5.90** | **7.94** | **+2.04** | **-8.70** | **<.001** |
| ***With your current level of experience, how comfortable do you feel about your ability to:*** | | | | | |
| Utilizing Motivational Interviewing with Survivors | 6.09 | 7.79 | +1.70 | -6.17 | <.001 |
| Practicing Motivational Interviewing to Build Alliance and Rapport | 6.32 | 7.97 | +1.88 | -6.17 | <.001 |
| Identifying brain-based and body focused interventions for survivors | 5.88 | 8.02 | +2.14 | -7.13 | <.001 |
| Incorporate body-based/ somatic approaches to therapy with survivor | 5.72 | 7.79 | +2.07 | -6.83 | <.001 |
| Using harm reduction techniques with survivors | 6.58 | 8.05 | +1.47 | -5.14 | <.001 |
| Acknowledge the need for self-work and self-reflection as a provider working with survivors | 7.48 | 8.50 | +1.02 | -3.83 | <.001 |
| Utilizing "parts-work" to manage assess and treat dissociation with survivors | 5.39 | 7.76 | +2.37 | -7.32 | <.001 |
| **Sum of self-efficacy items above** | **6.21** | **7.98** | **+1.77** | **-6.98** | **<.001** |

# Qualitative Training Feedback

Trainees' surveys also contained open-ended fields for written feedback about each of the trainings, and responses were generally few and very brief. About three quarters of the responses about the 101-training contained positive feedback, praising: the knowledgeable, engaging trainers; the interactive format, even on video conference; the knowledge they gained; their increased confidence; and the use of real-world examples. Constructive feedback included wanting more time for case-study-based breakouts, and a more trauma-informed presentation from law enforcement leaders.

Feedback via the 201-training survey's open-ended qualitative questions was comprised of two thirds positive comments, including praise for the knowledgeable speakers using real-life case examples, and their openness and responsiveness to questions. Commenters with constructive or negative feedback generally wanted more interaction, naming oral dialogue, vignettes, videos, and polls as options to increase interactivity. More advanced material as differentiated from the 101 course was also desired by multiple trainees.

In response to the open-ended questions about the 301 training, participants were equally balanced in mentioning areas of strength (positives) and areas for growth (negatives). Commenters enjoyed the engaging trainers and usefulness of the material and the inclusion/centrality of the voices of lived experience in the training. Participants wished for more time in interactive groups, more breakout activities, shorter lectures, pre-training materials, and more skill practice.

## Human Trafficking Clinician's Collaborative Feedback

When asked to evaluate the post-training Human Trafficking Clinician's

Collaborative (HTCC) gatherings, most clinicians mentioned being grateful for the case conceptualization, meeting and connecting with other clinicians, learning about new resources for survivors they serve, and having a place to ask questions and get an answer. Some participants mentioned building new skills in documentation, safety planning, and negotiating with insurance companies. When asked about HTCC's areas for improvement, clinicians mostly said "nothing" or "N/A", while two were disappointed that no resources for survivors were discussed from their county or region of the state. Responding to the two quantitative survey questions, nearly all agreed or strongly agreed that "the information provided was useful to me" (mean 4.27 of 5) and that "my knowledge increased regarding community resources and services" (mean 4.18 of 5).

When asked for new topic areas for future HTCC gatherings, clinicians requested more information on investigations and forensics, resources for survivors who are immigrants, practice modalities and trauma processing methods for trafficking survivors, labor trafficking. Participants wanted to receive legislative updates around trafficking and mental health. Clinicians also wanted support for serving young survivors, victims of child pornography, and those who return to sex work after leaving the life.

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# Appendix

# Appendix A

## Sample Curriculum Overview

### Content

**Section 1: Welcome and Introduction to Human Trafficking**

- Introductions and Orientation
- What is Human Trafficking and Child Sex Trafficking?
- Human Trafficking Laws & Human Trafficking Landscape

**Section 2: Dynamics of Child Trafficking**

- Types of Child Trafficking
- Methods of Recruitment and Control

**Section 3: Risk and Vulnerability**

- Risk and vulnerability factors contributing to Child Trafficking
- Red flags and identifying child victims

**Section 4: Responding to Victims**

- Child Welfare Response and SSA Directives

- Wrap up Morning Session

**Section 5: Afternoon Welcome and Transition**

- Survivor's Voices
- Brainstorm: Impacts of Sex Trafficking
- Case Mapping and Clinical Models

**Section 6: Case-by-Case: Game Play and Application**

- Case-By-Case: Working with Sex Trafficking Victims Instructions & Play
- Case-by-Case Game Debrief

**Section 7: Case Work Preparation and Q&A**

- Personal Training Plan
- Closure and Evaluation

# Appendix B

## Human Trafficking Language and Terminology

*(Excerpted from Engaging Child Victims of Sex Trafficking curricula handouts)*

**Bottom girl:** A trafficking victim who is the trafficker's main or "right hand" girl appointed to recruit, train and watch over new victims, enforce rules and inflict punishments. S/he has usually been with the pimp the longest and they may have children together. Bottom girls often endure significant abuse and are used as scapegoats to shield pimps from police attention.

**Brand:** A tattoo on the victim that indicates the trafficker owns and controls them. Examples of brands are initials, logos (like a crown), and names.

**Child Sex Trafficking:** The trafficking of a minor under the age of 18 in which the child is involved in a commercial sex act. This is a form of child abuse.

**Commercial Sex Act:** A sex act for which anything of value is given to or received by any person. The item of value can be money or valuable commodities like shelter, food, clothing, or drugs. Primary types of commercial sex are prostitution, pornography and exotic dancing/stripping.

**Commercial Sexual Exploitation of Children (CSEC):** The use of a child under 18 for sexual purposes in exchange for something of value or promise thereof.

**Daddy**: Used by male traffickers to control a victim or victims. The traffickerwill often require victims to refer to him as "Daddy" as a sign of respect and submission. By using this term, the trafficker reinforces his bond with the victim and reminds the victim of who is in control. Trafficker is often saved in victim's

phone under “Daddy.”

**Date:** The actual act of prostitution or commercial sex, often arranged online. (Ex. “Kandi had 5 dates that night.”)

**Date/John/Trick/Client:** Terms referring to the person, usually male, purchasing the commercial sex act.

**Domestic Minor Sex Trafficking (DMST):** The commercial sexual exploitation of any American citizen or lawful permanent resident under age 18. This term serves as a reminder that victims may be U.S. Citizens or foreign nationals.

**Human Trafficking:** The act of recruiting, harboring, transporting, providing, or obtaining a person for compelled labor or commercial sex acts through the use of force, fraud, or coercion. This term describes the crime in which individuals financially profit from the exploitation of others forced into either commercial sex acts or forced labor.

**The Life or The Game:** Describes the day-to-day experience of being involved in the commercial sex industry (prostitution, stripping, etc.) and the rules and expectations of the business. Used in reference to the “subculture” of pimping, these terms are more applicable to those under the control of a trafficker.

**SAFE:** This acronym stands for “sexual assault forensic examination” and is sometimes called a “rape kit.” This is the medical examination used to collect evidence in cases of sexual assault.

**SANE:** This acronym stands for “sexual assault nurse examiner.” SANEs are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of patients who have experienced sexual assault or abuse.

**Trafficker/Pimp:** The perpetrator responsible for exploiting the victim through forced labor and/or commercial sex and individual benefiting financially from this exploitation. Terms are often used interchangeably; "trafficker" is the more formal, legal term while "pimp" is slang. Victims may not be familiar with "trafficker."

**Victim and Survivor:** Both terms are used to refer to those who have been trafficked/commercially sexually exploited. Individuals will choose which term feels best for them or chose other language they feel more comfortable using. Offering both terms acknowledges that individuals may be at different stages of healing and recovery and may prefer a certain term at different points in their individual process.

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[1] In Public Safety. "Know the Language of Human Trafficking: A Glossary of Sex Trafficking Terms." July 3, 2014. Accessed at http://inpublicsafety.com/2014/07/know-the-language-of-human-trafficking-a-glossary-of-sex-trafficking-terms/ on March 1, 2017.

[2] Shared Hope International. "Common Sex Trafficking Language." Accessed at http://sharedhope.org/the-problem/trafficking-terms/ on March 1, 2017.

[3] Ibid.

# Training Project Partners and Sponsors