

Surviving to Thriving: A Qualitative Exploration of Direct Service Providers' Trauma-informed Work with Human Trafficking Survivors in Kentucky

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Abstract

Objective: Survivors of human trafficking, including commercial sex and labor exploitation, benefit from comprehensive, trauma-informed services, but more research is needed to establish best practices and identify effective models and strategies. The current study explored the lived experiences of seven direct service providers in agencies that support the recovery and development of human trafficking survivors in Kentucky. The aim of this study was to inform our understanding of how trauma-informed care better addresses the needs of human trafficking survivors in healthcare and social services settings. **Method:** Using qualitative, narrative inquiry methods, this study identified trauma-informed models and strategies currently employed in Kentucky agencies that serve trafficking survivors and participants' experiences with successful strategies and barriers to promoting trauma-informed care. The theoretical framework that guided this study is Bronfenbrenner's ecological systems theory. Participants' stories were collected through artifact presentations, semi-structured interviews, guided questionnaires, and a focus group. **Results:** Data analysis revealed the themes of (1) education and training, (2) responding to needs, (3) safety and transparency, (4) trusting relationships, and (5) standards of care. **Conclusions:** Implications for legislation in Kentucky to implement standards of care and support preventative efforts are explored.

Keywords: human trafficking, legislation, service providers, survivors, trauma-informed care

Clinical Impact Statement

Although it is well documented that survivors of human trafficking benefit from trauma-informed services, there is little research identifying or evaluating the trauma-informed models and strategies used by trafficking-specific agencies to establish best practices. Through the stories of direct service providers who work with trafficking survivors in Kentucky, findings from this study point to the importance of education and training on trauma-informed trafficking-specific needs and services, comprehensive resources for survivors, a focus on survivor safety and building healthy relationships, and legislation to establish, implement, and regulate evidence-based practice and standards of care.

Introduction

Human trafficking is defined as “the recruitment, transportation, transfer, harboring or receipt of persons” for the purpose of exploitation, through threat or use of force, fraud, deception, abduction, coercion, or abuse of power imbalances or vulnerability, or when the exploitation involves a person under 18 years of age (United Nations, 2000). Internationally, human trafficking primarily includes labor trafficking (42% of cases), sex trafficking (36%), or a combination of the two (8%) and is the second largest and fastest growing criminal enterprise in the world; in North America, 69% of trafficking cases involve sexual exploitation (United Nations Office on Drugs and Crime [UNODC], 2024). Kentucky’s proximity to multiple interstates and high-profile events, combined with the Commonwealth’s historically high rates of poverty, opioid use, and child maltreatment, put its residents at an elevated risk for human trafficking (Middleton et al., 2020). In 2024, the National Human Trafficking Hotline identified 139 human trafficking cases in Kentucky involving 256 victims, including 37 minors and 100 females (National Human Trafficking Hotline [NHTH], 2024). Many adult survivors first

entered a trafficking situation as children; in the U.S., the average age of entry into sex trafficking is 12-14 years old, and one in six victims are below age 12 (Thorn, 2018). In Kentucky, most confirmed cases of child trafficking are familial sex trafficking, often occurring in rural settings involving a mother-perpetrator trafficking her child(ren) in exchange for drugs (Sprang & Cole, 2018). Recognizing Kentucky's elevated risk for human trafficking, the trauma exposure experienced by trafficking survivors, and the scarcity of research focusing on trafficking-specific trauma-informed care (Rajaram & Tidball, 2018), the present study seeks to better understand the needs of human trafficking survivors in Kentucky through the lens of trauma-informed care.

Literature Review

Needs and Nuances of Human Trafficking Survivors

In a 2023 national survivor study, 75% of human trafficking survivors identified trauma-informed services as a primary need (Polaris Project, 2023, p. 31). Many survivors of human trafficking were victims of other forms of abuse or exploitation before entering a trafficking situation and have experienced long-term trauma exposure. In Polaris's adapted version of the Adverse Childhood Experiences (ACEs) questionnaire, customized to address experiences related to human trafficking, 96% of survivors experienced physical, sexual, or emotional abuse as children, 93% lived with someone who experienced substance abuse or other mental health challenges, 93% experienced substance abuse and mental health challenges themselves, 83% experienced poverty, and 69% ran away from home as children (Polaris Project, 2023, p. 25).

Trafficking survivors may also need education around what constitutes human trafficking. A 2018 survivor study identified lack of awareness and misinformation as a primary component that allows sex trafficking to thrive, to the point that many victims do not recognize

that they are being trafficked (Rajaram & Tidball, 2018). Despite the pervasive misconception that traffickers often violently capture their victims, trafficking victims are more likely to be groomed, manipulated, and exploited by a trafficker with whom they have a close relationship (Polaris Project, 2025; Rajaram & Tidball, 2018). For example, between January 2020 and August 2022, 44% of sex trafficking survivors who identified their trafficker were trafficked by a member of their own families, and 39% were trafficked by an intimate or romantic partner (Polaris Project, 2023). Data specific to Kentucky further details the reality of familial sex trafficking of minors. Of the 31 traffickers discussed in these cases, 20 were the victim's mother, ten were the father, and one was another family member. In nearly two-thirds of the cases, victims had ongoing contact with the trafficker after identification of the trafficking. In every case, the parent lived with the child-victim during the period of exploitation (Sprang & Cole, 2018). Due to traffickers' exploitation of trust and other manipulation tactics, survivors often have difficulty trusting their own decisions or establishing trusting relationships with service providers who seek to help them. Social power imbalances related to gender, age, economic stability, and access to support systems are entrapment factors traffickers use to recruit victims and maintain control (Preble, 2021). As a result, perceived power imbalances with service providers may cause resistance or even re-traumatization of survivors.

Economic instability is a significant predictor of re-entry into trafficking, so survivors may also need support to obtain the knowledge, skills, and resources to become independently financially stable (Rajaram & Tidball, 2018). Respondents to Polaris Project's 2023 survivor study identified safe and stable housing (70%), stable living-wage employment (69%), and education and job training (60%) as key areas of need (p. 31). Survivors of human trafficking may also require support for neurological or cognitive issues resulting from complex trauma

exposure or drug use. Many sex trafficking victims are exposed to illicit drugs by their trafficker to further control them; the resulting chemical dependency can further compound the stigma that survivors must navigate, often preventing them from seeking help (Rajaram & Tidball, 2018).

Trauma-Informed Care for Human Trafficking Survivors

Trauma-informed approaches in healthcare and social services often adhere to the Substance Abuse and Mental Health Services Administration's (SAMHSA) six principles of a trauma-informed approach, including 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5), empowerment, and 6) cultural, historical, and gender issues (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). SAMHSA's guidance (2023), as well as other trauma-informed guidance (e.g., National Child Traumatic Stress Network's System Framework, 2017), describe how implementation of trauma-informed care requires organizational change and training for all staff members.

The U.S. Department of Health and Human Services (HHS) recommends that providers who work with human trafficking survivors offer a comprehensive, trauma-informed approach in which the relationship between trafficking survivor and service provider is collaborative (Clawson et al., 2008). Because of survivors' experiences with violence and victimization, their participation, empowerment, and ownership in their healthcare and recovery processes are crucial to preventing re-traumatization and promoting healing (Erickson, 2019). Due to the fraud and coercion often involved in trafficking, survivors require an early and extensive focus on the SAMHSA principle of establishing safety and trustworthiness (Hemmings et al., 2016).

HHS is responsible for helping human trafficking survivors receive benefits and services, in accordance with the Trafficking Victims Protection Act of 2000 (TVPA). As part of HHS's commitment to the Federal Strategic Action Plan (SAP) on Services for Victims of Human

Trafficking (Powell et al., 2017), HHS published recommended procedures specifically for trafficking survivors to increase awareness and support training. Although it was not enacted, the Trafficking Awareness Training for Health Care Act of 2015 also promoted training for providers in clinical settings and educational programs. Healthcare professionals are uniquely positioned to screen and identify victims of trafficking in a safe environment, potentially while they are separated from their trafficker, as traffickers may allow victims to access emergency healthcare if victims are unable to work due to a health issue. In a study involving survivors of sex trafficking, nearly 88% of survivor-respondents reported that they had accessed healthcare services during their trafficking experience; over 63% received emergency room services (Lederer & Wetzel, 2014). Despite trafficking-specific legislation (e.g., Trafficking Victims Protection Reauthorization Act of 2013, Justice for Victims of Trafficking Act, Preventing Sex Trafficking and Strengthening Families Act), research expresses the need to standardize content and provide guidance for implementation (Powell et al., 2017). Research is also needed to evaluate the effectiveness of training programs and screening tools used to identify trafficking survivors in healthcare settings (Hemmings et al., 2016).

There is some consensus among providers regarding the need for trauma-informed and culturally appropriate support for survivors from identification through long-term recovery (Hemmings et al., 2016). Among trafficking-specific clinics, providers report higher rates of value on trauma-informed approaches that are patient-centered, team-oriented, comprehensive, and interdisciplinary (Recknor et al., 2020). Since the American Academy of Family Physicians and the American College of Emergency Physicians both established resolutions for human trafficking awareness in 2015, efforts have increased to educate providers on the identification of trafficking survivors and appropriate interventions (Powell et al., 2017). For example, Health,

Education, Advocacy, and Linkage (HEAL) Trafficking is a multi-disciplinary community of 4,000 professionals from 45 countries providing training and protocol development for health professionals that work with trafficking survivors. Following its 2019 implementation in Alameda County's Human Exploitation and Trafficking (HEAT) Institute, more trafficking patients were identified and offered support (HEAL Trafficking, 2023). Trafficking, Healthcare, Resources, and Interdisciplinary Victim Services and Education (THRIVE) Clinic in Miami, Florida, and the Greater Houston Area Pathways for Advocacy-based, Trauma-informed Healthcare (PATH) Collaborative in Houston, Texas are citywide models that involve partnerships between healthcare providers and community services providers, including homeless shelters, substance abuse recovery centers, the U.S. Department of Homeland Security, law enforcement, legal services, and universities. Both models provide survivors with access to peer mentorship and a team of medical, legal, and social service providers who are trained in trauma-informed care (Jain et al., 2022). These citywide models offer a promising start for developing and evaluating trauma-informed models for trafficking survivors. For example, PATH Collaborative received 560 referrals for suspected trafficking from October 2017 through September 2021 with 400 of those patients screening positively for trafficking, and THRIVE clinic served 214 confirmed trafficking survivors from June 2015 through September 2021 (Jain et al., 2022). A study of the THRIVE clinic's model credited its success to its patient-centered, trauma-informed approach; THRIVE patients received an average of three primary care visits and three specialty visits during their involvement with the clinic, and 100% of patients reported being satisfied with the medical care they received (George et al., 2018).

In her guidance for implementing the trauma-informed Sanctuary Model with sex trafficking survivors in long-term residential treatment, Bloom (2013) suggests that programs

should last at least eighteen months and include a care team with wrap-around services. The chronic abuse and manipulation many survivors experience often causes the victim to develop an affective bond toward their trafficker. This bond contributes to high rates of recidivism; one program serving adolescent survivors reported a 50% recidivism rate (Twill et al., 2010).

The HHS Guiding Principles for Agencies Serving Survivors of Human Trafficking (2018) were established by The Southeast Regional Human Trafficking Advisory Group for the Administration for Children and Families Region 4 Office. The Guiding Principles clarify beliefs and values for providers who serve survivors of human trafficking so that survivors are supported in their recovery and are not further harmed or re-traumatized by service providers (Department of Health and Human Services, 2018). However, evidence-based standards of care have not yet been established for organizations that serve human trafficking survivors. Some of the subject matter experts who contributed to the Guiding Principles are part of a Freedom Network USA workgroup drafting National Standards of Care for Anti-Trafficking Service Providers, expected to be published in 2025 (Freedom Network USA, 2024, December 27).

This study builds upon existing research of trauma-informed approaches in social services and healthcare by identifying and contextualizing the trauma-informed models and strategies currently employed in Kentucky agencies that serve trafficking survivors.

Theoretical Framework

This study is guided by Bronfenbrenner's ecological systems theory (1977), which outlines five interconnected systems that shape an individual's development: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem includes close relationships and settings such as family and friends. The mesosystem comprises the interactions between these microsystems. The exosystem includes broad influences like policies or media

that indirectly impact individuals. The macrosystem involves overarching cultural values and societal structures, while the chronosystem captures the dimension of time, like life transitions and historical context. Ecological systems theory has been applied in education and healthcare research due to its attention to context and development. Eriksson et al. (2018) emphasize the theory's utility in analyzing public health inequities and supporting systemic interventions.

Current Study

This study aims to contribute to the development of integrated trauma-informed guidance that addresses the needs of human trafficking survivors by exploring the stories of direct service providers who support trafficking survivors in trauma-informed trafficking-specific organizations in Kentucky. The research questions driving this study are: 1) What trauma-informed models and/or strategies are currently employed in agencies that serve trafficking survivors in Kentucky? 2) Which specific components of these models and/or strategies have proven successful with trafficking survivors? 3) What are the greatest barriers to success, as identified by the service providers and program leaders who support trafficking survivors? Addressing these three research questions is the first step toward understanding which models and strategies could be most effective in supporting the development of trafficking survivors.

Methods

Researchers employed a qualitative, narrative inquiry approach to authentically capture the lived experiences of service providers who support trafficking survivors' development. Connelly and Clandinin (1990) first used narrative inquiry as a methodology to illustrate the lived experiences of teachers through their stories. Narrative inquiry includes field texts collected from one or more individuals representing their stories of lived experience (Clandinin & Connelly, 2000; Creswell & Poth, 2018). Artifacts, interviews, and documents are recommended

field texts for narrative inquiry because they capture stories through an interpretive process and are created through collaboration of the participant and researcher (Clandinin & Connelly, 2000, p. 92). Using artifacts, interviews, questionnaires, and a focus group in this study, narrative inquiry allowed the participants in this study to metaphorically paint their own picture, establishing an understanding of the trauma-informed strategies and models available to human trafficking survivors.

Setting

Participants represented seven different organizations in Kentucky that serve survivors of human trafficking as their primary population and have programs for learning and development. Of the seven organizations represented in this study, five are located in urban areas and two are in rural parts of Kentucky. Four of these organizations are specifically affiliated with a faith practice, and three identify as secular. All seven organizations identify as trauma-informed on their websites or in program materials.

Participants

After Institutional Review Board (IRB) approval from the host institution, participants were recruited through convenience sampling based on relationships I have established through participation and leadership in the Kentucky Statewide Human Trafficking Task Force. The task force is a collaboration of over one hundred multidisciplinary organizations with a shared interest in preventing, addressing, and reducing human trafficking in Kentucky (Kentucky Statewide Human Trafficking Task Force, 2024). Participation in this study was limited to direct service providers from Kentucky organizations and programs that serve human trafficking survivors. At least 30% of participants' work responsibilities must have been in support of survivors' learning and development, which include high school equivalency programs, life

skills development, recovery, and job skills training. Survivor-leaders with personal trafficking experience were invited to participate only in their capacity as a program leader. Twenty-five potential participants were contacted via email, and ultimately, seven service providers participated; potential participants who declined cited staffing shortages within their organization, program transformation efforts, or other limitations related to workload capacity. Participants' age range, gender, race/ethnicity, education, and fluent language(s) are provided in the supplemental online material. Participants were not compensated and could withdraw from the study at any time. Pseudonyms (Lonnie, Sherry, Mary, Jane, Peggy, Bell, and Hannah) were used in data collection and analysis to maintain confidentiality.

Data Collection

Data collection took place through eight virtual meetings between October and December 2024. Participants were given a statement of my positionality and purpose for the research, and they provided written or verbal consent prior to data collection. First round data were collected through participants' artifacts, semi-structured interviews, and a guided questionnaire. The virtual interviews and focus group lasted approximately one hour each and were recorded and transcribed on Microsoft Teams. The interview protocol is included in the supplemental online material. Participants were invited to ask questions or stop data collection at any time; they received access to TELUS Lifeworks wellbeing resources following their individual interviews.

Interviews began with participants each presenting an artifact that represented their experience working with trafficking survivors. The second part of the interviews involved open-ended questions related to participants' experience with trauma-informed strategies in their work with trafficking survivors, including successes and barriers they experienced. Participants were then guided through a questionnaire that listed trauma-informed strategies and were asked to

identify any used in their current practice. If participants had experience with a given strategy, they were also asked to indicate the strategy's value using a four-point scale where *one* was least valuable and *four* was very valuable. Similarly, the questionnaire listed six trauma-informed models. If participants had experience with a given model, they were asked to indicate the model's value using the four-point scale. The questionnaire was developed based on the relevant literature, and responses are included in the supplemental online material. The guided nature of the questionnaire allowed for discussion, and participants expressed favorable feedback with the format. Following the first round of data collection, participants were invited to join a focus group to connect with other participants and expound on shared experiences, as identified in the interviews. Data collected in the focus group related to participants' common experiences and collaborative construction of meaning; these topics are included in the supplemental material.

Data Analysis

Data analysis was completed in phases: memos, in-vivo coding, and thematic analysis. The field texts generated through Microsoft Teams transcripts include artifact descriptions, interviews, focus group, and questionnaire responses. First, I reviewed the transcripts while listening to the respective recordings to ensure transcript accuracy while pausing to add memos in the margins to record significant events, such as changes in a participant's tone, long pauses, or personal biases that I recognized. Coding and memo writing are concurrent, reciprocal processes that challenge the researcher's biases and assumptions and support a deeper understanding of the phenomenon being studied (Saldaña, 2021). I also used memos to identify data that could be used for thick description. In the second phase, I coded the field texts using in-vivo codes, which were taken directly from participants' transcripts, rooting the data in participants' word choices (Saldaña, 2021). First, I read through each paragraph for familiarity,

then I re-read each paragraph to identify words or phrases that represented a pattern or theme. In the final phase of coding, I used thematic coding to categorize the in-vivo codes according to each theme. Categorical thematic analysis provides insight to patterns, shared meaning, and common language among participants and is a recommended coding method for participant-generated field texts (Saldaña, 2021).

Trustworthiness

Qualitative researchers can establish trustworthiness by applying Guba's (1981) constructs of credibility, transferability, dependability, and confirmability (Shenton, 2004). The construct of credibility addresses whether the research findings accurately represent the reality of the phenomenon being studied. This study used narrative inquiry and triangulated four data sources: artifacts, field texts from interviews and the focus group, and questionnaire responses. Although one researcher collected data, a committee of three additional researchers supported the research project and reviewed the data analysis. Transferability addresses whether the researcher provides enough context about the setting and participants for practitioners and researchers to determine if the study is relevant to their situation. Details about the participants, setting, selection criteria, and methods for data collection and analysis are described in this methods section. To promote dependability, data collection and analysis processes must be thoroughly documented so that a future researcher could replicate the study. Field texts were generated using Microsoft Teams video recording and transcriptions of participants' artifact descriptions, interviews, questionnaire responses, and focus group discussion. Lastly, confirmability addresses the researcher's concern for objectivity. The researcher engaged in reflexivity practices throughout the study, and participants reviewed their transcripts as a form of member checking (Creswell & Poth, 2018).

Findings

The themes identified include (1) education and training, (2) responding to needs, (3) safety and transparency, (4) trusting relationships, and (5) standards of care.

Education and Training

Education and training emerged as vital elements of participants' work in trauma-informed care. All participants either received or delivered training in trauma-informed approaches. Certifications and educational backgrounds varied, such as addiction recovery and targeted case management, reflecting the diverse expertise required to serve this population.

Participants emphasized staying within professional boundaries to avoid harm, as Sherry noted:

It's hard to have to say that we cannot provide that support, but we also have to be smart and do what it is that we do. Recognize when we can't go further. That has been an issue in the anti-trafficking field...because there weren't a lot of service providers, so people were doing things outside of the scope of their work, which can be harmful, and I don't want to be harmful. I don't do mental health services. It's not appropriate for me to do mental health services because I can end up doing more harm than good.

Several participants deliver training to other providers and communities, focusing on prevention, realities of trafficking, and survivor support. For example, Sherry trains youth, families, and professionals, with a focus on protective factors (e.g., understanding healthy relationships) and dispelling myths (e.g., trafficking always involves transporting victims across borders) (Polaris, 2025). She noted the importance of broadening the community's understanding of the vulnerabilities that intersect with trafficking: "We're not saying go fix homelessness tomorrow... But what can you look at in your specific community, your specific neighborhood, that are gaps that you can build protective factors for people?" Moreover, Hannah described the

role of cultural competence, especially when working with immigrant communities. She trains law enforcement to recognize trafficking when survivors are mischaracterized as runaways, saying, “That’s another huge barrier – the lack of cultural competency. Within not just the local police department, but the courts and even other nonprofit and governmental organizations.”

Furthermore, participants identified a widespread need for training among service providers and public agencies likely to encounter survivors. Referring organizations often panic upon hearing the word “trafficking,” leading to rushed, uninformed responses. As Peggy described, “We would be the ones acting like the 911 operator so many times.” Participants advocated for education to correct public misconceptions fueled by media and social stereotypes. Peggy explained, “That impacts victims every day. The reality is it impacts the identification of trafficking. When we think trafficking is only sex trafficking and not also labor, then we have lots of people who experience labor trafficking that don't identify and refer to services.”

Responding to Needs

Participants repeatedly highlighted the need to provide basic resources such as food, shelter, clothing, legal support, and healthcare because these are often deliberately withheld by traffickers to maintain control. Peggy discussed survivor-led prioritization of needs: “based on what they're telling us and what seems to be the priority for their overall health and well-being, we work on addressing those things first. And then it's after that that we'll sit down and do case planning with them once they're immediately safe and their immediate basic needs are met.”

Bell connected these dynamics to Maslow’s hierarchy, explaining how traffickers often manipulate basic needs to ensure dependence: “They're getting their basic needs - what we call basic in Maslow's hierarchy. So, we also consider that human trafficking.” Hannah described the importance of proactive service: “If they’re hungry, we invite them for rice and beans. If they're

needing clothes, if they're needing something in that moment, or if we even notice, without them telling us, we offer it to them.” Moreover, all participants cited the shortage of housing, addiction treatment, mental health support, and basic services as major barriers. Survivors who lack identification or have criminal records struggle even more to access services. Sherry named housing as the top obstacle: “Stable housing. Stable housing. Stable housing...If you don’t have stable housing, then it’s hard to get stability other places.” Participants noted that funding constraints limit the number of survivors programs can support, especially as costs rise, and competitive funding environments can discourage collaboration among service providers.

Safety and Transparency

Another key theme was the need for safety and transparency. Agencies ensured physical safety through secure locations and psychological safety through welcoming environments and transparency. Lonnie described using comfortable, home-like spaces to level power dynamics: “We have couches, and we’ll do our meetings in the living room, on couches where we’re all kind of on the same level. Having coffee pots and tea pots available. Just really trying to make a welcoming, warm space where they feel free to communicate.” Transparency in procedures and screening tools supports emotional safety. For example, Peggy reflected on the importance of individualized accessibility, including language, literacy, and disability considerations. When screening survivors, Sherry explained: “We also let them know the purpose. Here's why we're asking these questions.” Participants agreed that re-screening or repeating questions about survivors’ traumatic experiences can be harmful and should be avoided. Barriers to safety, such as access limitations, lack of autonomy, and stigmatization, were all cited as threats to survivors’ physical and psychological safety. Participants detailed the importance of creating choice, dignity, and transparency in all interactions. As Peggy noted, even well-intentioned providers

can do harm without the proper training and oversight: “people can offer services in any kind of way, and there's not oversight into how the services are provided or requirements around those.”

Trusting Relationships

Building strong, consistent relationships was cited as one of the most effective trauma-informed strategies, reflecting the SAMHSA (2023) principle of collaboration and mutuality. Mary said, “Consistency and trust is what success looks like.” Peggy described maintaining long-term connections with survivors: “You are building a healthy, trusting relationship and you are also doing the work that you're supposed to be doing with them.” Jane emphasized the power of mentorship to challenge generational trauma and teach new relational patterns. “People have been hurt. They have trauma sustained from relationships, and they don't trust. They don't attach. So, what do we do? We help them attach,” she said. Survivors often came to realize, “I thought that's just what the women in my family did.”

Moreover, participants underscored the benefits of letting survivors drive their own recovery. The SAMHSA (2023) principle of empowerment was universally rated as highly valuable. Sherry summarized this clearly: “The choice. Always the choice.” Peggy shared that success often came from asking: “What are your goals? What is it that you'd like to see happen for you, and how can we support you in doing that?” Hannah described empowering adult survivors to report crimes or show up to court as major milestones.

Treating survivors with dignity, respect, and flexibility was also indicated. Bell said, “Trauma survivors are the expert on their trauma.” Mary added: “We laugh. We cry. We have moms. We have dads. We have children. We have siblings. We have family. Where they're at in our life, they're still in our heart, and that's what matters most.” Participants made deliberate efforts to present themselves as non-threatening and approachable. Bell chose simple attire when

working in correctional facilities to avoid appearing inaccessible: “I didn't wear any makeup. I put my hair in a ponytail. I wore very, very basic clothes because I wasn't going to come in with anything that they didn't have access to...I wasn't going to come in with fingernail polish if they didn't have access to that, or my hair curled. I wanted to be as approachable as possible.”

Providers refrained from projecting their expectations or taking credit for survivors' progress. As Sherry explained, “We have to take ourselves out of it.”

Standards of Care

Participants stressed the need for statewide or national standards, and Sherry, Peggy, and Mary advocated for regulation to ensure agencies use evidence-based practices. Peggy said, “For example, in Kentucky, there's nothing in state law that requires services be done at a certain level like we see in other legislative spaces. Even in Kentucky, there are lots of things that are required for other sorts of criminalization and victimization. But we don't see that for trafficking, right?” Sherry also highlighted the need for standards of care in prevention efforts: “I also would like to see something done in legislation in regards to stronger efforts for prevention.”

Peggy further described how legislation could offer protections for victims of trafficking, including ethical considerations like discrimination, privacy, and accessibility:

In thinking about a trauma informed approach to this work, what would really be helpful to see more clearly in legislative spaces is additional protections for victims - various protections across the board. Protections about privacy and confidentiality. Protections around not having to participate in law enforcement actions or law enforcement anything to access the broad range of services they need. I think various legislative elements could better address those. More clarity around requirements for language access and culturally appropriate services. I don't think that can be in enough places honestly, because yes, it's

in federal civil rights law, but that's not sufficient because that's not doing it. So that that needs to be clearly addressed in state laws and in any other additional guidance that's provided at the local level or state level.

Questionnaire Findings and Artifacts

All 17 trauma-informed strategies presented in the questionnaire were used in the participants' agencies. Strategies such as building relationships, building trust, inclusion and belonging, and giving survivors a voice were universally rated as very valuable. Four of the six trauma-informed models presented in the questionnaire were used in participants' agencies. Among trauma-informed models, SAMHSA's six principles emerged as the most used and most highly valued. Other models employed include the Triune Care Model, Attachment, Regulation and Competency (ARC), and Support for Students Exposed to Trauma (SSET). Participants added two models that had been useful in their experiences: Trust-Based Relational Intervention (Jane) and HHS Guiding Principles (Sherry and Peggy). Notably, no participants reported experience with the National Child Traumatic Stress Network (NCTSN) Framework or the Sanctuary Model. Finally, a summary of artifact presentations and the questionnaire responses for the models and strategies are included in the supplemental online material.

Discussion

Education and training were widely cited by participants as foundational to implementing trauma-informed care. According to HHS (2018), service providers working with trafficking survivors require specific training comparable to that of criminal justice professionals. The National Child Traumatic Stress Network's System Framework (2017) and SAMHSA (2023) also highlight training in trauma-informed care as essential for all stakeholders. Participants in this study understood the benefits of education in trauma-informed care by undergoing training

in six trauma-informed models and using 17 various strategies. They also held certifications ranging from social work degrees to targeted case management and addiction peer support. Participants also viewed training as a safeguard against re-traumatization. Previous studies confirm that system-wide training correlates with reduced recidivism and improved service quality (Erickson et al., 2019). Participants indicated that organization-wide training promoted consistency, aligning with SAMHSA's (2023) principle of transparency and trustworthiness. The trauma-informed training topics aligned with HHS guidance: cultural competency, risk factor awareness, effective screening, and recovery pathways (Clawson, 2008).

Traffickers often maintain control over victims by exploiting unmet basic needs (Preble, 2021). Addressing needs like food, clothing, and shelter aligns with Maslow's hierarchy (1943), which suggests that physiological needs must be met before psychological growth can occur. HHS (2018) echoes this by urging providers to span both immediate and long-term support. Participants agreed that no single agency can meet all survivor needs, emphasizing the need for collaboration among providers. Clinics like THRIVE (Miami) and PATH (Houston) exemplify such multi-sectoral collaboration (Jain et al., 2022). The Sanctuary Model and NCTSN's tiered support model also recommend wraparound services, including case management, legal aid, addiction recovery, and cultural/linguistic accommodations.

Safety was also a recurring theme that is supported by SAMHSA (2023), the Sanctuary Model (Bloom, 2013), and HHS (2018), which all describe how physical and emotional safety are core principles, as well as how organizational commitment to survivor confidentiality, informed consent, accessibility, and nonviolence fosters safety. Survivors often arrive with deep mistrust, especially if abuse began in childhood (Hemmings et al., 2016). Participants reinforced the need to establish safety, citing the importance of trauma-informed screening, clear

information-sharing protocols, and maintaining survivor autonomy. Participants described how their practices with SAMHSA's principle of empowerment and trustworthiness, ensuring survivors were not retraumatized by assessments or interventions. Beyond receiving training, participants also conducted anti-trafficking education for youth, community groups, law enforcement, and service providers. Participants' preventative programs addressed grooming tactics, healthy relationships, and risk factor recognition, and community training programs, like those offered by HHS (Erickson, 2019), were viewed as opportunities to strengthen interagency support, share resources, and dismantle harmful stereotypes.

Relationship-building was rated as highly valuable. SAMHSA (2023) and TBRI (Purvis et al., 2013) prioritize attachment, mutual respect, and safe connection. Participants emphasized the need for consistency and availability, even when survivors stopped contact for extended periods. Many survivors returned later, seeking support from someone who had remained constant and judgment-free. The impact of relational strategies was also evident in peer mentorship and group-based support. Given how many traffickers are family members or romantic partners (Polaris Project, 2023), participants reported that building trusting relationships was essential. Participants also discussed the value of cultural competence, particularly when working with immigrant communities (NCTSN, 2017; SAMHSA, 2023).

Empowerment, choice, and collaboration emerged as vital to participants' efforts to employ trauma-informed strategies, and participants emphasized the need to reverse the powerlessness that survivors experienced during trafficking. However, HHS (2018) and SAMHSA (2023) caution against rescuer mentalities and encourage mutuality. Participants empowered survivors by centering their goals, from housing and legal support to education and sobriety. They viewed disengagement from programs as survivor-driven, not necessarily as

failure. This survivor-led model also helped individuals reclaim decision-making skills often suppressed by trauma (Twill et al., 2010). Participants warned against imposing timelines or pushing survivors beyond readiness. Rather, they championed dignity, autonomy, and cultural responsiveness (Hemmings et al., 2016; HHS, 2018; Rajaram & Tidball, 2018). Participants reported that honoring survivors' lived experiences helped to build rapport and trust.

Finally, participants described barriers to success, including a lack of public awareness, misperceptions, and provider panic. These responses mirrored concerns voiced by Rajaram and Tidball (2018) and Powell et al. (2017). Training for police, case workers, and healthcare professionals was seen as essential to accurate identification and appropriate intervention. HEAL Trafficking (2023) is one example of a model that improves survivor identification and intervention. Participants also cited gaps in housing, mental health, addiction recovery, legal aid, and language services. Polaris Project (2023) found that 70% of survivors identified housing as a critical need. These gaps were exacerbated by limited funding, grant competition, and rising costs. Participants noted that the absence of trained professionals with expertise in trauma and trauma-informed care created barriers to effective services. Finally, Hemmings et al. (2016), George et al. (2018), and Recknor et al. (2020) all advocate for coordinated, trauma-informed, and multi-disciplinary care. Participants in this study agreed, describing how collaborative partnerships were necessary to fill service gaps.

Implications for Legislation

Kentucky has no requirements for implementing trauma-informed care for trafficking-specific programs in existing regulations. Participants viewed this lack of standards as a serious risk to survivor safety (Clawson, 2008; Rajaram & Tidball, 2018). While the HHS Guiding Principles (2018) provide a foundational understanding of the benefits of trauma-informed care,

implementation remains optional. Participants advocated for legislative reform to mandate evidence-based, non-discriminatory trauma-informed practices. They supported regulation of confidentiality, survivor autonomy, cultural responsiveness, and informed consent.

In ecological systems theory, government policy and legislation exist within the third layer, the exosystem. Participants and the human trafficking survivors whom they serve are significantly impacted by exosystemic societal structures like trafficking-specific policies and macrosystemic cultural influences like public perceptions and misperceptions of human trafficking. Participants suggested that state legislation is needed to ensure evidence-based practices and standards of care in trafficking-specific organizations. Participants expressed that the lack of such legislation has resulted in further harm and re-traumatization for survivors of human trafficking. Participants also recommended that anti-trafficking legislation and policies include protections for trafficking survivors including nondiscrimination, accessibility, confidentiality, and transparency regarding organizations' requirements for services.

In addition to legislation that establishes and implements evidence-based standards of care, participants also identified the need to legislate preventative efforts. Exosystemic societal structures like law enforcement and child welfare agencies can implement trauma-informed trafficking-specific training for officials who will likely interact with survivors or influence policy that addresses human trafficking. The NCTSN (2017) recommends trauma-informed training for policymakers and other individuals who might influence legislation or policies supporting trauma-informed practice. Participants' discussion of barriers related to shortage of resources suggests that legislation might also provide funding for human trafficking awareness campaigns to combat public misperception and stigma.

Limitations and Recommendations for Future Research

Notable limitations of this study are the diversity of participants and the small sample size. All seven participants identified as women, and six participants identified as White. Women of color, immigrants, and gender-diverse folks are disproportionately impacted by human trafficking (Polaris Project, 2023); cultural competence may be limited when the demographic of providers is not comparable to the demographic of the population being served.

By identifying the trauma-informed models and strategies that are currently employed in agencies that serve trafficking survivors in Kentucky, this study provided context for future researchers to evaluate the impact of these models and strategies with trafficked populations. Future research could also explore the experiences of direct service providers across the U.S. with a larger and more diverse sample population.

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Supplemental Online Material

Table 1

Participant Demographics

Pseudonym	Age Range	Gender	Ethnicity	Education or Credentials	Language(s)
<i>Lonnie</i>	18-24	Woman	White/ Caucasian	Bachelor's degree, Biblical Christian Counseling	English
<i>Sherry</i>	45-54	Woman	White/ Caucasian	Bachelor's degree, Sociology	English, Spanish
<i>Mary</i>	45-54	Woman	White/ Caucasian	Some college, Ordination of Ministry	English, Spanish
<i>Jane</i>	25-34	Woman	White/ Caucasian	Bachelor's degree, Social Work	English
<i>Peggy</i>	45-54	Woman	White/ Caucasian	Master's degree, Social Work	English, Spanish
<i>Bell</i>	45-54	Woman	White/ Caucasian	Master's degree, Licensed Clinical Social Worker	English
<i>Hannah</i>	25-34	Woman	Hispanic or Latinx	Master's degree, Social Work	English, Spanish

Table 2

Summary of Artifact Presentations

Pseudonym	Artifact	Transcription
<i>Lonnie</i>	Clear, iridescent coffee mug that was gifted by a survivor-resident	Getting to learn and grow with her and developing a relationship, developing a friendship even, and then coming to the point where now, two years later, we're able to sit down and just have tea together and enjoy that time.

<i>Sherry</i>	Her work cell phone, an iPhone in a black case	I'm always cognizant of it. It's how I sometimes am putting out multiple fires. It's the way in which I tell everyone to reach me. Don't call my office phone. Call my cell phone. This is the best way.
<i>Mary</i>	Clear, glass award with engraving	I got a call from the FBI and said, "Hey, Mary, we just want you to know that we see you." And I'm like, "What do you mean?" But they said to me, "We see the work that you're doing. You're making a difference."
<i>Jane</i>	Brown disposable coffee cup from a local coffee shop	We've seen that healthy relationships can heal what has been broken in toxic relationships. So, my artifact is a coffee cup that is still a little bit warm from spending time with a youth in our program.
<i>Peggy</i>	Colorful stack of seven books	Books helped me to sort through the different circumstances I was finding myself in and various strategies to address them. I think it also helped me to learn about people's experiences with trauma from different perspectives.
<i>Bell</i>	Piece of writing that Bell wrote and printed on copy paper	It comes from different bits and pieces of things that people have told me that I've done right or wrong, or they wish someone had done. And since I supervise people and get them ready to do that type of work I just wrote, even though I'm not a survivor, just those bits and pieces that I thought would be some things that they can learn and internalize.
<i>Hannah</i>	Magnolia flower and monarch butterfly (description only, no item)	It does represent that hope and transformation of coming from something so horrible. Just to see my community with the lack of resources, continue to move forward like a butterfly, or continue to blossom like that magnolia flower.

Table 3

Questionnaire Responses: Trauma-Informed Strategies and Techniques

Strategy	Number of Responses	Minimum	Average	Maximum
Building Relationships	7	4	4	4
Building trust	7	4	4	4

Inclusion & Belonging	7	4	4	4
Giving survivors a voice	7	4	4	4
Ensuring Environmental/Physical Safety	7	3	3.86	4
Involving survivors in decision making	7	3	3.86	4
Recognizing the signs of trauma	7	3	3.71	4
Growth Mindset	7	3	3.71	4
Collaboration	7	2	3.57	4
Teaching emotional regulation	7	3	3.57	4
Self-care for compassion fatigue	7	0	3.43	4
Cultural awareness and consideration	7	2	3.43	4
Expecting unexpected responses	7	1	3.43	4
Teaching coping skills	7	2	3.43	4
Promoting predictability & consistency	7	2	3.29	4
Peer Support	7	2	3.14	4
Mentorship	7	0	3.14	4

Note. Strategies were rated from least valuable (1) to very valuable (4). A rating of zero (0)

indicates that the participant has no experience with this strategy.

Table 4

Questionnaire Responses: Trauma-Informed Models

Model	Number of Responses	Minimum	Average	Maximum
Substance Abuse and Mental Health Services Administration's (SAMHSA) Six Principles	7	0	3.29	4

The Institute for Survivor Care's Triune Care Model	7	0	1.71	4
Attachment, Regulation, Competency	7	0	1.14	4
Support for Students Exposed to Trauma	7	0	1.14	4
National Child Traumatic Stress Network (NCTSN)	7	0	0	0
The Sanctuary Model	7	0	0	0

Note. Models were rated from least valuable (1) to very valuable (4). A rating of zero (0)

indicates that the participant has no experience with this model.

Table 5

Trauma-Informed Strategies and Models Added by Participants

Strategy or Model	Number of Responses	Rating
Strategy: Reality Therapy	1	4
Model: Trust-Based Relational Intervention (TBRI)	1	4
Model: HHS Guiding Principles	2	4

Note. Strategies and models are rated from least valuable (1) to very valuable (4). The ratings of strategies and models added by participants are not comparable to items included in the questionnaire because other participants did not have an opportunity to rate their experience with these strategies and models.

Interview Protocol

1. Please begin by introducing yourself and describing your pathway to your current role.
2. You were asked to bring an artifact that represents your experience working with survivors. Take a moment to talk about the artifact and how it relates to your experiences.
3. What trauma-informed strategies or models are regularly used in your experience or in your organization? Probe: Is there a specific model required by your organization?
4. In terms of supporting trafficking survivors, what does “success” look like? Probe: Could you share a story that gives an example of success?
5. Which strategies have been most successful in supporting survivors, in your experience? Probe: Tell me about a time you used this strategy.
6. What barriers to success have you experienced? Probes: I’ve had some program leaders describe neurological damage as a significant barrier. Have survivors’ neurological problems been a significant barrier in your experience? Could you tell me about a time you’ve experienced this barrier and any strategies or techniques you used to overcome it? How common (percentage of cases) is this barrier?
7. During this portion of the interview, I will guide you through a questionnaire that identifies common trauma-informed strategies or techniques. You will be asked whether you have used these strategies and how successful they have been in your experience; you will also be invited to add to the list. When the data analysis for this study is complete, I will share the final list with you as a resource.
8. The last part of the questionnaire requests demographic information so that I can accurately represent participant demographics in my report. Are you comfortable providing this information?
9. As we come to the end of our time together is there anything else you would like to share with me that we did not discuss that you think is important for me to know?

Focus Group Topics

1. I requested participants’ responses to a brief overview of preliminary, common themes from my initial analysis of interview transcripts (Round 1 of data analysis), including:
 - a. Trauma-informed strategies of establishing trust, building relationships, creating a safe environment, offering choice, and involving survivors in decision-making.
 - b. Barriers due to lack of resources, including housing and basic needs, legislation and regulation, evidence-based practice and standards of care, funding, education and training for providers, law enforcement, and community partners.
2. Based on barriers identified in Topic 1, I asked participants what legislative changes are needed to support their work.
3. Based on strategies and barriers identified in Topic 1, I asked participants to expand on the meaning of standards of care and levels of services.
4. Based on barriers identified in Topic 1, I asked participants to expand on their experience with funding, grants, and the metrics required by grant funding.

5. Based on strategies and barriers identified in Topic 1, I asked participants which community partnerships have been most valuable in their experience and what community resources are needed.
6. Based on strategies and barriers identified in Topic 1, I asked participants how organizations could better collaborate with other providers, share best practices, and reduce siloes.
7. I confirmed that the organizations represented are voluntary programs.
8. I opened the discussion to any topics that the participants wanted to raise to the group. Participants discussed the need to track which resources are available because resource guides, capacity, and contacts change frequently.