Services to Trafficking Survivors in Illinois
Targeted Communities
Outcomes Study

HEARTLAND ALLIANCE
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Report Information & Acknowledgments

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Executive Summary

This report documents the implementation and participant outcomes of a partnership project intended to increase identification of and service provision to survivors of human trafficking by providing training and technical assistance to organizations in high-need areas in Illinois. Prior to the development of this partnership, anti-trafficking resources in Illinois had been concentrated in Chicago and the surrounding area. Other areas of the state, namely Peoria and Kankakee, had low levels of anti-trafficking resources and victim identification, despite high vulnerability factors for trafficking.

Freedom From Trafficking (FFT), a program of Heartland Human Care Services (HHCS), partnered with The Center for Prevention of Abuse (The Center) in Peoria, IL, and Kankakee County Center Against Sexual Assault (KCCASA) in Kankakee, IL, through a grant from the U.S. Department of Justice’s Office for Victims of Crime (OVC) to support the expansion of services to more intentionally and effectively identify and serve survivors of trafficking. This report will present findings from the analysis of program service provision data and assessment data to determine the extent to which services may have supported positive participant outcomes.

Partnership Implementation

- **Partner trainings** – Between October 2016 and September 2020, FFT facilitated 10 trainings with The Center and KCCASA to support the expansion of their programming to identify and provide specialized services for survivors of trafficking. Trainings covered a wide range of topics, including human trafficking basics, trauma-informed care, trainings for hotline staff on human trafficking screening, and intensive labor trafficking training.

- **Community outreach and education** – To increase identification of survivors, The Center and KCCASA began facilitating community education and trainings to groups in Peoria and Kankakee in early 2017. In total, 188 trainings were conducted between 2017 and 2020, reaching 5,689 people.

- **Survivor identification and support** – Through these trainings, referrals began coming in and The Center and KCCASA also began providing specialized services to survivors. A total of 63 survivors were involved in the program.
Evaluation

To assess the impact of these activities on survivors’ lives, the Social IMPACT Research Center conducted analysis on intake and follow-up assessment data and service provision data collected and tracked by service providers.

Findings – These analyses show that participants report significant changes from intake to follow up in the following areas:

- Decreased levels of psychological distress
- Decreased positive screenings for PTSD symptoms
- Increased positive feelings about stability in their living situation

Overall, we did not find a significant relationship between dosage of services and outcomes (changes in assessments). When we hone in on specific assessments and service types, however, we do see some significant relationships:

**Improvements**

- Participants who received more social service advocacy and explanation of benefits/entitlements/availability services reported larger reductions in stress levels and psychological distress from intake to follow-up.
- Participants who received more substance abuse treatment services reported lower levels of positive PTSD screenings at follow-up.

**Declines**

- Participants who received more criminal justice system-based victim advocacy services or more education services reported reductions in social support from intake to follow-up.
- Participants who received more social service advocacy and explanation of benefits/entitlements/availability services reported reductions in self-efficacy from intake to follow-up.

**Barriers** – Service provider staff shared that a lack of local resources for survivors, such as safe affordable housing, accessible legal support services, financial support, and additional human service providers in their areas, was the biggest barrier for their participants.

**Broader impact** – Leadership staff at partner agencies reflected that this partnership positively impacted their organizations’ ability to identify survivors of trafficking, to conduct education and outreach to increase identification in their communities, and to respond to crises, and to support and serve survivors of trafficking.
Background

Human trafficking persists as a serious problem in the United States and in Illinois – one that is largely under the radar, going undetected and under-reported. The US Department of State has estimated that only about 0.4% of the estimated total number of victims are identified, and that the prevalence of trafficking, globally, is about 1.8 victims per 1,000 inhabitants. The National Human Trafficking Hotline (NHTRC) reported that in 2019 alone, its national hotline received 48,326 contacts, including 30,506 calls, 8,412 texts, 2,830 emails, and 4,508 online tip reports, and 2,070 web chats, resulting in 11,500 cases of potential human trafficking. This is a 101% increase in cases identified compared with 2015, when the total number was 5,714, and a 77% increase in contacts to the hotline (27,290 in 2015). Specifically in Illinois, 844 contacts to the national hotline in 2019 resulted in 267 cases of potential human trafficking, 27% and 107% increases since 2015, respectively. The 2020 Trafficking in Persons Report issued by the Department of State (State) reports that during FY 2019, the Department of Justice initiated a total of 220 federal human trafficking prosecutions in the U.S., leading to 343 defendants charged (very similar to 2015, 208 initiated and 335 charged).

Human trafficking is defined as an act of recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting a person for compelled labor or commercial sex acts through the use of force, fraud, or coercion. Victims of trafficking are identified in a wide range of industries (e.g., hotels, restaurants, construction, agriculture, domestic work, nail/hair salons, and massage parlors). Victims’ lives and the lives of their families are threatened; they are physically, sexually, and emotionally abused; they are manipulated and misled; and they are taught to be afraid and to believe they have no rights. Youth, poverty, lack of legal status, unemployment, and a history of experiencing violence are among the factors that create a breeding ground for trafficking.

Geographic gap in response to problem

Specialized services are available to survivors of human trafficking in Chicago through a number of providers, including Freedom From Trafficking (FFT, a program of Heartland Alliance). FFT has provided comprehensive case management services to foreign-born survivors in Illinois since 2011. FFT has also trained attorneys, members of law enforcement, medical providers, and social service providers since 2011. FFT has provided training and education at conferences and through service provider networks. The program partners with legal service providers to support participants, and with the Illinois Department of Human Services (IDHS) to ensure that there is a trained liaison in each of the 80 IDHS Family Resource Centers across IL responsible for overseeing all public benefit applications for survivors of human trafficking, addressing issues, and training their case workers on human trafficking protocols. FFT is also a key member in the Illinois Statewide Task Force on Human Trafficking. Despite being a leader in statewide efforts and networks, FFT has not been able to provide services outside of Chicago prior to this partnership. Outside of the Chicago area, there were no specialized case management services for domestic survivors – adult or minor – in the state of Illinois prior to this partnership development.
Historically, anti-trafficking resources in Illinois have been concentrated in Chicago and the surrounding area. Other areas of the state, namely Peoria and Kankakee, had low levels of anti-trafficking resources and victim identification, despite high vulnerability factors for trafficking. Research consistently tells us that poverty, unemployment, and lack of income are contributing factors to human trafficking. Poverty rates are higher in both Kankakee and Peoria counties than in Illinois overall (12.2% and 14.8%, compared with 11.5% in 2019), as are child poverty rates (19.6% and 21.9%, compared with 15.7% in 2019). Unemployment is also higher (5% and 5.1%, compared with 4% in IL in 2019), and Kankakee and Peoria counties are ranked 14th and 20th out of 102 counties for worst unemployment rates in the state. Food insecurity and child food insecurity are also higher in these counties than the state average (12.2% and 14.3%, compared with 10.9%; and 16.4% and 17.7%, compared with 15.7% in 2019). Additionally, around 25% of households who rent in Peoria and Kankakee counties experience severe rent burden (paid over half of their income in rent in 2019). This is a risk factor for homelessness, which is another vulnerability factor for trafficking.

Vulnerability in these regions is high, but prior to this partnership, response and support services were basically nonexistent. The program partnership intended to provide much-needed protection and support for victims, potential victims, and survivors.

### Well-being indicators in Illinois, Kankakee, and Peoria

<table>
<thead>
<tr>
<th>Well-being Index</th>
<th>Illinois</th>
<th>Kankakee County</th>
<th>Peoria County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty Rate, 2019</td>
<td>11.5%</td>
<td>12.2%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Child Poverty Rate, 2019</td>
<td>15.7%</td>
<td>19.6%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Food Insecurity Rate, 2019</td>
<td>10.9%</td>
<td>12.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Child Food Insecurity Rate, 2019</td>
<td>15.7%</td>
<td>16.4%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Unemployment Rate, 2019</td>
<td>4.0%</td>
<td>5.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Rank by Unemployment Rate (1=worst, out of 102 counties), 2019</td>
<td></td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Percent Severely Rent-Burdened Households, 2019</td>
<td>22.5%</td>
<td>25.0%</td>
<td>26.1%</td>
</tr>
</tbody>
</table>

The communities of Kankakee and Peoria were also targeted for this partnership because there had been a high volume of calls to the National Human Trafficking Resource Center (NHTRC) hotline in the Peoria area, but no comprehensive services available for domestic victims or certain foreign national victims who may not receive U.S. Department of Health and Human Services (HHS) Certification. Kankakee had been raising awareness through the Kankakee Iroquois Human Trafficking Task Force (unfunded) and seeing an increase in identification of potential survivors, but they were not funded to work with domestic or foreign national victims who were not on a path to HHS Certification either. In these cases, victims and potential victims were referred to emergency services and subsequently left the communities because of safety reasons and lack of specialized services. HHCS collaborating with The Center for Prevention of Abuse (The Center) and the Kankakee County Center Against Sexual Assault (KCCASA) intended to fill this critical service gap by ensuring availability of trauma-informed, rights-based services for all trafficking survivors in the Peoria and Kankakee regions, and increasing identification of and support for survivors through capacity and infrastructure development.
Partnership Overview

Through this partnership, HHCS provided training and technical assistance to support the expansion of services at human service organizations in these communities. HHCS intended to ensure access to services for all survivors of human trafficking in Peoria, Tazewell, Woodford (Peoria Region), Kankakee, and Iroquois (Kankakee region) counties through two qualified and well-positioned subcontracted partner agencies: The Center and KCCASA. This partnership maximized the domestic violence, sexual assault, and human trafficking expertise represented among HHCS, The Center, and KCCASA. As outlined in the Federal Strategic Action Plan on Services for Victims of Trafficking in the U.S., increasing coordination between domestic violence (DV) and sexual assault (SA) organizations is critical to increase knowledge on trafficking within communities.15

Project goals, objectives, & activities

HHCS proposed to bridge the aforementioned service gaps through this partnership. New funding, training, and technical assistance provided by FFT to The Center in Peoria and KCCASA in Kankakee would allow them to provide critical services to domestic survivors, pre-certified foreign national survivors, and foreign national survivors who meet the federal definition of trafficking but will not receive HHS Certification. These activities would:

1. Ensure availability of services for all victims—regardless of legal status, geographic location, gender, sexual orientation, or type of trafficking—through The Center and KCCASA. This new partnership intended to allow The Center and KCCASA to respond to survivors wherever they are and in any setting (e.g., shelter, foster home, substance abuse treatment center, etc.). To do this, they planned to partner with emergency shelters, transitional and permanent housing providers, medical and mental health providers, education systems, substance abuse treatment agencies, drop-in centers, and faith-based providers to meet survivors’ needs.

2. Increase identification through capacity development. HHCS and its project partners intended to conduct 17 human trafficking trainings each year—directly reaching an estimated 1,700 individuals in 3 years in Peoria and Kankakee; and to serve a total of 90 survivors over the 3 years of the partnership.

Partner subgrantee overview

The Center for Prevention of Abuse (The Center) has grown from a single rape crisis hotline that started in 1975 to a highly respected statewide leader in working to end abuse and break the cycle of generational violence. The Center is the only agency in the state sanctioned to provide its combined services of response to domestic violence, sexual abuse/assault, human trafficking, adult protective services, and prevention education under one roof. The Center operates a 24-hour rape crisis hotline, as well as a domestic violence hotline, and an emergency shelter. They also provide support services for domestic violence survivors, including legal support services, court advocacy services, and 24-hour medical advocacy response to domestic violence and sexual assault victims at local hospitals. Additionally, they have 11 transitional housing apartments for survivors. The Center also assists senior citizens who have been abused, neglected or financially exploited. Staff members serve on community and state task forces that work to increase awareness about domestic violence and improve client services and participate actively on coalitions and networking groups that focus on issues faced by clients, including the Heart of Illinois Homeless Continuum of Care, the Peoria County Juvenile Justice Council, local LAN and Youth Service Network Panels, and Heart of Illinois Safe From The Start.
Kankakee County Center Against Sexual Assault (KCCASA) provides public education and professional training in the area of sexual assault and human trafficking, counseling and psychological support to adult and child survivors and their significant others, assistance throughout the medical and criminal justice process, 24-hour telephone and in-person response, and partnership with community agencies to improve response to the crime of sexual violence. KCCASA's counseling program provides therapy to victims of sexual violence not only in the general community, but also those who are incarcerated in the Dwight, Kankakee, and Westside Correctional Centers. KCCASA maintains a collaborative partnership with police, state's attorneys, advocates and medical personnel in Kankakee County to provide training and education. KCCASA is a member of the Illinois Coalition Against Sexual Assault and key member of the Kankakee County Multi-Disciplinary Response Team (MDT) Response Project. The MDT Project is a countywide collaboration of professionals including law enforcement, advocacy, medical personnel, prosecution, probation, secondary and higher education and social service providers.

Implementation

Between October 2016 and September 2020, FFT facilitated 10 trainings with The Center and KCCASA to support the expansion of their programming to identify and provide specialized services for survivors of trafficking. Trainings covered a wide range of topics, including human trafficking basics, trauma-informed care, trainings for hotline staff on human trafficking screening, and intensive labor trafficking training. Three of the trainings were conducted by a consultant from the International Institute of Buffalo on trauma-informed care. FFT also conducted three trainings for larger groups of external stakeholders and two at the Freedom Network.

FFT developed program manuals for use and reference by subgrantee partners (Center and KCCASA). FFT hosted monthly partner calls where staff from both agencies could discuss challenges and cases and ask questions. FFT intentionally hosted these calls with the partners together so they could support and learn from each other’s experiences. FFT used this time to provide guidance on engagement with people still in trafficking situations, to troubleshoot coordination with law enforcement and child welfare, and to share on practices gleaned from doing the work in the Chicagoland area. FFT brought expert guest speakers such as the Department of Children and Family Services, the FBI, and the Illinois Attorney General’s Office, the National Human Trafficking Hotline, and legal aid providers to monthly calls when needed, and connected The Center and KCCASA with additional partners such as legal aid providers, the FBI in their jurisdiction, etc. FFT led annual partner summits as well, where the partners gathered for one to two days to reflect on the year and discuss the year to come. FFT also provided ongoing technical assistance to the partners, as needed.

The Center and KCCASA began facilitating community education and trainings to groups in Peoria and Kankakee in early 2017. In total, 188 trainings were conducted between 2017 and 2020, reaching 5,689 people. Trainings were conducted for key stakeholders who may have the ability to screen and identify for human trafficking and serve vulnerable populations. This included almost 1,777 medical and healthcare providers, 622 state and local law enforcement, 551 staff within the school setting, and 537 within the civic/business community or within businesses such as utilities, water, etc. Through these trainings, referrals began coming in and they also began providing services to survivors.
Participant demographics

A total of 63 survivors were involved in the program; 57 agreed to allow their data to be part of this study (analysis included in this study reflects only those participants’ information). Most participants (85%) worked with The Center compared to KCCASA (15%). The vast majority (97%) of participants were female. Over half identified as white/Caucasian, about a quarter as Black or African American, almost 10% as Hispanic/Latino, and about 5% as Bi-Racial/Multi-Racial or other. The majority (90%) of participants’ country of origin was the United States. Most participants’ primary language was English (91%); other primary languages included Spanish and other languages (Creole, French, and Javanese). Most participants (80%) were between the ages of 22 and 56 years old, with an average age of 35. Most participants were survivors of sex trafficking (80%), 11% were survivors of both sex and labor trafficking, and 9% were survivors of labor trafficking.

Participants served by The Center and KCCASA

The vast majority of participants

- Spoke English as a primary language: 91%
- Were women: 97%
- Were born in the US: 90%

Participant race and ethnicity

- White/Caucasian: 62%
- Black/African American: 24%
- Hispanic/Latino: 9%
- Bi-Racial/ Multi-Racial or other: 5%

Survivor trafficking type

- Sex trafficking: 80%
- Sex and labor trafficking: 11%
- Labor trafficking: 9%
At intake, about half of participants were single (55%) and most did not have children under 18 living with them (79%). Participants with children at intake generally reported children being in a safe situation (85%). Nearly half of participants with children who did not live with them reported at intake that they were working to reunify with their children. 69% of participants have at least a high school degree or GED, and 66% reported having a criminal record.

Service needs

At intake, participants were asked about service needs. The top five services participants reported needing were:

- Housing
- Transportation
- Clothing
- Food
- Rental Assistance

At follow-up, the top five services participants needed were:

- Food
- Utility bill assistance
- Dental
- Transportation
- Rental assistance

Only one participant remained in a trafficking situation at intake; however, at follow-up, no participants were still in trafficking situations. 50% of participants were in excellent, very good, or good health at intake. Of those participants with health problems, the most pressing health conditions at intake were: PTSD, pregnancy, mental health and stress, and Hepatitis C. Most participants (79%) reported having health insurance at intake.

Most participants reported that they were eating well (59%) and felt very safe or moderately safe (80%) at intake. Over half of participants (57%) reported at intake that they were not sleeping well.

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For more information about service need options, see the assessment in Appendix 1.
Service utilization

Based on service utilization data from the Trafficking Information Management System (TIMS) data, over the 3 years of the grant cycle, the most frequently utilized services (by total hours) included:

- Ongoing Case Management
- Mental Health and Treatment (Emergency/Long-Term)
- Emotional/Moral Support (Non-Mental Health)
- Housing/Shelter Advocacy
- Employment Assistance

It should be noted that the service types in the service delivery tracking system in TIMS do not perfectly align with the service needs listed in the program assessments, so some misalignment between survivor-identified needs and service delivery is due to differences in data collection and tracking. To see the detailed listing of service needs listed in the assessment, and the list of service delivery terms and definitions in TIMS, see Appendix 2.

ii To see definitions of service provision terms, see Appendix 2.
### Most-utilized services by total hours

<table>
<thead>
<tr>
<th>Top 10 most frequently used services</th>
<th>Total hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing Case Management</td>
<td>814</td>
</tr>
<tr>
<td>Mental Health and Treatment (Emergency/Long-term)</td>
<td>191</td>
</tr>
<tr>
<td>Emotional/Moral Support (Non-Mental Health)</td>
<td>188</td>
</tr>
<tr>
<td>Housing/Shelter Advocacy</td>
<td>161</td>
</tr>
<tr>
<td>Employment Assistance</td>
<td>84</td>
</tr>
<tr>
<td>Transportation</td>
<td>82</td>
</tr>
<tr>
<td>Housing/Rental Assistance</td>
<td>58</td>
</tr>
<tr>
<td>Client Intake</td>
<td>44</td>
</tr>
<tr>
<td>Legal Services (including Civil and Immigration Advocacy)</td>
<td>42</td>
</tr>
<tr>
<td>Protection/Safety Planning</td>
<td>41</td>
</tr>
</tbody>
</table>

### Most-utilized services by total number of participants

<table>
<thead>
<tr>
<th>Top 10 services utilized by participants</th>
<th># of participants receiving services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing Case Management</td>
<td>56</td>
</tr>
<tr>
<td>Emotional/Moral Support (Non-Mental Health)</td>
<td>47</td>
</tr>
<tr>
<td>Client Intake</td>
<td>45</td>
</tr>
<tr>
<td>Housing/Shelter Advocacy</td>
<td>44</td>
</tr>
<tr>
<td>Protection/Safety Planning</td>
<td>40</td>
</tr>
<tr>
<td>Transportation</td>
<td>38</td>
</tr>
<tr>
<td>Client Orientation</td>
<td>32</td>
</tr>
<tr>
<td>Housing/Rental Assistance</td>
<td>27</td>
</tr>
<tr>
<td>Employment Assistance</td>
<td>26</td>
</tr>
<tr>
<td>Medical (Emergency/Long-term)</td>
<td>24</td>
</tr>
</tbody>
</table>
Evaluation

The data analysis that follows will assess whether the program reached its goals as they relate to participant outcomes. Service providers administer intake and follow-up assessments with participants to inform service provision and referrals. Those same data are used here to assess change over time in participant responses, and relationship between change over time and service utilization. This will allow us to determine whether participants reported improvements in their lives, and if these changes are related to services provided through this program. 61 participants completed at least one assessment. Of those, 57 agreed to allow their data to be included in this study.iii

Intended long-term outcomes for participants

Beyond identification of survivors and victims of trafficking, increasing community awareness and knowledge, and increasing access to services for survivors, this program intended to improve the lives of program participants. Goals related to participant outcomes include:

- reduction in feelings of stress
- increase in housing stability
- improved English language proficiency
- enhanced employment status
- increased feelings of safety
- increased feelings of autonomy
- increased feelings of well-being

Research questions:

- How do supportive services help survivors achieve positive outcomes?
- What services are most impactful at helping survivors achieve positive outcomes?
- What barriers prevent survivors from achieving positive outcomes?

Data sources:

To assess changes in participant well-being and relationship between those changes and service utilization, this evaluation analyzes program service provision data and participant assessment data, both collected and reported by program staff. Participant assessments are administered at intake and ideally, every 6 months thereafter. In reality, assessments were not conducted at perfectly regular intervals. Assessments were often not completed in one session, due to the length and emotional burden of completing some of the sections. Service utilization was also at times irregular or infrequent, which impacted timing of assessments. Distinct sections in the assessments included:

- Survivor information
- Emergency/service needs
- Family information

Participants were given the choice to participate in this study by their service provider, who facilitated an informed consent process.
Interviews with leadership staff from FFT, The Center, and KCCASA helped to inform and frame analysis and interpretation of quantitative data, but were not coded and analyzed rigorously.

Findings

Research Question 1: How do supportive services help survivors achieve positive outcomes?

Within the assessments are specific questions and scales that relate closely with the program’s proposed outcomes. We see significant improvements from intake to follow up in psychological distress, PTSD symptoms, and participants’ feelings about their current living situation. We did not see significant change in stress, social support, self-efficacy, employment status, or feelings of safety.

Below are descriptions of these scales and questions, and aggregate scores/responses at intake, and following are more detailed findings from analysis of changes in those metrics in the pre- and follow-up assessments.

- **Stress Scale**: participants are asked to report their stress level from 1 (completely calm) to 10 (most distressed). At intake participants were severely stressed.

- **Psychological distress scale**: participants are asked a series of questions about feelings of anxiety or depression (questions are from the Patient Health Questionnaire 4, a method used to screen for symptoms of anxiety and depression); responses are assigned numeric values. The values are added together to determine the “score”; the lower the score, the lower the distress participants are experiencing. The higher the score, the more severe clients’ distress levels. At intake, participants report being moderately distressed.

- **Social support survey**: participants are asked a series of questions about whether or not they have help or support available for anything from basic life needs to emotional support when they need it from their support network. Responses are assigned numeric values. The values are added together to determine the “score”; the higher the score the more support participants have and the lower the score, the less support participants have. Scores range from 8 to 40; this assessment does not have categorical score ranges for interpretation, it is used to track change over time.

- **Self-efficacy scale**: participants are asked a series of questions about their feelings of confidence to reach their goals and overcome challenges. Responses are assigned numeric values. The values are added together to determine the “score”; the higher the score, the higher self-efficacy participants feel, and the lower the score, the lower self-efficacy participants feel. Scores range from 10 to 40; this assessment does not have categorical score ranges for interpretation, it is used to track change over time.

- **PTSD screening**: participant are asked a series of questions about symptoms of post-traumatic stress, such as nightmares and being constantly on guard. If participants
respond ‘yes’ to 3 of the 4 screening questions, they have screened positive for possible PTSD. At intake 63% of participants screened positive for potential PTSD.

- **Housing stability question:** participants are asked to rate their housing stability with Likert scale response options. At intake, 71% reported being somewhat or very stable in their housing, and 29% reported being not very or not at all stable in their housing.

- **Employment question:** participants are asked about their employment status, with multiple choice options: employed; employed, but not currently working (has a job, but for some reason isn’t reporting to work now); in school or training full time; unemployed and not in school or training full time; retired; disabled and not able to work; or other. At intake, 26% were employed, 48% were unemployed, 22% were disabled and not able to work, and 4% were in school or training full time.

To determine if meaningful change occurred for participants for these outcomes between intake and follow-up assessments, statistical significance testing was done. Not all participants completed a follow-up assessment and many participants completed multiple follow-up assessments. For that reason, we conducted both paired and unpaired means comparison tests, using paired and unpaired t-tests and chi-square test. By matching participants’ assessments, we can control for between-subject variability. Unmatched assessments provide an average look at participants at two points in time. Without matching, it cannot be directly determined if any change being experienced by participants is because of the composition of the group of participants taking the pre- and post-assessments. Whenever possible, we compare means using matched testing, but small numbers of follow-up assessment limit our ability to rely solely on this method. Unmatched means comparison testing can still tell us whether, on average, there were changes from one point in time to the next, in a given measure.

Prior to preforming tests, it was determined data met the assumptions for each test. The assumptions for the unpaired t-test are: independence, normal distribution, and equality of variance. The assumptions for paired t-test are: independence, normal distribution, continuous outcome data, and no outliers. The assumptions for chi-square test are: cells have counts of cases, variables are mutually exclusive, and independent. For participants who completed multiple follow-up assessments, we only used the most recent follow-up assessment.

### Changes in participant outcome areas from intake to follow up (matched testing)

<table>
<thead>
<tr>
<th>Change from intake to follow-up for matched assessments</th>
<th>Intake</th>
<th>Follow-up</th>
<th>Difference</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress scale (n=15)</td>
<td>7.3</td>
<td>6.6</td>
<td>-0.7</td>
<td>0.1432</td>
</tr>
<tr>
<td>Psychological distress (n=24)</td>
<td>6.5</td>
<td>4.9</td>
<td>-1.6</td>
<td>0.0444*</td>
</tr>
<tr>
<td>Social support survey (n=17)</td>
<td>27.5</td>
<td>27.7</td>
<td>0.2</td>
<td>0.9423</td>
</tr>
<tr>
<td>Self-efficacy scale (n=23)</td>
<td>30.4</td>
<td>30.3</td>
<td>-0.1</td>
<td>0.9425</td>
</tr>
<tr>
<td>PTSD screening (n=24)</td>
<td>58%</td>
<td>63%</td>
<td>5%</td>
<td>0.1486</td>
</tr>
</tbody>
</table>

*Statistically significant at 5%

iv The following are the hypotheses for the unpaired t-tests:
   • The null hypothesis ($H_0$) is that the true difference between these group means is zero.
   • The alternate hypothesis ($H_1$) is that the true difference is different from zero.

The following are the hypotheses for the paired t-tests:
   • The null hypothesis ($H_0$) is that the true mean difference is zero.
   • The alternate hypothesis ($H_1$) is that the true mean difference is not equal to zero.

The following are the hypotheses for chi-square test:
   • The null hypothesis ($H_0$) is that there is no association between the variables.
   • The alternate hypothesis ($H_1$) is that there is an association between the variables.
Average psychological distress scores decreased by 25% and this decrease was statistically significant. Despite other changes we can observe from the average pre- to post-scores, the majority of these differences are not statistically significant. By simply comparing means, we can see that from intake to follow up, participants also showed a decrease in stress, positive PTSD screening, and an increase in social support. However, using matched comparison tests, we learn that these changes were not statistically significant, so we cannot say with certainty that these changes are meaningful or substantial.

### Changes in participant outcome area scores from intake to follow up (unmatched testing)

<table>
<thead>
<tr>
<th>Change from intake to follow-up for unmatched assessments</th>
<th>Intake</th>
<th>Follow-up</th>
<th>Difference</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress scale (intake=38; follow-up=16)</td>
<td>7.1</td>
<td>6.5</td>
<td>-0.6</td>
<td>0.3765</td>
</tr>
<tr>
<td>Psychological distress (intake=42; follow-up=25)</td>
<td>6.3</td>
<td>4.9</td>
<td>-1.4</td>
<td>0.1521</td>
</tr>
<tr>
<td>Social support survey (intake=35; follow-up=22)</td>
<td>24.4</td>
<td>28.5</td>
<td>4.2</td>
<td>0.0997</td>
</tr>
<tr>
<td>Self-efficacy scale (intake=42; follow-up=25)</td>
<td>28.9</td>
<td>30.6</td>
<td>1.7</td>
<td>0.2607</td>
</tr>
<tr>
<td>PTSD screening (intake=44; follow-up=24)</td>
<td>64%</td>
<td>38%</td>
<td>-26%</td>
<td>0.0386*</td>
</tr>
</tbody>
</table>

*Statistically significant at 5%

Using unmatched testing, we see that the number of people reporting PTSD symptoms decreased by 26% from intake to follow-up, and this difference was statistically significant. Unmatched testing shows no significant change for all other outcome areas. Despite seeing differences from intake to follow-up in stress, distress, and increasing social support, these changes were not statistically significant. These changes reflect average change; assessments were not matched and all intakes and all most recent follow-up assessments were included in the analysis.

**Housing stability**

Matched testing showed that there was a significant, meaningful change in participants’ feelings about stability of their current living situation from intake to follow-up. **Participants’ feelings of stability increased from intake to follow-up.**

### Changes in participant feelings of housing stability

<table>
<thead>
<tr>
<th>Feeling of stability at current living situation (n=20)</th>
<th>Intake</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very stable</td>
<td>15%</td>
<td>40%</td>
</tr>
<tr>
<td>Somewhat stable</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>Not very stable</td>
<td>30%</td>
<td>0%</td>
</tr>
<tr>
<td>Not at all stable</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>p-value</td>
<td></td>
<td>0.0163*</td>
</tr>
</tbody>
</table>

*Statistically significant at 5%
**Employment status**

Neither matched nor unmatched testing showed any significant change in participants’ **employment status** from intake to follow-up.

**Changes in participant employment status**

<table>
<thead>
<tr>
<th>Employment status</th>
<th>% at intake (n=46)</th>
<th>% at follow-up (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>48%</td>
<td>39%</td>
</tr>
<tr>
<td>Disabled and not able to work</td>
<td>22%</td>
<td>22%</td>
</tr>
<tr>
<td>In school or training full time</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Feelings of safety**

Neither matched nor unmatched testing showed any significant change in participants’ **feelings of safety** from intake to follow-up.

**Changes in participant feelings of safety**

<table>
<thead>
<tr>
<th>Feelings of safety</th>
<th>% at intake (n=44)</th>
<th>% at follow-up (n=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very safe</td>
<td>32%</td>
<td>42%</td>
</tr>
<tr>
<td>Moderately safe</td>
<td>48%</td>
<td>46%</td>
</tr>
<tr>
<td>Unsafe</td>
<td>14%</td>
<td>4%</td>
</tr>
<tr>
<td>Extremely unsafe</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Research Question 2: What services are most impactful at helping survivors achieve positive outcomes?

- Are there certain services that have stronger relationships with certain participant outcomes?

- What is the relationship between different services and participant outcomes?

Looking at correlation helped determine the effect size and the direction of the relationship between dosage of services and outcomes. After removing outliers, dosage of services ranged from 7 to 282 units\(^v\), with an average of 99 (in hours, this ranged from 1.75 to 70.5 hours, with an average of 24.75). Overall, we did not find a significant relationship between dosage of services and outcomes (changes in assessments). This means we cannot say with certainty that there was a substantial, meaningful relationship between overall service dosage and outcomes.

**Relationship between service dosage and outcomes**

<table>
<thead>
<tr>
<th>Correlation between dosage and assessment</th>
<th>( R^2 )</th>
<th>Effect size</th>
<th>Relationship</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress scale (n=15)</td>
<td>0.06</td>
<td>small</td>
<td>no relationship</td>
<td>0.8415</td>
</tr>
<tr>
<td>Psychological distress (n=24)</td>
<td>0.01</td>
<td>small</td>
<td>no relationship</td>
<td>0.9552</td>
</tr>
<tr>
<td>Social support survey (n=17)</td>
<td>-0.09</td>
<td>small</td>
<td>no relationship</td>
<td>0.7517</td>
</tr>
<tr>
<td>Self-efficacy scale (n=23)</td>
<td>-0.12</td>
<td>small</td>
<td>no relationship</td>
<td>0.6178</td>
</tr>
<tr>
<td>PTSD screening (n=24)</td>
<td>-0.10</td>
<td>small</td>
<td>no relationship</td>
<td>0.6653</td>
</tr>
</tbody>
</table>

When we hone in on specific assessment metrics and service types\(^vi\), we do see some significant relationships:

**Improvements**

- Participants who received more social service advocacy and explanation of benefits/entitlements/availability services reported reductions in stress levels from intake to follow-up.

- Participants who received more social service advocacy and explanation of benefits/entitlements/availability services reported reductions in psychological distress from intake to follow-up.

- Participants who received more substance abuse treatment services reported lower levels of positive PTSD screenings at follow-up.

**Declines**

- Participants who received more criminal justice system-based victim advocacy services reported reductions in social support from intake to follow-up.

- Participants who received more education services reported reductions in social support from intake to follow-up.

- Participants who received more social service advocacy and explanation of benefits/entitlements/availability services reported reductions in self-efficacy from intake to follow-up.

---

\(^v\) Units of service as tracked in TIMS are 15 minute increments.

\(^vi\) For a full list and definitions of service types, see Appendix 2.
The tables below provide information on the strength of the relationships and effect size between specific assessment metrics and service types.\textsuperscript{vii,viii}

**Stress Scale**

The strongest relationship and largest effect size that was also statistically significant was between social service advocacy and explanation of benefits/entitlements/availability and stress—this means participants who received more of this service also reported reductions in stress levels from intake to follow-up. The services that had large effect sizes and strong relationships with changes in stress, but were not statistically significant were: medical (emergency/long-term), housing/shelter advocacy, and mental health and treatment (emergency/long-term).

**Relationship between service dosage by type and changes in stress**

<table>
<thead>
<tr>
<th>Type of service</th>
<th>R</th>
<th>Effect size</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Orientation (n=12)</td>
<td>0.58</td>
<td>Large</td>
<td>Somewhat strong relation</td>
</tr>
<tr>
<td>Crisis Intervention or 24-Hour Hotline (n=4)</td>
<td>-0.27</td>
<td>Medium</td>
<td>Weak relation</td>
</tr>
<tr>
<td>Employment Assistance (n=4)</td>
<td>-0.42</td>
<td>Medium</td>
<td>Weak relation</td>
</tr>
<tr>
<td>Housing/Rental Assistance (n=9)</td>
<td>0.46</td>
<td>Medium</td>
<td>Weak relation</td>
</tr>
<tr>
<td>Housing/Shelter Advocacy (n=10)</td>
<td>-0.52</td>
<td>Large</td>
<td>Somewhat strong relation</td>
</tr>
<tr>
<td>Legal Services(Including Civil and Immigration Advocacy) (n=8)</td>
<td>0.61</td>
<td>Large</td>
<td>Somewhat strong relation</td>
</tr>
<tr>
<td>Mental Health and Treatment (Emergency/Long-Term) (n=4)</td>
<td>-0.78</td>
<td>Large</td>
<td>Strong relation</td>
</tr>
<tr>
<td>Medical (Emergency/Long-Term) (n=3)</td>
<td>0.93</td>
<td>Large</td>
<td>Strongest relation</td>
</tr>
<tr>
<td>Ongoing Case Management (n=4)</td>
<td>-0.26</td>
<td>Medium</td>
<td>Weak relation</td>
</tr>
<tr>
<td>Protection/Safety Planning (n=10)</td>
<td>-0.44</td>
<td>Medium</td>
<td>Weak relation</td>
</tr>
<tr>
<td>Social Service Advocacy and Explanation of Benefits/ Entitlements/Availability (n=5)</td>
<td>-0.99*</td>
<td>Large</td>
<td>Strongest relation</td>
</tr>
<tr>
<td>Transportation (n=12)</td>
<td>0.36</td>
<td>Medium</td>
<td>Weak relation</td>
</tr>
</tbody>
</table>

*Statistically significant

\textsuperscript{vii} Effect size speaks to magnitude of the relationship between the two variables; the greater the effect size, the greater the association between the two variables: 0 to .01 (no effect); .10 to .20 (small); .21 to .50 (medium); and .51 to 1 (large). Strength of the relationship speaks to the linearity of the relationship between the two variables; the closer the estimate is to 1 the stronger the relationship, 0 means no relationship between variables: 0 to .01 (no relationship); .10 to .50 (weak relationship); .51 to .7 (somewhat strong relationship); .71 to .80 (strong relationship); and .81 to .99 (strongest relationship).

\textsuperscript{viii} Services and assessment metrics with no relationship are not included here. For full list of service descriptions, see Appendix 2. For assessment metrics, see Research Question 1.
Psychological distress

The strongest relationship and largest effect size that was also statistically significant was between social service advocacy and explanation of benefits/entitlements/availability and psychological distress—this means participants who received more of this service also reported reductions in psychological distress levels from intake to follow-up assessments. The other services and psychological distress outcome that had a strong relationship and large effect size but were not statistically significant were substance abuse treatment, mental health and treatment (emergency/long-term), and criminal justice system-based victim advocacy.

Relationship between service dosage by type and changes in psychological distress

<table>
<thead>
<tr>
<th>Type of service</th>
<th>R</th>
<th>Effect size</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Justice System-based Victim Advocacy (n=4)</td>
<td>0.75</td>
<td>Large</td>
<td>Strong relationship</td>
</tr>
<tr>
<td>Crisis Intervention or 24-Hour Hotline (n=7)</td>
<td>0.30</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Education (n=8)</td>
<td>-0.52</td>
<td>Large</td>
<td>Somewhat strong relationship</td>
</tr>
<tr>
<td>Housing/Rental Assistance (n=14)</td>
<td>0.46</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Mental Health and Treatment (Emergency/Long-Term) (n=5)</td>
<td>-0.78</td>
<td>Large</td>
<td>Strong relationship</td>
</tr>
<tr>
<td>Ongoing Case Management (n=4)</td>
<td>-0.57</td>
<td>Large</td>
<td>Somewhat strong relationship</td>
</tr>
<tr>
<td>Social Service Advocacy and Explanation of Benefits/Entitlements/Availability (n=8)</td>
<td>-0.88*</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
<tr>
<td>Substance Abuse Treatment (n=5)</td>
<td>0.70</td>
<td>Large</td>
<td>Strong relationship</td>
</tr>
</tbody>
</table>

*Statistically significant
Social support survey

The strongest relationships and largest effect sizes that were also statistically significant were between criminal justice system-based victim advocacy and social support, and education and social support. Both of these services were related to reductions in reported social support. Participants who received more criminal justice system-based victim advocacy and participants who received more education services also reported reductions in social support from intake to follow-up assessments. This finding may seem counter-intuitive, but we speculate that through receiving these services, participants may realize that the criminal and education landscapes are not easy to navigate by themselves, necessitating the need to seek out advocates and additional supports. Or, in seeking out and receiving these services, participants may have also made changes to their social network. The other services that had a strong relationship with changes in social support, and large effect size, but were not statistically significant were social service advocacy and explanation of benefits/entitlements/availability and ongoing case management.

Relationship between service dosage by type and changes in social support

<table>
<thead>
<tr>
<th>Type of service</th>
<th>R</th>
<th>Effect size</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Intake (n=14)</td>
<td>-0.34</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Client Orientation (n=8)</td>
<td>0.49</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Criminal Justice System-based Victim Advocacy (n=3)</td>
<td>-1.00*</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
<tr>
<td>Education (n=5)</td>
<td>0.91*</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
<tr>
<td>Employment Assistance (n=6)</td>
<td>0.48</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Legal Services (Including Civil and Immigration Advocacy) (n=11)</td>
<td>0.40</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Mental Health and Treatment (Emergency/Long-Term) (n=4)</td>
<td>0.51</td>
<td>Large</td>
<td>Somewhat strong relationship</td>
</tr>
<tr>
<td>Ongoing Case Management (n=4)</td>
<td>-0.74</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
<tr>
<td>Protection/Safety Planning (n=15)</td>
<td>0.31</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Social Service Advocacy and Explanation of Benefits/Entitlements/Availability (n=5)</td>
<td>-0.78</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
<tr>
<td>Substance Abuse Treatment (n=4)</td>
<td>-0.51</td>
<td>Large</td>
<td>Somewhat strong relationship</td>
</tr>
</tbody>
</table>

*Statistically significant
Self-efficacy scale

The strongest relationship and largest effect size that was also statistically significant was between social service advocacy and explanation of benefits/entitlements/availability and self-efficacy—this service was related to reductions in reported self-efficacy. This means that participants who received more of this service also reported reductions in self-efficacy from intake to follow-up. Again, this finding may seem counter-intuitive, but we speculate that through receiving this service and discussing benefits and entitlements, participants may begin to feel that government bureaucracy is not easy to navigate on their own and requires them to seek out advocates for themselves.

Relationship between service dosage by type and changes in self efficacy

<table>
<thead>
<tr>
<th>Type of service</th>
<th>R</th>
<th>Effect size</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical (Emergency/Long-Term) (n=7)</td>
<td>-0.37</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Protection/Safety Planning (n=17)</td>
<td>0.47</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Social Service Advocacy and Explanation of Benefits/ Entitlements/Availability (n=8)</td>
<td>-0.77*</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
<tr>
<td>Substance Abuse Treatment (n=6)</td>
<td>0.47</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
</tbody>
</table>

*Statistically significant
PTSD screening

The strongest relationship and largest effect size that was also statistically significant was between substance abuse treatment and positive PTSD screening—this means participants who received more of this service reported fewer positive PTSD screenings at follow-up. The other service that had a strong relationship with PTSD screening and large effect size but was not statistically significant was mental health and treatment (emergency/long-term).

Relationship between service dosage by type and changes in PTSD screening

<table>
<thead>
<tr>
<th>Type of service</th>
<th>R</th>
<th>Effect size</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Intake (n=18)</td>
<td>0.37</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Client Orientation (n=10)</td>
<td>0.49</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Criminal Justice System-based Victim Advocacy (n=4)</td>
<td>-0.33</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Crisis Intervention or 24-Hour Hotline (n=7)</td>
<td>-0.38</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Education (n=8)</td>
<td>0.40</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Housing/Shelter Advocacy (n=19)</td>
<td>-0.26</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Medical (Emergency/Long-Term) (n=8)</td>
<td>-0.30</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Mental Health and Treatment (Emergency/Long-Term) (n=5)</td>
<td>0.51</td>
<td>Large</td>
<td>Somewhat strong relationship</td>
</tr>
<tr>
<td>Social Service Advocacy and Explanation of Benefits/Entitlements/Availability (n=8)</td>
<td>-0.35</td>
<td>Medium</td>
<td>Weak relationship</td>
</tr>
<tr>
<td>Substance Abuse Treatment (n=5)</td>
<td>-0.92*</td>
<td>Large</td>
<td>Strongest relationship</td>
</tr>
</tbody>
</table>

*Statistically significant

Research Question 3: What barriers prevent survivors from achieving positive outcomes?

- Are there certain barriers that have stronger relationships with certain participant outcomes?

To answer this question, we would like to compare changes in assessments between groups of participants—those who indicated they were experiencing certain barriers, such as criminal background or chronic health problems, and those who did not report those barriers—to determine if certain barriers were significantly impacting their outcomes. Data limitations, explained in the next section, prevent us from conducting this level of in-depth analysis with the small sample of quantitative data.

Since quantitative data were limited or not available, we instead use interviews with service provider staff to explore this research question. Service provider staff shared that a lack of local resources for survivors, such as safe affordable housing, accessible legal support services, financial support, and additional human service providers in their areas, was the biggest barrier for their participants. They also shared that mental health challenges posed a barrier for some participants, especially when participants were not interested in or ready to pursue treatment for their mental health. More detail can be found in the discussion section of this report.
Limitations of analysis

Data completeness

Completeness of data varied from participant to participant; less than 50% of participants completed even one follow-up assessment, leaving the follow-up sample very small. This limits our ability to conduct additional in-depth analysis on changes from intake to follow-up assessment scores and responses.

Assessment completion counts

<table>
<thead>
<tr>
<th></th>
<th>Stress scale</th>
<th>Social support survey</th>
<th>Self-efficiency scale</th>
<th>PTSD screening</th>
<th>Psychological distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>38</td>
<td>35</td>
<td>42</td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>completing intakes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants</td>
<td>16</td>
<td>22</td>
<td>25</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>completing follow up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up response rate</td>
<td>42%</td>
<td>63%</td>
<td>60%</td>
<td>55%</td>
<td>60%</td>
</tr>
</tbody>
</table>

In addition to a small sample size, we are limited in our interpretation by only analyzing changes in the metrics included in intake and follow-up assessments. By doing this, researchers define success and barriers to success, rather than survivors defining their own success metrics and challenges. Additional data sources and context from the program or from survivors would help to frame the analysis for more meaningful findings, but this was not within the current project scope.

Length of time receiving services

There are no hard and fast start and end dates for most participants. Their length of stay in the program varies and is dependent on their situation. Most participants have been in the program for less than one year (65%). While this is in line with the program model, it may not be a long enough timeframe to see significant changes in the types of assessments used as outcome indicators in this research. Many of the outcomes relate to mental health and general well-being, which can take time to stabilize and improve. This may indicate the need for shorter-term indicator data points for future research. Additionally, mental health stabilization and improvement are often not linear, with dips and peaks along the way. Ideally, we would like to assess overall trends over a longer timeframe.

Service delivery

The service delivery environments of the two sites are very different. The Center is a domestic violence agency that has shelters with 31 beds and is able to provide many services, all on-site; KCCASA is a rape crisis center that provides drop-in services. Being a drop-in site may have made completing follow-up assessments difficult, if engagement and service utilization was shorter-lived or less consistent. While a drop-in center may be a lower threshold point of entry to service provision, it does mean that people may drop in once rather than access services over time, and there is less time to build relationship and rapport. The assessment’s length may have also hindered completion at a drop-in site, especially follow-up assessments. There were also variables in each region around the ability to maintain continued engagement with survivors who were debating leaving trafficking situations.
Discussion

Participant impacts

Staff from both The Center and KCCASA reported that they observed changes in their participants from intake to program exit. They reported that safety was a top concern for most participants – many worried that they would be found by their trafficker. That translated into different goals for different participants – one survivor had the goal of going to the grocery store without feeling like they had to constantly be looking over their shoulder. Another wanted to find housing that they truly felt safe in – in a safe neighborhood, with a good landlord, etc. Service providers reported that they used those goals and provided services to try to help reach them and to help boost confidence in those life areas.

Staff at The Center reported observing overwhelmingly positive changes in their participants. Primarily, they saw improvement in self-confidence. Staff reported that at intake, survivors felt that they had nothing to offer employers, and had very fractured family relationships. Staff focused a lot of time working with participants on building up their support networks and reengaging with family, when that was a goal of the participant. Staff observed increases in employment and safety of participants. They did note that at times, assessments reflected the opposite, particularly if survivors were adjusting to communal living in shelter, but longer-term, staff observed positive changes.

Staff at KCCASA shared an anecdote about a particular participant who made significant life improvements through supports and service utilization. The participant had struggled to escape and recover from a cycle of violence. Through comprehensive supports and services, the survivor was able to secure a job and safe housing, which helped her to gain some stability. This was also an important learning for the service provider, who admitted they hadn’t been aware of the cyclical nature of risk and re-victimization inherent to trafficking – survivors are not permanently safe upon exiting a trafficking situation; they are often vulnerable to re-victimization, as the factors that made them vulnerable in the first place are frequently still their reality if they escape their traffickers. Many survivors reached out to service providers long after they had left trafficking situations, but they still needed support and were suffering from long-term negative impacts from those situations.

Staff from The Center felt that much of their success can be attributed to their strong approach to case management, and that they have so many supports available to their participant all in one place. They have on-site shelter and clinical therapy, and surround their participants in comprehensive case management with a victim-centered approach.

It is unclear why some of these reflections do not fully align with findings from analysis of program assessments. It is possible that the limitations outlined above do not allow for complete enough analysis to illustrate the impact of the program. It is also possible that service providers naturally remember and focus on successful cases. Based on these reflections, we would expect to see significant improvements in self-efficacy scores in particular, but there was no significant change observed in the assessments, and, in fact, there were some relationships between some services and reductions in feelings of self-efficacy and social support. The significant changes in psychological distress do support the staff reflections. As noted in the data limitations section, we may need a larger sample of data to better assess outcomes, and perhaps a longer timeframe to allow for meaningful changes to occur.

Barriers to positive participant outcomes

Service provider staff at KCCASA shared that one of the most challenging barriers to positive outcomes for survivors was mental health. Though not the most common barrier, staff shared that when participants had significant mental health problems but chose not to pursue treatment, it created serious roadblocks preventing survivors from achieving their goals. Staff acknowledged
that systems had failed survivors in the past, so building enough trust to reach the point of readiness for these services was difficult and took time. Staff felt that for this reason, it was particularly important and helpful for participants to drive service provision by setting their own goals, which staff would cater services to support.

Staff at The Center shared that some challenges also arose when participants set goals that were beyond what the organization could help them with. Staff struggled to find financial support for participants to go back to school, for example. In other cases, staff felt that participants had a different idea of The Center’s role in their lives than The Center was able to play.

Staff at The Center reported that lack of local legal support services was a barrier between participants and their goals. Legal resources based in Chicago area were logistically difficult – engaging participants throughout the process was challenging because it wasn’t face to face. Local providers with expertise would have been more beneficial. Staff also noted a lack of local permanent, safe, affordable housing as a huge barrier.

These reflections and bits of context are especially helpful in interpreting and understanding some of the challenges faced by both survivors and series providers. While we potentially could test the impact of individual-level barriers on participant outcomes, it would be much more difficult to quantitatively factor in geographic, systemic, or environmental factors. We would need an even larger sample size to be able to make the number of comparisons necessary to feel confident in the findings.

**Most impactful services**

Generally, staff from both organizations found that survivors who had recently escaped their trafficking situation understandably had more emergency needs – for things like shelter, clothing, food, cell phones, etc.; they generally felt overwhelmed trying to set goals. Survivors who had been out of their trafficking services for a longer time were generally ready to engage in longer-term planning, stayed engaged with services with less follow-up from staff, and needed support in connecting to mental health services or finding affordable housing, education, or employment supports.

In Kankakee, service providers felt that being able to provide housing support was particularly helpful for their participants. KCCASA partners with a domestic violence service provider with an emergency shelter, but they are generally focused on responding to emergency needs related to very recent assaults. Service providers found that survivors needed this support even if their trafficking situation was in the past, and found that it was a very important support to have available. Initial response sometimes meant a night in a hotel and support in starting the process of finding housing. Staff felt that though this support felt small, it helped with the daunting process, as many survivors were starting with nothing.

Staff from The Center felt that clinical therapy was particularly beneficial for survivors. They also noted that participants had multiple points of contact and support with different people within the organization, which gave them a sort of protective bubble. Additionally, any sort of financial or other tangible resources like cell phones or transportation help made a big difference in lightening their burdens and keeping survivors engaged in services.

These perspectives provide more nuanced reflections of the impact of different services. Again, quantitative evidence of these relationships may be limited by lack of sufficient data, or these reflections may be merely anecdotal. Context around how recently a participant has left a trafficking situation and the types of service they need and are ready to engage with is particularly informative, as it is not fully captured in assessment data. Contextual variables like these may also be impacting participant outcomes, and may warrant additional research.
Implementation challenges and lessons learned

Initially, staff from both organizations worried that screening and finding survivors would be a challenge. Screening and referrals did prove to be a challenge for KCCASA more than for The Center. While The Center learned after staff trainings and internal participant screenings that they were already serving a number of trafficking survivors through their other programs, KCCASA did not have as large of a client base to start from. Though they conducted many trainings with partner service providers, it did not result in a large number of referrals. The domestic violence service providers that they partner with continued to serve participants identified as trafficking survivors in-house rather than referring them to KCCASA. The partnership was still beneficial in that KCCASA was able to provide training to help with identification, but collaboration did not grow as much as they’d hoped. KCCASA did build an important relationship with healthcare providers and was able to respond to needs of survivors identified through the local hospital system. Staff also reflected that some survivors who had been identified ended up moving on to another location rather than staying in Kankakee, and did not enroll in services.

Staff from The Center shared that prior to engaging in the partnership with FFT, they had some awareness of the issue of trafficking, but were surprised at the pervasiveness and severity of the problem once they began training staff and identifying survivors in their current caseloads.

Staff also worried that community interest and understanding of trafficking would be a challenge, but there turned out to be a high demand for training, and both The Center and KCCASA were able to conduct a surprisingly high amount of training and community outreach, and far surpassed their goals. However, staff at both organizations noted that general community outreach and education with interested community members generally did not result in many new referrals, and were probably less impactful. Some of the most likely identifiers of cases were more hit or miss – some health care providers or law enforcement officers were very interested and eager for training, while others were not as excited to participate.

The Center also found that though they were able to find many willing partners to host trainings, the next steps around implementing what they’d learned remained a challenge. Engagement and interest in partnership varied among law enforcement officers, and even with interest, The Center found that it takes constant re-engagement to keep them involved and making referrals.

KCCASA shared that they felt they had saturated the market for Trafficking 101 trainings, and are preparing to move to the next step beyond 101s and lead more advanced trainings with partners. They plan to still provide basic training as well, but look forward to going beyond the basics where appropriate. They and staff from The Center acknowledge that misinformation in the general public is still a huge challenge, but feel that their effort may be better spent on systems change – to make trainings about human trafficking part of internal policy for health care or law enforcement, for instance. Rather than only engaging with people who are already interested in the issue, they feel that a more comprehensive approach would have a bigger impact.

The Center also struggled with community understanding of their role in response to human trafficking. People would call them with tips about “sketchy businesses” and staff would redirect them to call the police—The Center is a human service organization, and it does not conduct investigations. Staff did not want to discourage community interest, but also tried to help curtail wild misconceptions and tales spread through social media, which took focus and energy away from real cases.
Staff from The Center reflected that they wished they’d had a stronger strategy for their public education and trainings in the first two years of the partnership. They learned over that time that they should target the most impactful partners – those most likely to identify survivors. This included people who were in positions to interact, identify, and at times, intervene on behalf of participants – people like health care providers and law enforcement officers. Staff learned through their experience that other well-meaning social or civic groups were simply less likely to be in situations where they would be able to identify cases of trafficking, so should be lower priority when planning their training schedules. They identified 3 top-tier groups to target for trainings: 1. First responders such as law enforcement and health care providers; 2. Child welfare agencies and schools; and 3. Utilities and other service providers that are often admitted into people’s homes, and transportation providers, such as bus drivers. The third tier has only just been determined by staff, so they hope to target them for future trainings. Development of these tiers was based on reflection of the first two years, assessing pre- and post-training assessments to determine who had low levels of knowledge before the training; and paying attention to which trainings then later led to referrals.

**Impacts on partner/subgrantee organizations**

KCCASA staff shared that partnering with FFT was an eye-opening experience when it came to how they had traditionally provided case management services, and what was expected through this grant. This experience has changed their organization’s case management model. They realized that they needed a deeper referral process and connections to more service providers and opportunities for participants.

KCCASA staff also felt that this partnership generally helped them develop a framework of how to approach and respond to trafficking in their community. They felt it opened their eyes to the issue. It helped them to enhance their services in a way that will help all of their participants, not just trafficking survivors. They felt that this partnership helped them build capacity to respond to more types of crises and support survivors more effectively.

The Center reported that this partnership had positive impacts on their organization as well. It increased their awareness of human trafficking, therefore allowing them to serve their participants more effectively. The expansion of services to a new population and addressing a new issue also increased community interest in their organization. Human trafficking was a new human rights issue for people to care about both internally and external to the organization – local civic groups and media were interested and wanted information and stories. They are also now a lead service provider in the Central Illinois Trafficking Task Force. Additionally, this has allowed one of their clinicians to get specialized training and is now a niche expert in serving survivors of trafficking.
Conclusion

Leadership staff at partner agencies reflected that this partnership improved their organizations’ ability to identify survivors of trafficking, to conduct education and outreach to increase identification in their communities, and to respond to crises and support and serve survivors of trafficking. Our analysis of program data shows some change in participants' reported well-being between enrollment in services and follow-up assessments, particularly participants' levels of psychological distress and PTSD symptoms, as well as their feelings about their current living situation. We also found some significant relationships between specific assessment metrics and certain service types, notably social service advocacy and explanation of benefits/entitlements/availability being related to changes in stress, psychological distress, and self-efficacy.

Evidence of the program’s impact on participants is limited by the amount of complete data available in this report’s analysis, but we do see some promising findings. Future research with larger sample sizes and longer time frames for follow-up data collection would allow for a more comprehensive assessment of the impact of services. Future research would also benefit from developing a more survivor-led focus; i.e., analyzing outcomes based on survivor-defined success metrics would allow for a more meaningful assessment of program impact.
Endnotes


3 Ibid.

4 Ibid.


10 Ibid.


12 Ibid.

13 Ibid.

14 Ibid.

Appendix 1: Participant needs assessment
**Before beginning intake, ensure the survivor has read, understood and signed documentation on Confidentiality.**

Client ID: ____________________________  Staff Member: ____________________________

Date Interviewed: ____________________________

- The participant has signed the Outcomes Study Consent Form and agrees to participate.
- The participant has refused participation in the Outcomes Study and therefore did not sign the Outcomes Study Consent Form.

**Survivor Information**

Have you received, or are you currently receiving services from another service provider?  
☐ Yes  ☐ No

If yes, from where? ____________________________________________  Service period: ____________

Services Provided: ____________________________________________

Language:
Primary Language: ____________________________  English Proficiency:  
☐ Basic  ☐ Intermediate  ☐ Advanced

Other Languages Spoken: ____________________________________________

Interpreter Required?  
☐ Yes  ☐ No  Language ____________________________

Is there someone you would like to interpret for you?  
☐ Yes  ☐ No

Literacy Level:  
☐ Basic  ☐ Intermediate  ☐ Advanced

**Current Immigration Status:**

☐ No Documentation  ☐ Continued Presence  ☐ Visa (e.g. K, T, Student, Temp Work, Tourist) ____________
☐ US Citizen  ☐ Lawfully Permanent Resident  ☐ Other: ____________________________

**Documents In Client's Possession (check all that apply): It is recommended that case managers keep a copy of identification documents in the participant file for easy-access and to have a safe and secure copy.**

- Passport
- Birth certificate
- State ID: ____________
- Social Security Card
- Work Authorization
- Marriage Certificate
- Other: ____________________________

**HHS Certification (foreign-nationals only):**  
☐ Pre-Certified  ☐ Certified
### Emergency/Service Needs

**Do you need assistance in any of these areas? (select all that apply)**

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Short-term financial</th>
<th>General support</th>
<th>Health</th>
<th>Legal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
<td></td>
<td></td>
<td>General Legal</td>
</tr>
<tr>
<td>Shelter</td>
<td></td>
<td></td>
<td></td>
<td>(Family, Immigration,</td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
<td></td>
<td></td>
<td>Criminal, Civil)</td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
<td>Repatriation</td>
</tr>
<tr>
<td>Safety (order of protection? Other?)</td>
<td></td>
<td></td>
<td></td>
<td>Family Reunification</td>
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<tr>
<td>Other emergency support:</td>
<td></td>
<td></td>
<td></td>
<td>Child custody/parental</td>
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<td></td>
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<td></td>
<td>rights</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Criminal record help</td>
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<tr>
<td>Other financial assistance:</td>
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<td>Other legal support:</td>
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</tr>
</tbody>
</table>

**Comments:**

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
**Client ID:** ___________________  **Staff Member:** ___________________

**Date Interviewed:** ___________________

## Family

### Marital/Relationship Status:
- [ ] Single
- [ ] Partner
- [ ] Married
- [ ] Divorced
- [ ] Widowed

### Family Member/Partner Names and Location:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Location</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Do you have children under the age of 18 living with you?**
- [ ] Yes  [ ] No

**Are the children survivors of trafficking?**
- [ ] Yes  [ ] No

**Are the children enrolled in school?**
- [ ] Yes  [ ] No

**Do you have children under the age of 18 not living with you?**
- [ ] Yes  [ ] No

**Are the children survivors of trafficking?**
- [ ] Yes  [ ] No  [ ] I don’t know

**Are the children currently in a safe situation?**
- [ ] Yes  [ ] No  [ ] I don’t know

**Are you currently working to reunify with your children?**
- [ ] Yes  [ ] No  [ ] I don’t know

**Comments:**

________________________________________________________________________________________

________________________________________________________________________________________
### Legal

**Are you currently still in the trafficking situation?**
- [ ] Yes
- [ ] No
- [ ] I don't know

**Comments:**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**Do you have a criminal record?**
- [ ] Yes
- [ ] No
- [ ] I don't know

- [ ] Yes
- [ ] No
- [ ] I don't know

**Are you working with an attorney?**
- [ ] Yes
- [ ] No

- [ ] Immigration
- [ ] Civil
- [ ] Criminal

**Would you like us to refer you to an attorney?**
- [ ] Yes
- [ ] No

- [ ] Immigration
- [ ] Civil
- [ ] Criminal

**Has there been any other police involvement?**
- [ ] Yes
- [ ] No
- [ ] I don't know

**Comments:**
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**Are you interested in learning how to report the crime?**
- [ ] Yes
- [ ] No

*A referral to an attorney should be made prior to reporting to law enforcement.*

### Health

**In general, would you say your health is:**
- [ ] Poor
- [ ] Fair
- [ ] Good
- [ ] Very good
- [ ] Excellent

**Do you have health insurance coverage for yourself now?**
- [ ] Yes, private insurance.
- [ ] Yes, public insurance, such as County Care, medical card, Medicaid, Medicare, or veteran’s insurance.
- [ ] No, I am uninsured.
- [ ] Other [write detail in blank space]: ______________________________

**Do you have health insurance coverage for your family?**
- [ ] Yes, my family has health insurance.
- [ ] Some of my family does, some doesn’t
- [ ] No, my family doesn’t have health insurance.
- [ ] I don’t know

**Do you currently see a medical doctor on a regular basis?**
- [ ] Yes
- [ ] No

**If no, would you like help setting up an appointment for a check-up?**
- [ ] Yes
- [ ] No

4
Client ID: ____________________________  Staff Member: ____________________________
Date Interviewed: ______________________

Do you have any outstanding medical bills to date?  
  ➔ Do you need financial assistance for these bills?  
  □ Yes  □ No  □ I don’t know

Do you have any pressing health problems or medical conditions that you need assistance with?  
  ➔ If so, what are those health problems? ____________________________

Has a doctor or medical provider told you that you have any chronic health problems?  
(high blood pressure, diabetes, etc.)  
  ➔ If so, what health problems do you have? ____________________________
  ➔ Are you getting all the treatment you need?  
  □ Yes  □ No

Are you currently taking any medication right now?  
  ➔ If yes, for what?  
__________________________________________________________________________
__________________________________________________________________________

Comments:  
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Eligibility and Benefits/Financial Well-being

What is your estimated monthly income?  $________________/month

Is this enough to make ends meet (meet basic needs)?  
  □ Yes  □ No  □ I don’t know

Do you have any credit history (or a credit report)?  
  □ Yes  □ No  □ I don’t know

Do you know your credit score?  
  ➔ Credit score: ____________________________
  □ Yes  □ No

Do you have any unpaid debt that we haven’t already noted?  
  ➔ Amount of debt: ____________________________
  ➔ Type of debt: ____________________________
  □ Yes  □ No  □ I don’t know

Do you have any savings?  
  □ Yes  □ No  □ I don’t know
CONFIDENTIAL  *Required Form

Client ID: ________________________  Staff Member: ________________________

Date Interviewed: ________________________

**Are you eligible for/receiving any of the following benefits/resources?**

**Supplementary Security Income (SSI)**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Social Security Disability Income (SSDI)**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Social Security**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**TANF/welfare/cash assistance**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Child support**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Veterans benefits**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Unemployment benefits**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Medicare**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Medicaid**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Food Stamps/LINK Card/SNAP/EBT**
- [ ] Yes, eligible
- [ ] Not eligible
- [ ] I don’t know
- [ ] Applied
- [ ] Currently receiving

**Other Benefits Applied for:**
____________________________________________________________________________________
____________________________________________________________________________________

**Comments:**
____________________________________________________________________________________
____________________________________________________________________________________
Client ID: ________________________  Staff Member: ________________________
Date Interviewed: ________________________

Transitional/Long-Term Needs: Education/Employment/Transportation

Do you have an Employment Authorization Document (EAD) Card (immigrants only)?   □ Yes  □ No

*Required Form

Highest education Level (Circle one: US or Abroad): ________________________________

Type of Degree: ___________________  Area of Study: _________________________________

Client ID: ________________________  Staff Member: ________________________
Date Interviewed: ________________________

What is your current employment situation?

☐ Employed (has a job and is working in it; includes working and also in school)
  ➢ On average how many hours per week do you work? ____________________________
  ➢ What type of work do you do (in your main job, if more than one job)?______________
  ➢ How long have you had this job? ______ years and ______ months
  ➢ How stable do you feel in this job?
    ☐ Not stable
    ☐ Somewhat stable
    ☐ Stable
  ➢ How satisfied are you with this job?
    ☐ Very satisfied
    ☐ Somewhat satisfied
    ☐ Not very satisfied
    ☐ Not at all satisfied
  ➢ What is your average monthly income from your job(s)? ____________________________

☐ Employed, but not currently working (has a job, but for some reason isn’t reporting to work now)
☐ In school or training full time
☐ Unemployed and not in school or training full time
☐ Retired
☐ Disabled and not able to work
☐ Other: _______________________________
Additional Notes (referrals, how religion impact services, concerns, potential risks, etc.):
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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AFTER SERVICE PLAN:
How many goals did the participant set? ___________________________________________________
Were goals related to any of the following (check all that apply)?:
☐ Education
☐ Employment
☐ Health
☐ Housing
☐ Economic well-being
☐ Other: _______________________________________________________________________

Are the goals that the participant set mostly short-term or long-term? _______________________
Was it challenging or easy for participants to come up with goals for their service plan?(circle one): EASY CHALLENGING

Intake Staff Printed Name: ______________________________________________________________
Intake Staff Signature: ____________________________________________ Date: ________________

Interpreter Printed Name: _____________________________________________________________
Interpreter Signature: ____________________________________________ Date: ________________

This product was supported by grant number 2016-VT-BX-K050 awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.
Appendix 2: TIMS Service Provision Measurement Chart
TIMS Online Service Provision Terms and Units of Measurement

The data you enter into TIMS Online are used to provide evidence-based information to federal agency leaders on the services used by trafficking victims. Therefore, it is important that the service provision terms and units of measurement you enter into TIMS Online accurately reflect the amount of work and services provided to each client you serve. Please review the service provision terms, units of measurement, and examples in order to ensure that services provided to clients are properly captured in TIMS Online.

Quick Reference: Service Provision Terms, by Type of Service

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Service Provision Terms</th>
<th>Type of Service</th>
<th>Service Provision Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy and Legal Assistance</td>
<td>▪ Criminal Justice System-Based Advocacy</td>
<td>Health-Related Services</td>
<td>▪ Dental (Emergency and Long-Term)</td>
</tr>
<tr>
<td></td>
<td>▪ Legal Services (see Legal Services table for additional information)</td>
<td></td>
<td>▪ Medical Care (Emergency and Long-Term)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Substance Abuse Treatment</td>
</tr>
<tr>
<td>Client Coordination</td>
<td>▪ Client Intake</td>
<td>Provision of Material and Housing Assistance</td>
<td>▪ Child Care</td>
</tr>
<tr>
<td></td>
<td>▪ Client Orientation</td>
<td></td>
<td>▪ Financial Assistance</td>
</tr>
<tr>
<td></td>
<td>▪ Ongoing Case Management</td>
<td></td>
<td>▪ Housing/Shelter Advocacy</td>
</tr>
<tr>
<td></td>
<td>▪ Social Service Advocacy and Explanation of Benefits/Entitlements/Availability</td>
<td></td>
<td>▪ Housing/Shelter Assistance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Personal Items</td>
</tr>
<tr>
<td>Client Safety and Well-Being</td>
<td>▪ Crisis Intervention</td>
<td>Reunification and Repatriation Assistance</td>
<td>▪ Family Reunification</td>
</tr>
<tr>
<td></td>
<td>▪ Emotional/Moral Support (Informal Counseling)</td>
<td></td>
<td>▪ Repatriation</td>
</tr>
<tr>
<td></td>
<td>▪ Mental Health Treatment (Emergency and Long-Term)</td>
<td></td>
<td></td>
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<td>▪ Protection/Safety Planning</td>
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<tr>
<td>Education/ Employment Assistance</td>
<td>▪ Education</td>
<td>Support Services</td>
<td>▪ Interpreter/Translator</td>
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<td></td>
<td>▪ Employment Assistance</td>
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<td>▪ Transportation</td>
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Please enter into TIMS Online the services provided to clients as accurately as possible, using the terms and units of measure outlined below. The service provision terms were compiled from grantees currently using TIMS.

Alphabetical List: Service Provision Terms, with Units of Measurement and Examples
<table>
<thead>
<tr>
<th>Service Provision Term</th>
<th>Definition</th>
<th>Measured Per</th>
<th>Unit of Measurement</th>
<th>Examples</th>
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</thead>
</table>
| Child Care             | Supervision of a client’s child by your organization or another organization or individual | Incident     | 1 unit of service = 1 incident of child care | - Staff or volunteers from the OVC grantee organization babysit for a client’s child while the mother meets with an immigration attorney  
- The OVC grantee uses grant funds to pay for babysitting services so that a client may attend a counseling appointment  
- Another organization provided babysitting services and provided this service as in-kind |
| Client Orientation     | Services provided to a client to help orient him/her to a new situation or environment | Time         | Total # min. spent:  
1 unit of service = 15 minutes of time spent  
4 units of service = 1 hour | - Client screening and assessment for OVC Eligibility  
- Initial client interviews and documentation thereof  
- Explanation of legal rights and protections upon intake as a service recipient of the organization  
- Explanation of confidentiality policies and procedures  
- Explanation of the responsibilities of both the client and the program staff  
- Initial service plan development  
- OVC grantee orients client to new shelter setting or community  
- OVC grantee provides orientation on how to access certain services  
- Staff accompanies a client using public transportation to educate clients on how to use the local transportation system |
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</table>
| Criminal Justice System-Based Advocacy | Information and support provided to your clients in order to help clients understand and exercise their rights as victims of crime within the criminal justice process | Time | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | • Accompaniment to court or appointments with criminal justice system professionals  
• Meetings with law enforcement in which you are representing your client  
• Explanation of victims’ rights and assisting clients to exercise those rights  
• Meetings between clients and victim/witness professionals  
• Orientation to court/pre-trial services |
| Crisis Intervention or 24-Hour Hotline | Interventions and services provided to a client or potential client currently in crisis | Time | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | • Assistance or referrals provided for client emergencies  
• Provision of intervention techniques aimed at alleviating emotional distress |
| Dental (Emergency and Long-Term) | Services provided to a client in regard to the medical care of a client’s teeth | Incident | 1 unit of service = 1 incident of dental service | • Referrals or making appointments with dental providers on behalf of client  
• Client attended dental appointment  
• Payment for prescription related to dental care or assistance with filling prescription  
• Payment of bill related to dental care |
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| Education              | Provision of services related to client education                           | Incident     | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | ▪ Payment for or provision of public education, ESL classes, personal health classes, typing classes, driving classes  
▪ OVC grantee accompanies client to educational class  
▪ Assisting clients in enrolling in GED program |
| Emotion/Moral Support (Informal Counseling/Peer Support) | Emotional support and informal counseling provided to a client by organization staff or volunteers who are not mental health providers | Time         | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | ▪ Teaching relaxation techniques  
▪ Helping clients identify and understand their own trauma reactions  
▪ Supportive listening in-person or on the phone  
▪ Peer Support Group or Recovery Group (not led by a clinician)  
▪ Accompaniment to/from appointments for moral support, which includes more than simply providing transportation |
| Employment Assistance  | Activities and services in regard to providing the client with assistance in finding employment | Time         | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | ▪ Assistance with needed paperwork for employment  
▪ Accompaniment to/from job fairs and interviews  
▪ Referrals to job placement programs |
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</table>
| Family Reunification   | Activities and services to support a client to reunify with his or her family members in the United States | Time         | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour                                              | ▪ Phone calls made to arrange family reunification  
▪ Meetings held with staff and client to prepare for family reunification  
▪ Assistance obtaining and completing appropriate reunification paperwork |
| Financial Assistance   | All types of money given to the client, including phone and gift cards       | Incident     | 1 unit of service = $1 of financial assistance | ▪ The OVC grantee provides a gift card for food or personal items  
▪ The OVC grantee provides a phone card  
▪ The OVC grantee provides cash assistance or stipend |
| Housing/Shelter Advocacy | Actions taken for the client to secure housing (does not include financial assistance) | Time         | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour                                              | ▪ Phone calls made to locate and place a client in housing  
▪ Meetings held with housing staff and client to assist in client placement  
▪ Assistance with paperwork to enroll in housing/shelter programs |
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<tr>
<td>Housing/Rental Assistance</td>
<td>Payment or partial payment of a client’s rental bill</td>
<td>Incident</td>
<td>1 unit of service = 1 incident of rental assistance</td>
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<td>• OVC grantee pays for client’s rent or a portion thereof</td>
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<td>• OVC grantee pays for shelter stay, hotel/motel stay, or portion thereof</td>
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<td>• Project partner provides housing/shelter assistance as in-kind service</td>
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<tr>
<td>Interpreter/Translator</td>
<td>A specialized interpreter or translator is secured by the OVC grantee in order to assess service needs and/or provide services to a client</td>
<td>Incident</td>
<td>1 unit of service = 1 incident of interpretation/translation</td>
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<td>• Interpreter is used at time of intake and initial social service assessment</td>
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<td>• Interpreter is used at time of interview or appointment with attorney or medical provider</td>
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<td>• OVC grantee pays for use of Language Line for a victim</td>
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<td>• OVC grantee pays for special interpretation or translation equipment on behalf of a client</td>
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<tr>
<td>Medical Care (Emergency and Long-Term)</td>
<td>Services provided to a client in regard to the client’s medical health</td>
<td>Incident</td>
<td>1 unit of service = 1 incident of medical service</td>
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<td>Medical health includes vision care</td>
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<td>• Referrals or appointments made on the client’s behalf for initial medical evaluation or followup care with a clinic, a general physician, or a specialist (includes alternative medical practices)</td>
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<td>*Dental care is a separate service category</td>
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<td>• Client attended medical appointment</td>
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<td>• Payment for prescriptions or assistance with filling medical prescriptions</td>
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<td></td>
<td>• Payment for medical bill</td>
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| Mental Health and Treatment (Emergency and Long-Term) | Services provided to a client by a licensed mental health provider, including assessment and treatment | Incident     | 1 unit of service = 1 incident of mental health service | ▪ Referrals or appointments made on behalf of the client for individual therapy, in-patient or out-patient psychiatric evaluation, or alternative therapeutic techniques  
▪ Client attended appointment for individual therapy, psychiatric care, alternative treatment, or support group (led by a therapist)  
▪ Payment for prescriptions or assistance with filling prescriptions  
▪ Payment for bill related to mental health treatment |
| Ongoing Case Management                | Coordination of services to support a client's needs after intake into the program | Time         | Total # min. spent:  
1 unit of service = 15 minutes of time spent  
4 units of service = 1 hour | ▪ Administrative actions, documentation, and paperwork conducted on behalf of the client  
▪ Locating/providing information and/or referrals  
▪ Explanation of available services and programs  
▪ Effort taken to identify local resources to address a client's needs  
▪ Formal referrals to other programs  
▪ In-person or phone contact with a client for purposes of case management  
▪ Attempts to reach a client in person or via phone  
▪ Updating service plan |
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<td>Other</td>
<td>Activities or services allowable under the OVC grant that do not fall within the other categories described above</td>
<td>Incident</td>
<td>1 unit of service = 1 “other” incident</td>
<td>▪ Other services not listed.</td>
</tr>
<tr>
<td>Personal Items</td>
<td>Material goods provided to the client, including toiletries, clothing, food items</td>
<td>Incident</td>
<td>1 unit of service = 1-10 items of clothing provided or one trip to clothing bank 1 unit of service = 1 day of meals, 1 use of shower or laundry facility</td>
<td>▪ OVC grantee provides donated clothing, food items, personal supplies, housing supplies, etc. ▪ OVC grantee uses grant funds to pay for new clothing, food items, personal supplies, housing supplies, etc. ▪ Payment of bill related to the provision of personal items, such as clothing, food, and housing supplies</td>
</tr>
<tr>
<td>Protection/Safety Planning</td>
<td>Services provided and activities surrounding client protection and safety planning</td>
<td>Time</td>
<td>Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour</td>
<td>▪ Routine safety planning done at time of intake ▪ Safety planning done at time of increased risk (victim verbalizes fear or new threat) ▪ OVC grantee may engage law enforcement or encourage client to talk to law enforcement</td>
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| Repatriation           | Services provided and activities related to the client’s intention to return to his/her country or country of citizenship | Time         | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | ▪ Staff calls to Consulate or other programs/offices that assist in reunification  
▪ Assistance with documents |
| Social Service Advocacy and Explanation of Benefits/Entitlements/Availability | Services provided to a client to address social service needs and to inform clients of available benefits and services | Time         | Total # min. spent: 1 unit of service = 15 minutes of time spent 4 units of service = 1 hour | ▪ OVC program staff explain current and future programs for which the client is or will be eligible  
▪ Staff explain policies/rules of programs in which the client is enrolled  
▪ Staff contacts local refugee resettlement program to facilitate referral of a newly certified client for services  
▪ Staff assists victim in completing Crime Victim Compensation application  
▪ Staff assists client in filling out application for Social Security card  
▪ Staff follows up with Office of Refugee Resettlement to find out why a Certification Letter is delayed  
▪ Staff advocates for victim who was denied a service or program for which they should have been determined eligible  
▪ Explanation of the Unaccompanied Refugee Minor program to an eligible trafficking victim |
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<tr>
<td>Substance Abuse Treatment</td>
<td>Formal in-patient or outpatient programs or support for substance abuse</td>
<td>Incident</td>
<td>1 unit of service = 1 incident of substance abuse treatment services</td>
<td>- Client participation in support groups</td>
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<td>- Payment for client to take part in substance abuse treatment program</td>
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<tr>
<td>Transportation</td>
<td>Services provided to a client related to transportation to ensure clients have access to services and other activities</td>
<td>Incident</td>
<td>1 unit of service = 1 incident of transportation to services/activity</td>
<td>- Provision of bus passes or tokens</td>
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<td>- Payment of taxi fare</td>
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<td>- Case manager provides transportation for client to attend interviews or appointments</td>
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</tbody>
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**Legal Services**

Services are provided by legal professionals. All legal services are time-based. 1 unit of service = 15 minutes of time spent, 4 units of service = 1 hour.

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<tr>
<td>Legal Services/General Consultation</td>
<td>Services provided to the client to address legal needs.</td>
<td>- Interview/screening by attorney to determine if a victim meets the definition of human trafficking as defined by the TVPA</td>
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<td></td>
<td>Attorneys provide clients with information about their legal options, and follow through to provide legal remedies as requested by client</td>
<td>- General Legal advice (when not included in the below categories)</td>
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</tbody>
</table>
| **Immigration Legal Services** | Assistance to foreign nationals to remain in the United States | - Immigration assistance  
- Advocacy and follow up by the attorney with law enforcement to request law enforcement endorsement for T and U visas and/or Continued Presence status on behalf of the victim  
- Visa applications, including T, U, VAWA, and other forms of relief  
- Repatriation |
| **Family Law Services** | Legal assistance with civil or family court issues | - Protection/restraining order  
- Child custody and support  
- Separation/divorce  
- Guardianship/adoption |
| **Victims’ Rights Law/Advocacy** | Enforcement of victims’ rights | - Representation when victim is a witness in a criminal case  
- Restitution  
- Victim Impact Statements |
| **Expunging or Sealing Criminal Records** | Assistance with criminal record history as a result of the trafficking situation | - Sealing/expunging criminal records  
- Vacate arrests/convictions |
| **Employment/Wage and Hour Claim** | Advocacy and legal assistance for clients who have been subjected to labor violations under local, state, or federal law | - Claims under local or state minimum wage laws  
- Harassment or discrimination complaints |
| **Public Benefits Law** | Assistance and advocacy to access public benefits | - Assistance with administration appeals, litigation, and legislation advocacy involving public benefits |