INSTITUTE for SHELTER CARE

Substance Use Disorders Report

A Survey of Residential Programs Across the Nation

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The Samaritan Women

The Samaritan Women
INSTITUTE for
SHELTER CARE

The Samaritan Women Institute for Shelter Care conducts regular surveys, site visits, and interviews with those who operate residential programs serving victims of exploitation and trafficking. Our mission in these endeavors is to provide evidence-based reporting that will inform the decisions and practices of shelter providers so that we can continue to improve the quality of care offered to survivors.

We do this work at no cost to the agencies who benefit from these studies.

If your agency has participated in any of our studies, again we thank you. You are contributing to a national body of work and collective understanding to benefit survivors anywhere.

Introduction

Survivors of domestic sex trafficking present with a myriad of needs, often complex and co-occurring.[1] [2] The most prevalent shared characteristic among victims of domestic sex trafficking is a history of childhood sexual abuse and substance use/abuse occurs is the second most presenting condition for survivors.[3] In a study of 130 women, 75% of women involved in commercial sexual exploitation reported using drugs and 26% reported using alcohol.[4] Across a decade of service to this population, one shelter provider documented that substance abuse disorders (SUD) occurred in 87% of cases.[5][6] Therefore, this study sought to identify the treatment approaches in practice across trafficking shelter programs in the United States and to explore the interventions that these agencies are finding to be most effective.

Methods

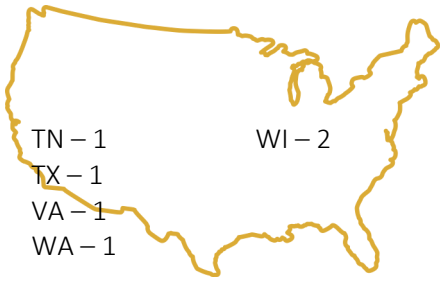
An email invitation with survey link was sent in February 2020 to 142 agencies nationwide that were identified as providing residential care to survivors of domestic sex trafficking. Responses were collected using SurveyMonkey, a web-based survey and analytic tool. There were 34 questions and the survey took 22 minutes to complete. Respondents were not compensated for their entries and no personal identifying information was collected. The survey was active for five weeks. A total of 78 emails were opened from which 26 agencies (33%) responded to the survey.

Respondents

Twenty-one states are represented in this sample. Respondents represented 38% cities; 35% suburbs; 15% rural locations, and 4% remote areas and 4% have multiple shelters in different types of settings. The following states are represented.

Table 1: *States with Participating Respondents*

AL – 2	GA – 1	KY – 2	ME – 1	TN – 1	WI – 2
CA – 1	IA – 1	LA – 1	MN – 1	TX – 1	
CO – 1	IL – 1	MA – 1	NB – 1	VA – 1	
FL – 2	KS – 1	MD – 1	OR – 1	WA – 1	



One responding agency has shelters in NY, NJ, CA, and NV.

[1] Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L. M., Stanley, N., . .. Oram, S. (2016). Responding to the health needs of survivors of human trafficking: A systematic review. *BMC Health Services Research*, 16(1), 320. doi:10.1186/s12913-016-1538-8

[2] Herman, J. L. (1997). *Trauma and recovery* (Rev. ed.). New York: Basic Books

[3] Herman, J. L. (1997). *Trauma and recovery* (Rev. ed.). New York: Basic Books

[4] *Farley M, Cotton A, Lynne J, Zumbeck S, Spiwak F. Prostitution and Trafficking in Nine Countries. J Trauma Pract. 2008; 2 (3): 33 - 74. doi: 10.1300/J189v02n03.*

[5] The Samaritan Women, (2019).

[6] O'Brien, J. E. (2018). "Sometimes, somebody just needs somebody – anybody – to care:" the power of interpersonal relationships in the lives of domestic minor sex trafficking survivors. *Child Abuse & Neglect*, 81, 1-11. doi:10.1016/j.chiabu.2018.04.010

Most survey respondents were the Executive Directors (54%) or chief leaders of these organizations. Other respondents include a Program Director or similar role (38%) and Clinical Directors (8%). The number of years these agencies have been serving survivors of trafficking was grouped into six timeframes with the average across this sample being 6.5 years.

≤ 2 years – 3 agencies	4-6 years – 6 agencies	11-14 years – 3 agencies
3-5 years – 5 agencies	7-10 years – 5 agencies	≥ 15 years – 4 agencies

The survey asked each agency to account for the number of unique clients in 2018 and 2019. Each year is broken down by the number of unique residents under the age of 18 and unique residents age 18 and older. One agency's count for unique residents was omitted for each year due to the exceptionally high volume (385 and 351 residents, respectively). This organization has multiple locations, each with a much higher capacity than other responding agencies.

Table 2: *Collective Totals of Residents Served in 2018 and 2019*

	2018	High	Low	2019	High	Low
Minors	103	33	3	62	28	3
Adults	278	55	4	353	79	1

796 survivors are represented by the agencies in this survey

Program Type and Duration

Time and setting can be critical elements in the recovery process.[7] One study found a common experience among trafficked women that they were only able to detox when forced to do so in jail or prison,[8] a mandated period of time when these women are removed from their substance-using environments. For an unfortunate number of trafficking victims, incarceration might be the only opportunity to be removed from their abuse and use. For those who are removed from exploitation and given a chance at a therapeutic residential program, odds of recovery may be even better, but the key lies in having the right structures in place. Participation in a recovery residence can decrease in-treatment and post-treatment relapse rates and significantly increase recovery at up to 2-years of follow-up. These benefits are contingent on adequate lengths of stay (more than 6 months) and a supportive community environment[9] [10] Other outcome studies show that the longer an individual remains in a recovery or treatment environment, the greater are her or his chances of sustaining recovery.[11] A potential

[7] Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandevelde, S. (2013). Therapeutic communities for addictions: A review of their effectiveness from a recovery-oriented perspective. *The Scientific World Journal*, 2013, 22.

[8] Gerassi, L. B. (2018). Barriers to accessing detox facilities, substance use treatment, and residential services among women impacted by commercial sexual exploitation and trafficking. *Behavioral Medicine*, 44(3), 199-208.

[9] National Association of Recovery Residences (NARR). (2016) National Standard 3.0. *Compendium*. Retrieved from: narronline.org.

[10] Polcin, D. L., Korcha, R., Bond, J., Galloway, G., & Lapp, W. (2010). Recovery from addiction in two types of sober living houses: 18-month outcomes. *Addiction Research & Theory*, 18(4), 442-455. doi:10.3109/16066350903398460

[11] Fisher, B. (2012). A new understanding of recovery residences: NARR standards delineate residential levels of support. (national association of recovery residences). *Addiction Professional,* 10(1), 16.

advantage to residential placement is the ability to provide more comprehensive services due to greater structure and longer hours of operation.[12] Therefore, we asked how these agencies define the duration of their services. Of the respondents to this question (n =21), they reflected primarily long-term (12+ months) residential placement.

Table 3: *Respondents by Type of Shelter Program and Duration*

Percentage of Respondents	Type of Shelter Program and Duration
4%	Emergency Shelter – 24-72 hour holding, usually in coordination with law enforcement
4%	Stabilization Program – up to 90 days of residential care; goal is to determine long-term course of action
88%	Restorative Program – 12 months or more offering comprehensive services with the goal of social re-entry
4%	Graduate Housing – 12 months or more of supportive independent housing with accountability

Service Population

These agencies serve an average of 18 survivors each year. The total number of reported unique residents in 2018 and 2019 was 796.

Twenty three percent of the responding agencies serve only verified victims of sex trafficking, 46% serve victims of any kind of sexual exploitation, and 19% serve victims of any kind of human trafficking.

Fifty eight percent of responding agencies only serve U.S. citizen survivors, 46% serve both U.S. citizens and foreign nationals, and 15% are able to serve undocumented individuals, asylees, and refugees.

None of the responding agencies exclusively serve male survivors, a consistent area of need in the field of shelter services. Only 12% of responding agencies indicated that they serve all genders, and 88% serve only female survivors.

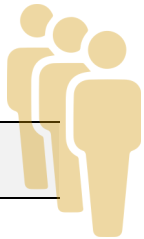


Table 4: *Client Age Group Distribution*

Client Age Groups	Percentage of shelters serving this age group	Number of shelters serving this age group
Younger Minors (14 and under)	15.38%	4
Older Minors (15-17)	38.46%	10
Younger Adults (18-21)	88.46%	23
Adults (22-35)	88.46%	23
Older Adults (36 and over)	76.92%	20
Adults with Child(ren)	26.92%	7

[12] Chan, M., Sorensen, J. L., Guydish, J., Tajima, B., & Acampora, A. (1997). Client satisfaction with drug abuse day treatment versus residential care. *Journal of Drug Issues, 27*(2), 367-377. Retrieved from http://eres.regent.edu:2048/login?url=https://search-proquest-com.ezproxy.regent.edu/docview/208835325?accountid=13479

In the chart below, the numbers for substance use before the age of 18 and the numbers for PTSD and depression/anxiety are very close. This is not only uncommon but is to be expected. According to the Journal of Child and Adolescent Psychiatric Nursing, "more than half of young people diagnosed with PTSD will later develop substance abuse problems."[13] Data collected from respondents to this survey show that, among residents in shelter homes, the correlation between mental illnesses and an early onset of substance use is quite a bit more than half.

Table 5: *Documented Conditions of Residents*

Condition Documented:	Average across 2018-2019	Actual across 2018-2019
Substance use onset at/before age 10	19%	152
Substance use onset between ages 11-18	56%	449
Substance Use Disorder diagnosis	77%	611
Post-Traumatic Stress Disorder [14] [15]diagnosis	75%	596
Depression or Anxiety diagnosis[16]	80%	634
Bipolar Disorder diagnosis	29%	231
Other diagnoses	51%	406

A study done at the University of Wisconsin-Madison states, "more than 50% of women entering substance abuse treatment in the United States reported having traded sex for money or drugs in their lifetime." The same study shows that 88.9% of sexually trafficked women suffered physical violence, 83.3% suffered sexual violence, and 100% experienced psychological violence. Because of these high numbers, the author states, "trauma-informed substance use interventions may be important for this population." [17] Given this study's data plus the above data from our respondents, it is not a matter of if a shelter agency will encounter someone with a comorbidity of trauma and substance abuse, but when. It is important to know the limitations of the program, staff, and external resources when deciding whose needs can be met within your program and who would need to be referred elsewhere. Either way, it is critical for a shelter to develop policies and procedures to care for individuals with the comorbidity of trauma and substance abuse.

[13] Bougard, K. et al. (2016) Turning the Tides: Coping with Trauma and Addiction Through Residential Adolescent Group Therapy. *Journal of Child and Adolescent Psychiatric Nursing*. 29, 196-206.

[14] Patients with PTSD have been shown to be up to 14 times more likely than patients without PTSD to have a SUD (McCauley, et.al 2012).

[15] PTSD and SUD are among the most prevalent diagnoses of adolescents in inpatient psychiatric care (Bougard, et al 2016)

[16] An analysis of 74 sex trafficking victims' mental health histories showed that 48% had been diagnosed with Depression, Anxiety, PTSD and Bipolar—not one, but all four--conditions (The Samaritan Women, 2019).

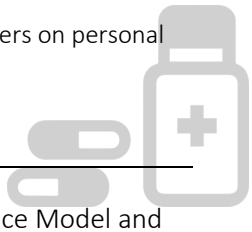
[17] Gerassi, L. B. (2018). Barriers to accessing detox facilities, substance use treatment, and residential services among women impacted by commercial sexual exploitation and trafficking. *Behavioral Medicine*, 44(3), 199-208.

Substance Use Philosophy

We asked responding agencies to choose which model most reflects that of their program when it comes to residents with substance abuse.

Table 6: *Shelter Treatment Philosophy*

Percentage of Responses	Treatment Philosophy
7.69 %	We align most closely with the Harm Reduction model. In general, this model does not seek to stop substance use, but to ensure that the resident who chooses to continue to use can do so as safely as possible.
19.23%	We align most closely with the Medicalized model. In general terms, this model treats substance use as a disease and endeavors to reduce the risk of overdose, acute withdrawal symptoms, etc. with medication (and sometimes with behavioral interventions).
26.92%	We align most closely with the Behavioral model. In general, this model sees substance use as a choice and relies most heavily on cognitive and behavioral interventions.
38.46%	We align most closely with the Abstinence model. In general, this model centers on personal will and seeks to equip the resident to live a life that is free of substances.
3.85%	We don't have a philosophy; we do whatever each resident needs.
3.85%	We have not defined our program's philosophy.



We can see here that the two most popular substance use philosophies are the Abstinence Model and the Behavioral model. Agencies can base their decision on which model to follow by seeking advice from the individual(s) or treatment facilities that will be working with their residents, looking at curriculum or other resources available to the agency for sobriety support, and by looking at the individual needs of their residents.

Barriers to Service

The same University of Wisconsin cited above found that there are several barriers to accessing treatment for women who have been commercially sexually exploited and struggle with substance use. The main barrier is a requirement for a certain number of days clean before entering a program. Even the requirement to pass a drug test can be a limitation for women coming directly out of a trafficking situation.[18] Getting into a detox facility presents issues as there are often long wait times. A service provider interviewed for the study stated, "people have to have gone through some period of time they weren't using, and that's really hard when they're on the streets…three days on the street sober is a lot of time." Another survivor in the University of Maryland study offered: "when you're ready, you need it *right then* because anything can happen…the waiting is too long, and then you just don't do it."

None of the responding agencies in this sample require a candidate to have more than 30 days sobriety before entering their programs; 46% require at least 30 days; 35% require the candidate to have at least detoxed before entering their programs and; 19% have no restriction on sober time before entering their programs. Twelve percent of agencies stated that they do not accept residential candidates under Medication Assisted Treatment (MAT).

[18] Gerassi, L. (2018) Barriers to Accessing Detox Facilities, Substance Use Treatment, and Residential Services Among Women Impacted by Commercial Sexual Exploitation and Trafficking. *Behavioral Medicine*. 44(3), 199-208.

This is not to say that shelter programs should relax their clean time policies. It is of the utmost importance that programs protect the physical and mental safety of their current residents. Having someone come in the house who is high or is detoxing certainly poses a danger to current residents. Ideally, a shelter agency would seek out and form a partnership with a local detox facility that can care for their residential candidates until it is safe for them to enter the shelter home.

Medication Assisted Treatment

There are many medications prescribed to help treat the effects of drug and alcohol addiction. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) states that Medication Assisted Therapy (MAT) can "improve patient survival, increase retention in treatment, decrease illicit opiate use and other criminal activity, increase a patient's ability to gain and maintain employment, improve birth outcomes among pregnant women with substance use disorders, …and reduc[e] the potential for relapse." According to SAMHSA, MAT is only used to treat about a quarter of all opioid and heroine addictions in the nation and can only be prescribed by a certified opioid treatment program.[19]

The debate on MAT in addiction recovery homes has escalated to two prominent organizations: the National Association of Recovery Residences (NARR) and the American Society of Addiction Medicine (ASAM) both of whom are collaborating to put sober homes on the continuum of care. NARR holds that "MAT is one of many viable recovery tools… Recovery residence owners/operators cannot legally deny admission solely on the basis of an applicant's current use of physician-prescribed medications." However, there may be some conflict between NARR and ASAM over medications like methadone and buprenorphine (Knopf 2018). For this survey population, the responses are similarly divided in terms of what medications will or will not impede a candidate's access to services.

Table 7: *Policy on Medication Assisted Treatment*

Medication	Number of Responding Agencies			
	Will Accept	Might Accept	Won't Accept	No Policy
Methadone (opioid)	5	4	13	1
Naloxone (opioid)	8	4	11	1
Buprenorphine (opioid)	7	4	11	1
Naltrexone (opioid or alcohol)	14	3	6	1
Acamprosate (alcohol)	6	3	8	7
Disulfiram (alcohol)	6	3	6	9

[19] Substance Abuse and Mental Health Services Administration (2020) Retrieved from: https://www.samhsa.gov/medication-assisted-treatment/treatment

Drug Testing

Agencies were asked to share their protocols in frequency of drug testing. Nineteen percent of agencies do not conduct drug testing at any point in the program. Other agencies tested at the following intervals.

Table 8: *Protocol for Drug Testing*

Percentage of Responses	Protocol for Drug Testing
58%	Drug testing performed at intake
15%	Drug testing is performed once a week
15%	Drug testing is performed once a month
12%	Each resident has an individual plan for drug testing frequency
31%	Drug testing is as ordered by court, parole officer, or other legal entity
58%	Drug testing is performed randomly
50%	Drug testing is performed when use is suspected

For the health and safety of all residents, it is critical to have in place a plan for what to do when a resident is found using drugs or alcohol. Principle 19 of the National Association of Recovery Residences is to "plan for emergencies including intoxication, withdrawal, and overdose," because, "emergency preparedness protects the health and safety of residents (physical environment) and solidifies community (authority base; recovery orientation)." Having a plan in place that is known by the residents helps them to feel secure, knowing that should the worst happen, staff and volunteers are prepared to handle the situation.

How, then, do these agencies respond to substance use in the program? Among respondents, 69% said that they handle substance use infractions on a case by case basis; 50% reported that a resident would be placed on program probation; 38% indicated the resident would be dismissed. One agency stating that a resident can return in 2 weeks if s/he remains sober and complies with the requirements set forth by the agency. Fifteen percent of agencies would require the resident to attend counseling; 12% of agencies have a 3-strikes policy and 8% have a 2-strikes policy prior to dismissal. One agency reported that it would call the police, but not press charges until the third time the police had been called for the same resident.

Dispensing Medication

Who dispenses medicine can be a difficult decision to make, especially when some of the medications can have narcotic effects if taken incorrectly, or mixed with other stimulants or depressants. if the agency is required by its state to have a licensed medical professional oversee all medication administration, that decision may be predetermined. For example, the position authorized to hold and dispense medications may be determined by the clients served (eg, minors) and the state in which the shelter program resides. Of course, this concerns not only Medical Assisted Treatment for addictions, but also prescriptions and Over-the-Counter (OTCs) medications.

Of all respondents, 19% did not answer the question regarding medication distribution. Eight percent stated that they have a licensed medical professional on staff to distribute residents' medications. In 12% of the agencies, residents are in control of their own medications. Nineteen percent of agencies take residents to a local clinic to receive their medication. Thirty five percent of agencies have their staff members either administer the medication or observe the resident as s/he takes the medication.

Supporting Recovery

The National Association of Recovery Residences states within their policies and procedures manual, "if the physical home is the 'heart' of the recovery residence, the recovery support offered there is the 'soul'." [20] As residential programs for survivors of trafficking, we must consider more than substance abuse recovery, but also a variety of comorbid conditions that arise from childhood neglect and abuse and the trafficking situations from which our residents survived. For that reason, it is important to seek out sobriety resources that can be integrated into the overall, holistic restorative programming within trafficking shelters. It is also important to evaluate sobriety resources available and determine which promote the overall recovery of our residents.

Safety plans are an excellent way to get residents participating in their recovery. A staff member helps the resident to identify triggers, feelings, and thoughts that lead to an urge to use. Staff and resident together come up with a course of action that works best for the resident and helps her/him feel safe and secure, knowing that when the urge is overwhelming, there is someone s/he can turn to or actions s/he can do to get through it. Of the responding agencies, 73% stated creating safety plans for each of their residents.

While having a licensed addictions recovery expert on staff is ideal, it is not always possible. Only 19% of responding agencies stated having a licensed addictions or alcohol and drug counselor on staff. An alternative to having a specialist on staff is contracting with a community partner to provide professional services for residents struggling with addiction. Over half, 58%, of responding agencies use this method to provide services for their residents.

Another method is to train a current staff member, which 38% of responding agencies have chosen. Nine of the agencies responded to the question of how to train a staff member to counsel residents with addictions recovery needs. One common way that agencies train their staff is to use a combination of professional curriculum and inviting a licensed specialist to teach the designated staff members. Other organizations hire individuals with addictions recovery backgrounds, including those who have been in successful recovery for several decades. These individuals may not have a license in addictions counseling but they are effective in working with residents who are just beginning their sobriety journey. One agency states that they use the Terrence Gorski curriculum. This publisher provides a variety of resources for starting sobriety and staying sober.

Peer Mentors

Peer mentors are another way to come alongside residents as they begin their sobriety journey. Half of all responding agencies use this method to help their residents through recovery. Thirty one percent of the agencies who report using peer mentors have survivors who have maintained recovery mentor their residents. One agency pairs survivors who are further along in recovery with newer residents. One agency has two survivors who are on staff who mentor their residents. Another agency partners with other trafficking agencies to find survivor mentors for their residents. This method is beneficial to both the mentor and the mentee. The authors of an overview of addictions intervention programs state, "when people recovering from alcoholism and drug use provide help to an individual who is abusing substances, they are furthering their own 12-step work, which is of benefit to them."[21]

[20] National Association of Recovery Residences (NARR). (2016) National Standard 3.0. *Compendium*. Retrieved from: narronline.org.

[21] Donovan D. et al. (2013) 12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview. *Soc Work Public Health*. 28(0), 313-332.

Sobriety Groups

Not every agency will be able to easily find trafficking survivors in recovery to mentor their clients. Another method is to find mentors who are in recovery from substance abuse but are not necessarily survivors of human trafficking. Some agencies find these mentors through their church or civic contacts. Volunteers are screened to meet requirements set forth by the agency and registered before working with residents. Both in-house and outside training for peer mentors are used by 25% of the agencies who responded to this question while 33% connect their residents with programs such as Start Right Mentoring. Some agencies also look to programs like Alcoholics Anonymous and Celebrate Recovery to find mentors for their residents.

Nearly all responding agencies, 88%, stated that they have regular, in-house groups on addiction, coping skills, substance use alternatives, and similar topics. Of those that responded to the question about contracted services. The most popular curriculum is Seeking Safety (25%), followed by Teen Challenge: Breaking Free (17%) and 12-Step recovery resources (17%). Other resources that responding agencies find effective are Celebrate Recovery curriculum, Amazing Grace Addiction Bible Study by Michael Mason, and the Genesis Program.

Outside groups can also be a major source of encouragement for residents in recovery. In a report by CNN based on a study including 10,000 individuals in recovery, Alcoholics Anonymous (AA) has been proven to be an effective recovery tool, largely because it treats SUD as a long term, chronic illness rather than a problem with a short term or one-off solution. In the same report, a clinical psychologist states that this study did not include individuals with serious comorbid mental health issues and recommends that such individuals concurrently seek professional counseling. [22]

As seen in the data earlier in this report, survivors of commercial sexual exploitation have a high likelihood of serious mental health issues. Because survivors of human trafficking can have one or more comorbid conditions specifically linked to their trafficking situation, it is helpful to incorporate external groups, such as AA and Celebrate Recovery, with in-house groups specifically geared towards the residents' unique needs. In their overview of recovery programs, Donovan et al. explore the challenges various people face given that the majority of meetings like AA are populated by Caucasian males. They state that, "concurrent involvement in specialty treatment and in 12-Step groups contributes to better outcomes than either alone."[23]

Each agency must decide how to handle external sobriety group interaction for their residents. Half of agencies that responded to this section saying that they take all of their residents to a community-based sobriety support group (AA, NA, CR, etc.) once a week or less. Only 8% take just certain residents and 12% stated that residents were not required to go to meetings but would be taken as needed or as desired. One agency requires residents to attend meetings more than once a week and each resident is responsible for their attendance.

Fifty eight percent of agencies responded to the question of whether they found external, community-based sobriety groups to be helpful for their residents' sobriety. The majority response, 60%, found these types of groups helpful for their residents, 33% found them both helpful and challenging, and 7% found the groups challenging for their residents. The most reported benefit is the chance for residents to build a

[22] Rogers, K. (2020, March 11). Alcoholics Anonymous may be the most effective path to abstinence, study says. Retrieved March 27, 2020, from https://www.cnn.com/2020/03/11/health/alcoholics-anonymous-abstinence-wellness/index.html

[23] Donovan D. et al. (2013) 12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview. *Soc Work Public Health*. 28(0), 313-332.

social support network of other people who are in recovery. Agencies reported that this social support network continues to be a strength for residents after they've left the residential program. A common challenge reported is that the meetings, or specifically the individuals attending the meetings, can often be triggering for the residents and can provoke a sense of discouragement rather than encouragement.

Here are some other commonly reported benefits and challenges for residents attending community-based sobriety support groups.

Table 9: *Reported Benefits and Challenges of Community-based Groups*

Benefits	Challenges
• Residents struggling with addiction do not feel singled out • Residents find encouragement in other people's testimonies • Receiving milestone coins • Residents get connected with a sponsor • Instills in residents the habit of attending groups once they leave the program	• "13th Steppers" – men who approach female residents with the goal of starting a romantic relationship under the guise of mentorship • No restrictions in the meetings – sometimes people arrive high or drunk • If other attendees only share their problems, it can be discouraging to residents

Sobriety and Spirituality

We asked whether faith is part of the responding agencies' residential program and how that impacts their residents' response to sobriety. Twelve percent of agencies indicated that their programs do not include any kind of spiritual or religious programming; 31% include spiritual programming but do not promote a faith position and 58% stated that they have religious programming and are distinct in their religious character. For those who do integrate faith, they reported common activities such as teaching residents to pray and/or having daily devotions. One agency stated that during devotions, residents have been able to connect their struggles with those of people they read about in the Bible. This section of the survey invited other open-ended comments on how faith practices are evident:

- survivor's mindset about his/her place in the world."
- "Spirituality is used to show the residents that there is no condemnation or judgement because of use/abuse."
- "The idea of a higher power (such as in the 12-Step program) is used for implementation of hope, and forgiveness, and love."
- "We use the Word of God to transform thinking therefore resulting in new ways to deal with issues that leads to a lasting transformation and the byproduct is sobriety."

The prevalent theme throughout the answers of those who actively incorporate spirituality or religion is the creation of new, positive thought patterns for residents who have largely lived their lives with negativity towards themselves, others, and the world. A study done in Taiwan on faith-based residential substance treatment programs concluded that individuals who convert during their stay seem more likely to finish the program and remain sober.[24] Though the report does admit several shortcomings of their

[24] Chu, D. et al. (2012) Religious Conversion and Treatment Outcomes: An Examination of Clients in a Faith-Based Residential Substance Treatment Program. *Journal of Drug Issues*. 42(2), 197-209. Retrieved from http://jod.sagepub.com.

study, one can see by the incorporation of spirituality into groups such as AA, NA, and CR, that there is a benefit to seeking a power higher than oneself when recovering from substance abuse.

Evaluation

When asked about the effectiveness of certain interventions implemented in their programs, the most mentioned was 12-Step programs and faith-based programming. This is followed closely by Seeking Safety, an evidenced-based curriculum focusing on Cognitive Behavioral Therapy methods to overcome both trauma and substance abuse. Mentorship and a supportive and open community also ranked highly.

Other interventions included safety planning, sobriety management meetings, and ways to have fun that do not include substance use. One agency stated that the most important determinant is the individual's desire to get and stay clean. In a study done on outcome metrics implemented by different recovery homes, the authors state, "the lack of consistency in models and outcomes made it difficult to assess evidence across programs."[25] This is an issue that trafficking shelters likely have in common with addiction recovery homes.

Metrics

Some outcome metrics used by addiction recovery homes include abstinence from substances, avoiding criminal activity, and/or maintaining employment.[26] Nineteen agencies responded to how their program measures impact for residents who have SUDs. Over half of the agencies (63%) determine a resident's success either by having goals that s/he achieves or by marking progress through milestones. Programs focus on improvement in interpersonal relationships, personal responsibility (such as hygiene, chores, or initiative during groups or academic time), and aspects that are integral to moving onto the next phase of the program or individual plan.

Other methods used to track sobriety include charting clean days, symptom reduction, drug test results, medical reviews, and self-reporting. Tracking relapses and having a relapse prevention plan is another frequently mentioned metric. One agency reported tracking residents for up to five years after they have left the program, which is an area of opportunity for future research. At least one study suggests that women in residential treatment programs (in contrast to intensive outpatient) may have greater vulnerability for relapse given an under-developed social support network post-residential program.[27]

Programs should not be discouraged or think that they do not have a significant impact on a survivor's sobriety journey. They serve as a starting point and as a critical bridge between life on the street, where substance use is the only escape, and long-term recovery programs where survivors can learn a new way to live.

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Program Improvements

Respondents were asked to self-assess their current interventions and services as far as client substance use recovery using a scale of 1 (poor) to 5 (excellent). The average response was 3.5.

1 – 0%	2 – 12%	3 – 40%	4 – 32%	5 – 16%

We then asked what improved services, as far as substance abuse recovery, they would like to see developed for shelter homes. Some of the responses include:

- More in-house support groups to go along with NA meetings
- More materials specific to SUD incorporated into the treatment program / affordable curriculum
- Mental health support
- More education among psychiatric service providers so that residents aren't just treated with a "cocktail of drugs approach"
- Education for residents about the impact of diet and exercise on their sobriety
- Support for comorbid conditions such as eating disorders and trauma
- More addiction training for staff members
- More peer support volunteers
- Sustainability for residents who have left the program

Discussion

Shelter programs serving victims of domestic sex trafficking may not be all that distinguished from addiction recovery homes. Both are providing two critical ingredients to the recovery process: a change of setting, and time, with the same goal of endeavoring to effect sustainable change in the person who is suffering. Beyond those commonalities, there are a variety of approaches in practice. The addiction recovery space has a larger service population, more longevity, more treatment options, and a deeper base of research and outcomes research on which to draw. There is much from which trafficking shelters can glean.

What trafficking shelters are bringing into the forefront, perhaps, is the issue of comorbidity between addictions and chronic, complex and relational trauma. Current studies of addiction recovery houses points to a best practice that is a holistic approach to improving the overall health and wellbeing of the individual—beyond substance dependence.[28] As the field of shelter care for trafficked persons matures, we hope to see greater collaboration with "art and science" of addictions recovery and a deeper understanding of how trauma and addiction must be considered as twin sisters in the harms done to human life.

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