PATTERNS OF EXPLOITATION:
A NATIONAL ANALYSIS OF HUMAN TRAFFICKING TRENDS

JANUARY 2023 - DECEMBER 2025

SAFE HOUSE PROJECT

MISSION & VISION

Safe House Project's mission is to increase survivor identification beyond one percent through education, provide emergency services and placement to survivors, and ensure every survivor has access to safe housing and holistic care by accelerating safe house capacity and development across the United States.

510K

People trained to increase the identification rate beyond one percent since 2018

4,710

Survivors served through emergency support services since 2021

22.9K

signals received to report human trafficking and connect victims to support in 2025

Learn more at www.safehouseproject.org
For questions or permissions, contact: info@safehouseproject.org

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Dear Reader,

At Safe House Project, we work at the intersection of identification and placement. Every day, we see what happens after a survivor is identified, when law enforcement, hospitals, task forces, or community partners ask the same urgent question:

Where can this survivor go right now?

Our mission is to raise the identification rate of survivors beyond one percent through education, provide emergency services to survivors, and ensure that every survivor has access to safe housing and holistic care. Since 2018, we have:

This report is grounded in the operational data generated through that work.

The analysis that follows is drawn from cases referred for residential placement and stabilization support within our national network. It reflects real-time placement barriers, eligibility constraints, clinical complexity, safety concerns, and geographic limitations encountered during service coordination.

This report is not a prevalence study. It does not measure how trafficking manifests in the general population. It reflects survivors seeking placement and stabilization, a specific and high-need subset of individuals. Because this data was originally collected for operational coordination rather than research publication, it carries inherent limitations. Variability in reporting, evolving data fields, and incomplete responses influence certain findings. Those limitations are outlined in the section that follows. Despite these constraints, consistent patterns emerge across thousands of cases.

The purpose of this report is threefold:

- To clarify the complexity of survivor needs at the point of placement
- To identify systemic barriers that restrict access to safe housing and stabilization
- To equip community-based organizations, safe home partners, and law enforcement with actionable insight

No single organization can meet the needs represented in this data alone. However, by aligning program models, funding structures, and policy decisions with the realities survivors present, the field can strengthen collective response.

This analysis is offered in that spirit.

Safe House Project

VICTIM IDENTIFICATION & SURVIVOR SUPPORT TRENDS 2023-2025

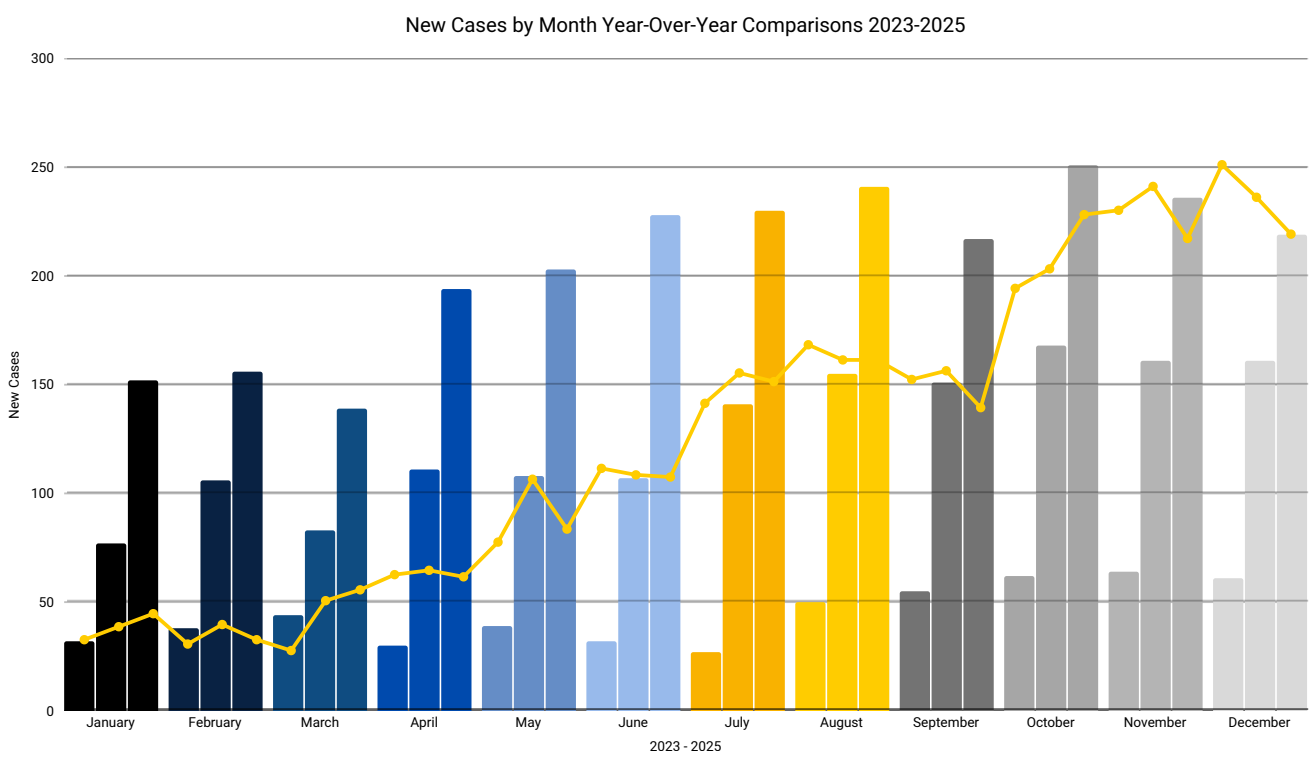
Methodology Overview

This analysis was prepared using de-identified ticket description data drawn from Safe House Project's case files. All identifying information was removed prior to analysis to protect the survivor's privacy. Cases represent actual survivors who contacted Safe House Project for assistance between January 2023 and December 2025. Because certain data points were not consistently captured across all cases, each chart and graph references an "n" value indicating the number of responses included in that specific analysis.

Data Limitations

This dataset reflects survivors of trafficking who were referred to Safe House Project specifically for residential or housing-related support and should not be interpreted as representative of the broader survivor population. Survivors who are not seeking or in need of housing services are not captured in this analysis. It is important to note that individuals pursuing residential support are more likely to be experiencing homelessness, higher acuity needs, and complex or co-occurring challenges — factors that may skew findings relative to what might be observed across a more general survivor population.

2023-2025 HUMAN TRAFFICKING CASES



The data reveals a critical increase in victim identification and service connections over the three-year period. In 2023, 534 individuals were identified and connected to services. This number rose to 1,529 in 2024 and 2,466 in 2025—representing more than four times as many survivors accessing the support they need compared to just two years prior. These numbers reflect the strengthening of identification systems, increased awareness among frontline professionals, and improved pathways for survivors to access trauma-informed care.

New cases by Quarter & Year from 2023-2025

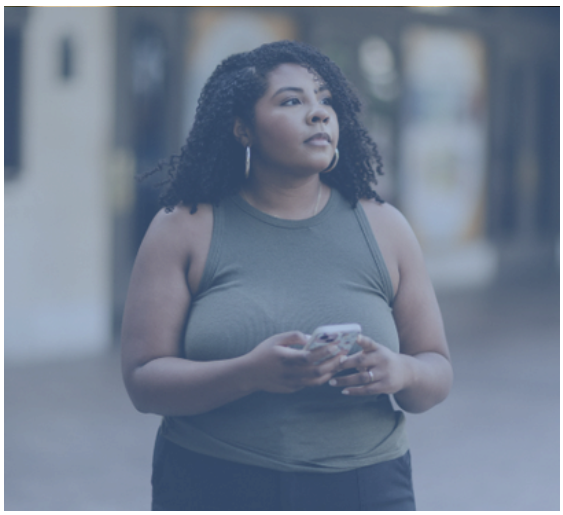
	2023	2024	2025
Quarter 1	114	266	447
Quarter 2	102	326	625
Quarter 3	132	446	688
Quarter 4	187	490	706
TOTAL	**534**	**1529**	**2466**
YOY Growth		186%	61%

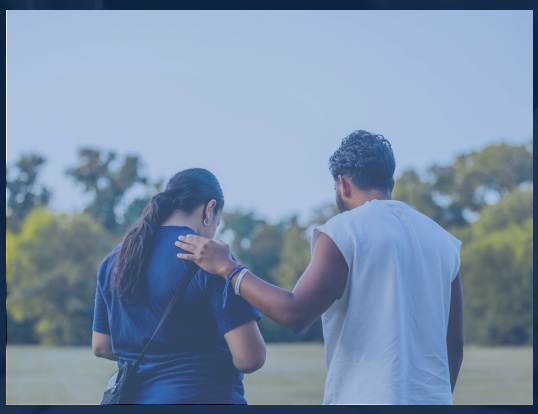
SAFE CONTACT METHODS

Single-channel communication systems are insufficient for the majority of survivors. With 70% utilizing multiple contact methods, organizations that rely on a single channel risk excluding individuals with variable or safety-sensitive access.

70% of survivors require multiple contact methods due to surveillance, isolation, and technology access barriers. 27% cannot be contacted directly and require advocate intermediaries. No single communication approach reaches all survivors.

Contact Method (n=1,009)	Usage
Phone - Safe for Voicemails	69.50%
Text	66.10%
Email	54.60%
Through Advocate Only	27.40%
Phone - Unsafe for Voicemails	9.40%
Secure App (Signal/WhatsApp)	0.80%





CRITICAL SAFETY BARRIERS

- **Active surveillance:** 9.4% are unsafe to receive voicemails due to monitored phones. True prevalence may be higher, as monitoring is not always disclosed or recognized.
- **Communication intermediaries required:** 27.4% rely on advocates for all contact, limiting direct communication and potentially delaying urgent response.
- **Secure communication gap:** Only 0.8% report using encrypted applications, suggesting barriers related to digital literacy, device access, data limitations, or external device control.

RECOMMENDATIONS

1. Single-channel communication models risk excluding survivors. Organizations should provide multiple concurrent options, including phone, text, email, and advocate-mediated contact.
2. Staff require training in discreet communication practices. Unintended voicemails, visible caller identification, or poorly timed outreach can increase risk for individuals under surveillance.
3. Contact information frequently changes due to device loss, relocation, or safety-related movement. Systems must support flexible, multi-channel engagement and incorporate routine verification of safe contact methods.

DEMOGRAPHIC INFORMATION

Age Group (n=2,046)	% OF TOTAL
Adults >25	**80.3%**
Minors <18	**5.9%**
Transitional Age Youth (18-24)	**13.8%**

One of the most critical—and often misunderstood—realities in anti-trafficking work is the significant gap between when exploitation begins and when victims are identified. While identification efforts often capture adults over 25, the trafficking itself typically started years earlier, when these individuals were minors. The adults identified today are the children we failed to protect yesterday. Breaking this cycle requires acknowledging that human trafficking is overwhelmingly a crime that begins in childhood.

Gender Breakdown

Gender Identity	Adult (25+)	Transitional Age Youth (18-24)	Minor (Under 18)	Total
Female	93.10%	88.80%	92.30%	92.40%
Male	3.60%	3.70%	6.20%	3.80%
Nonbinary	1.50%	4.10%	0.00%	1.80%
Transgender	1.80%	3.20%	1.40%	2%
n	2,869	508	209	3,586

The gender identity data shows that females comprise the vast majority of individuals served at 92.4%. In terms of age distribution, adults over 25 constitute 80.3% of the population, followed by Transitional Age Youth (18-24) at 13.8%, and minors under 18 at 5.9%. It's critical to recognize that this data reflects who is currently being identified and connected to services rather than the full demographic scope of trafficking victims.

While these patterns help us understand the needs of those we're reaching today, they also underscore the importance of developing targeted initiatives to identify and serve under-represented and under-reported populations—including male victims, LGBTQ+ individuals, and minors—who may face additional barriers to identification and disclosure. Ensuring our outreach, training, and identification strategies actively address these gaps will be essential to building a more comprehensive and equitable response to human trafficking.

RACIAL/ETHNIC DISTRIBUTION WITHIN EACH AGE GROUP			
Race/Ethnicity	**Adults**	**Transitional Age Youth**	**Minors**
White	46.60%	31.50%	27.20%
Black or African American	18.60%	31.30%	34.00%
Mixed Race	19.60%	20.10%	13.10%
Prefer not to say	6.80%	5.10%	4.60%
Hispanic or Latino	5.60%	8.80%	18.50%
American Indian/Alaska Native	2.80%	1.70%	2.60%
Asian	0.00%	1.50%	0.00%
n	2,645	467	195

MINORS

Among minors served, Black or African American youth are dramatically overrepresented at 36.4% compared to 13% of the U.S. population—nearly three times their demographic proportion—while White (27.2% vs 52%) and Hispanic/Latino (18.5% vs 25%) youth are significantly underrepresented.

TRANSITIONAL AGE YOUTH

Black or African American individuals comprise 31.9% of those served—2.5 times their proportion in the general population—while White youth at 31.5% and Hispanic or Latino youth at 8.8% are both significantly underrepresented at roughly half their demographic proportions.

ADULTS

White individuals represent 46.6% of the population (slightly below their general population proportion), while Black or African American adults are overrepresented at 18.6%—1.4 times their demographic proportion. Mixed race individuals account for 7.5% of adults served. Notably, Hispanic or Latino adults are significantly underrepresented at just 5.6%, less than one-third of their proportion in the general U.S. population, suggesting substantial gaps in identification and outreach to this community.

SURVIVOR REFERRAL & SUPPORT NEEDS

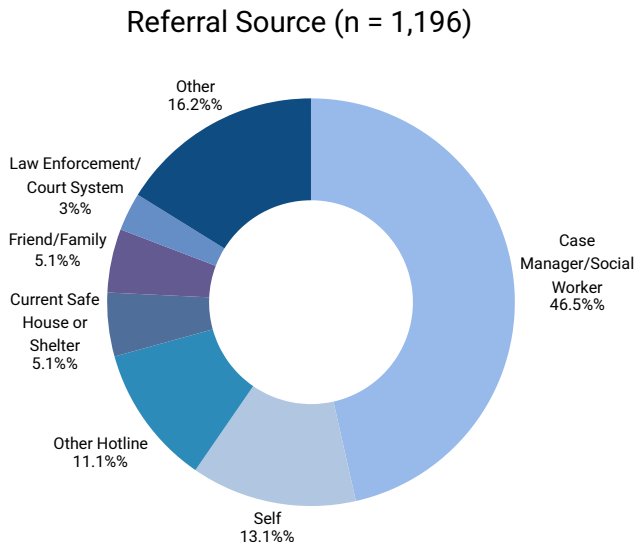
Safe House Project receives referrals from multiple sources, including law enforcement, healthcare providers, other hotlines, and industry partners using Simply Report. Each referral is assessed to verify trafficking indicators, determine immediate safety needs, and identify the survivor's medical, housing, and support service requirements.

Safe House Project connects survivors to their network of Safe House Certified or vetted providers equipped to address the complexity of each case. For survivors in regions without adequate local resources, Safe House Project provides care navigation and work to fill gaps through their national partnerships, ensuring connection to appropriate care rather than defaulting to programs ill-equipped to serve survivors.

VICTIM LOCATION WHEN SEEKING SERVICES BY PERCENTAGE

Location	Adult	Transitional Age Youth	Minor
Homeless	27.80%	23.40%	0.50%
In a Shelter	17.30%	13.20%	4.30%
With Family/Friends	9.80%	14.50%	19.60%
In a Residential Program	7.10%	6.60%	8.20%
In the Community	5.40%	4.60%	0.50%
With Trafficker	5.20%	7.90%	3.80%
Hospital	3.80%	6.60%	37.00%
Behavioral Health Hospital	3.10%	3.60%	10.30%
With Advocate	2.20%	3.10%	1.10%
With Law Enforcement	1.30%	2.30%	3.80%
Other	17.10%	14.20%	10.90%
n	2,240	393	184

REFERRAL FOR SERVICES



Time Since Exiting Trafficking	Percentage
Still being trafficked (pre-exit)	23.20%
Same day	0.10%
Within 1 week	0.70%
Within 1 month	2.10%
1–3 months	5.10%
3–6 months	7.90%
6–12 months	18.50%
Over 1 year	42.30%

KEY IMPLICATIONS FOR INDIVIDUALS STILL BEING TRAFFICKED:

- Services are being accessed while individuals remain under trafficker control

Required Response

- Immediate safety planning
- Crisis intervention capacity
- Coordinated exit support and resource navigation
- Protection strategies to mitigate trafficker retaliation

KEY IMPLICATIONS FOR POST-EXIT SURVIVORS:

- Trauma and fear, requiring time to feel safe enough to disclose
- Limited awareness of available services and support pathways
- Shame and stigma associated with exploitation
- Ongoing psychological manipulation or control by traffickers
- Distrust of law enforcement or social service systems
- Survival-focused priorities such as housing, income, and basic needs
- Lack of self-identification as having experienced trafficking

Proficiency Level	Adult	Transitional Age Youth	Minor
Fluent in English	98.10%	97.00%	91.80%
No English Proficiency	1.00%	2.00%	4.10%
Limited English Proficiency	0.80%	1.00%	4.10%
n	2,274	398	146

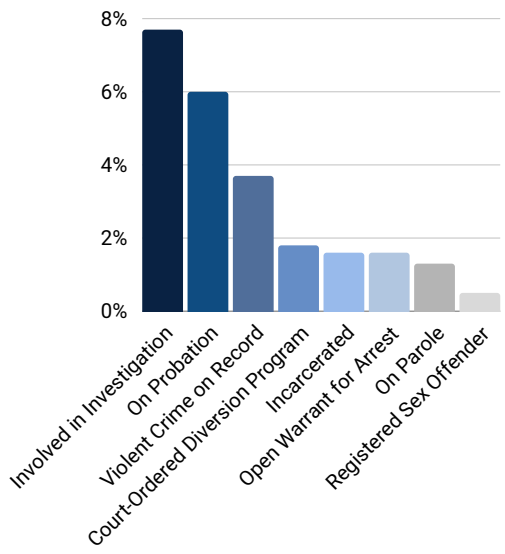
SURVIVORS WILLINGNESS & ABILITY TO LEAVE THE STATE			
Response	**Adult**	**Transitional Age Youth**	**Minor**
Yes - Would Leave the State	95.80%	96.40%	98.70%
No - Would Not Leave the State	4.20%	3.60%	1.30%
n	1,481	276	78

While 82% of survivors have no reported criminal record, the 18% who do have a criminal record face barriers, like limited housing, employment, and education, despite charges stemming directly from trafficking.

More critically, 17% of survivors have no identity documents whatsoever, with documents confiscated by traffickers or lost during exploitation, and only 39% hold REAL ID-compliant driver's licenses needed for domestic flights and federal facilities after May 2025. This creates cascading barriers: survivors cannot open bank accounts, verify employment, access healthcare, secure housing, or flee dangerous situations requiring interstate travel. Willingness to relocate is nearly universal—76% of survivors would leave their state if safe housing existed elsewhere, rising to 96-99% among minors and youth—yet without documentation, interstate relocation becomes nearly impossible. Even survivors with social security cards (53%) and birth certificates (50%) face months-long bureaucratic obstacles to obtain REAL ID documentation, increasingly required for basic functioning, all while navigating recovery.

Legal Involvement (n=2,360)	Percent
Legal Involvement	18.20%
None	81.80%

Legal Involveent Breakdown for 18.20%



SURVIVORS WITH IDENTIFICATION DOCUMENTS				
	Adult	**Transitional Age Youth**	**Minor**	**Total**
Yes	80%	71%	19%	76%
No	19%	29%	81%	24%
n	2,131	366	147	2,644

Documentation Type
People with NO Documents: 17.2%

Primary ID Documents
REAL ID Driver's License: 39.1%
Non-REAL ID Card: 29.2%
State or Tribal REAL ID Card: 8.6%
Passport: 7.8%

Supporting Documents
Social Security Card: 53.0%
Birth Certificate: 50.4%
Visa: 2.3%
Resident Card (Green Card): 0.8%

HOUSING AND SUPPORT LEVEL NEEDS: AGE-SPECIFIC ACUITY REQUIREMENTS			
Level of Need	**Adults (n=2,084)**	**Transitional Age Youth (n=363)**	**Minors (n=105)**
Inpatient / Medical – Intensive medical or specialized mental health treatment setting	8.40%	10.20%	32.40%
High Acuity – 24/7 on-site supervision and structured support	14.90%	16.80%	34.30%
Moderate Support – Staff on-site during daytime hours; no overnight supervision	34.20%	38.00%	21.90%
Low Support – Independent setting with weekly check-ins and no on-site staff	42.50%	35.00%	11.40%

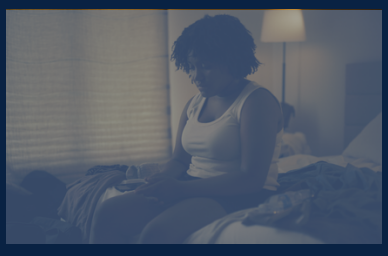
The level of support survivors require varies dramatically by age, revealing that no single housing model serves this population effectively. While 42.5% of adults can manage independent settings with weekly check-ins and 34.2% need moderate support with daytime staffing, nearly a quarter (23.3%) require high-acuity 24/7 supervision or inpatient medical settings—a reality most transitional housing programs are not equipped to provide. Transitional Age Youth show the highest concentration in moderate support settings (38%), reflecting mixed needs requiring responsive models that balance structure with autonomy.

Minors present the starkest contrast: 66.7% require either high-acuity 24/7 staffing or inpatient clinical care, with only 11.4% ready for independent settings, yet specialized residential facilities with embedded psychiatric services and intensive supervision for trafficked minors remain critically scarce.

The field needs both step-down pathways supporting adults' transition to independence and high-acuity facilities capable of managing medically and psychiatrically complex cases across all age groups—not a one-size-fits-all transitional housing model that serves the minority of survivors with low support needs while failing those requiring intensive care.

ADULTS

- Majority prefer low or moderate autonomy
- Significant minority require high or clinical care
- Systems must support step-down and independence pathways



TRANSITIONAL-AGED YOUTH (TAY)

- Highest concentration in moderate-level care
- Transitional population with mixed acuity needs
- Requires flexible, developmentally responsive models

MINORS

- Predominantly require high-acuity and clinical-level care
- Limited suitability for autonomy-only models
- Strong indication for specialized facilities, 24/7 staffing, and embedded psychiatric services

The placement process represents a critical opportunity to return agency to survivors who have had their autonomy systematically stripped away through exploitation. When determining appropriate housing and services, honoring survivor preferences is a foundational element of trauma-informed care that directly impacts engagement, retention, and long-term outcomes. The data reveal significant variations in survivor preferences across age groups, underscoring the need for individualized approaches rather than one-size-fits-all solutions. For instance faith-based programming preferences vary substantially, with minors or minor placing agencies showing notably higher preference for secular options (24.2%) compared to adults (15.3%), while requirements around faith participation also shift across age groups.

REPORTED NICOTINE USAGE AMONGST SURVIVORS SEEKING SERVICES			
Category	**Adult (n =2,109)**	**Transitional Age Youth (n=352)**	**Minor (n=138)**
No tobacco/vaping use	42.90%	56.50%	69.60%
Cigarettes only	25.70%	9.70%	2.20%
Vapes only	15.60%	19.30%	21.70%
Both cigarettes and vapes	15.60%	13.90%	6.50%

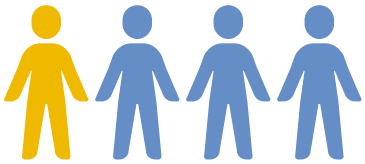
SURVIVOR STATED WILLINGNESS TO ENGAGE WITH FAITH-BASED PROGRAMS			
Program Type	**Adult (n=1,787)**	**Transitional Age Youth (n=325)**	**Minor (n=99)**
Yes	5.70%	3.70%	3.00%
Yes - a Christian program with required faith elements	17.20%	15.10%	21.20%
Yes - a Christian program with optional faith elements	55.60%	59.40%	43.40%
Yes - with no Christian elements	0.40%	0.90%	2.00%
Yes - a faith other than Christianity	5.80%	6.50%	6.10%
No	15.30%	14.50%	24.20%

These preference patterns underscore why placement matching must be survivor-driven rather than provider-driven. When survivors are placed in environments that conflict with their stated preferences we risk replicating the control and choice-denial dynamics of their trafficking experience. Conversely, when survivors exercise genuine choice in their placement and see their preferences honored, the process itself becomes therapeutic, demonstrating that their voice matters and their autonomy will be respected. In an anti-trafficking response system, every interaction either reinforces survivors' agency or undermines it. Placement decisions represent one of the most consequential moments to get this right.

ELIGIBLE FAMILY MEMBERS

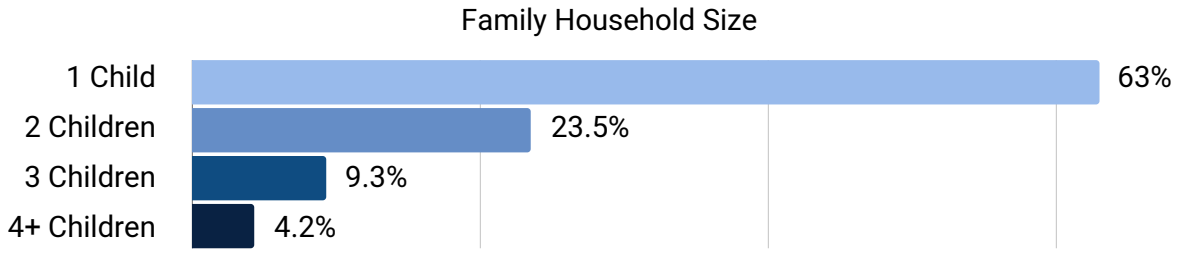
1 in 4 survivors either require co-placement with children or dependents immediately or are planning reunification post-program, yet the vast majority of programs are designed for individuals, forcing survivors to choose between their own safety and keeping their families together.

SURVIVORS REQUIRING CO-PLACEMENT WITH AN ELIGIBLE FAMILY MEMBER



Response (n=734)	Percentage
No Co-Placement	75.60%
Yes – Co-Placement Required	15.50%
Deferred (Reunification Post-Program)	8.90%

Eligible Family Members Age	Boys	Girls	Not Specified	% of All Children
Infant (0-1 year)			100%	9%
1-2 years old	14%	13%		12%
3-4 years old	18%	16%		15%
5-8 years old	27%	30%		26%
9-11 years old	14%	14%		13%
12-15 years old	16%	19%		16%
16-17 years old	11%	9%		9%
n	132	152	29	313



CHILDREN AND DEPENDENTS: FAMILY-CENTERED CARE REQUIREMENTS

Survivors requiring co-placement bring an average of 2.1 children into services, with young children predominating—69% are ages 0-11, including 34% under age 5 and 29 infants (8.5%) requiring intensive daily care that severely limits survivors' capacity to work, attend appointments, or engage in treatment.

Elementary-age children represent the largest cohort, with 35% ages 5-11 and the 5-8 age range alone accounting for nearly a quarter of all children (23.5%), introducing complex scheduling demands, school transportation, educational coordination, and childcare needs that standard programming rarely accommodates. These high childcare demands fundamentally affect survivors' ability to meet program requirements designed for individuals without dependents—attendance at therapy sessions, employment training, or support groups becomes impossible without accessible, affordable childcare that understands trauma.

Adolescents ages 12-17 comprise 23% of children and present distinct challenges: they may carry secondary trauma from witnessing parental exploitation, often present with their own behavioral or mental health needs requiring therapeutic intervention, and face elevated trafficking risk themselves given their vulnerability and exposure. The resource intensity of infant care—formula, diapers, medical appointments, around-the-clock attention—combined with the educational and emotional needs of school-age and adolescent children means that survivors parenting while in recovery are managing two full-time jobs simultaneously, yet services rarely provide the family-centered support, flexible programming, and childcare infrastructure that would enable both survivor healing and child wellbeing.

OVERVIEW: CRITICAL BARRIERS FOR SURVIVORS WITH CHILDREN

EMPLOYMENT BARRIERS:

- 69.4% of kids are under 12, requiring childcare while the survivor is at work
- 34.1% are under 5, requiring expensive infant/toddler care
    - Single parents (assumed for most survivors) cannot work standard hours without childcare

HOUSING BARRIERS:

- Families need 2-3 bedroom units (more expensive)
- 13.5% have 3+ children requiring even larger units
- Most programs don't accommodate large families

SERVICE ENGAGEMENT BARRIERS:

- Court dates, therapy, and case management meetings require childcare
- Medical appointments for the survivor are complicated by childcare needs
- Educational/job training is difficult without childcare support

FINANCIAL BURDEN:

- Children needing food, clothing, school supplies, therapy, medical care, and more.
- Average 2.1 children per survivor on a single income

POLICY & PROGRAM RECOMMENDATIONS

1. CHILDCARE AS CRITICAL INFRASTRUCTURE

- Provide on-site childcare at service locations
- Offer childcare subsidies to support employment and treatment participation
- Ensure evening and weekend childcare to accommodate non-traditional work schedules

2. AGE-RESPONSIVE SERVICE MODELS

- Integrate childhood care specialists into family-serving programs
- Provide trauma-informed therapists for children and adolescents
- Implement adolescent trafficking prevention and early-intervention programming

3. FAMILY-SIZED HOUSING CAPACITY

- Expand availability of three-bedroom units (37% of families have two or more children)
- Develop capacity for four-bedroom or larger units when needed

4. EDUCATION STABILITY SUPPORTS

- Assist with school enrollment and records transfer
- Address educational disruption caused by trafficking or relocation
- Provide structured after-school programming to support stability and supervision

5. FINANCIAL STABILIZATION SUPPORTS

- Enforce child support where appropriate
- Maximize eligibility for TANF, SNAP, and related public benefits
- Facilitate access to child tax credits and refundable benefits
- Provide back-to-school financial assistance

6. TRAUMA SERVICES FOR CHILDREN

- Recognize that children have directly or indirectly experienced trafficking-related trauma
- Provide age-appropriate, trauma-informed therapeutic services
- Offer sibling-focused therapy for families with multiple children
- Support parent–child relationship repair and attachment restoration

THE CHILD WELFARE NEXUS

Nearly half of all minor victims of trafficking have documented child welfare system involvement.

This analysis identifies a significant systems intersection: **47.7% of minor trafficking victims and 18.7% of transitional-age youth (TAY)** have documented child welfare involvement.

Across 736 cases examined (222 minors and 514 TAY), **27.3% of all cases** include foster care, group home, or child protective services history.

These findings indicate that child welfare involvement is a common factor among youth who have experienced trafficking. The system represents both a point of vulnerability and a critical intervention opportunity. Strengthening identification, placement stability, and trafficking-informed practices within child welfare settings may materially reduce exploitation risk.

Involvement	Minors (n=106)	TAY (n=96)
Custody Disruption	34%	22%
Elopement Episodes	41%	7%
Child Welfare Involvement	34%	11%
Active Foster Care Placment	17%	23%
Missing Person	26%	6%
Active Group Home/RTC Placement	26%	32%
Legal Guardianship in Place	7%	3%
ActiveKinship Care	1%	0%

16% of TAY cases state that aging out of care systems resulted in trafficking

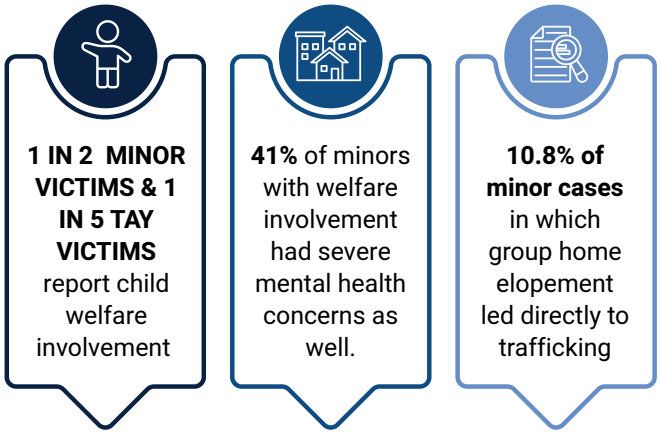
In 12.6% of minors cases the child was missing at the time of referral

51% of TAY cases report that housing instability is the reason for being trafficked.

RESIDENTIAL CARE AS A RISK AMPLIFIER

Youth with histories of placement in residential facilities—including group homes, congregate care settings, and treatment facilities—represent a disproportionate segment of trafficking cases.

Traditional congregate care environments present elevated trafficking risk when strong screening, monitoring, and meaningful youth engagement protocols are not consistently in place. Young people with histories of multiple residential placements require enhanced risk assessments and targeted prevention supports to address their specific vulnerabilities.



FAMILY DISRUPTION = VULNERABILITY

Cases frequently involve custody disputes, parental rights termination, and prolonged legal instability that creates cascading trauma and system entanglement. Reports include wrongful removals, contested placements, and family separation trauma that destabilize youth at critical periods. The pattern is consistent: family instability precipitates child welfare involvement, which increases vulnerability to trafficking, revealing how protective processes inadvertently expose children to heightened risk.

ACTIVE SYSTEM INVOLVEMENT FAILS TO PROTECT

Perhaps most troubling is the pattern of trafficking occurring while youth remain under active Child Welfare supervision. Multiple cases involve youth in care at the time of exploitation, with ongoing protective services cases commonly documented throughout trafficking incidents. This reveals a critical finding: protective status alone does not mitigate risk. The formal engagement of child welfare systems, without enhanced screening protocols and robust cross-system coordination, proves insufficient to prevent trafficking victimization among youth.

THE ELOPEMENT-TO-EXPLOITATION PIPELINE

Youth frequently leave foster homes, group homes, or residential placements immediately prior to trafficking incidents. Elopement and runaway episodes are repeatedly documented in case histories, establishing a clear pattern: youth are departing formal care environments and directly entering situations that result in trafficking exposure. These departure episodes represent critical intervention windows that current systems fail to adequately address. The pathway from placement instability to exploitation is well-established yet inadequately interrupted.

MISSING FROM CARE AS A TRAFFICKING INDICATOR

Missing person reports show significant overlap between youth reported missing from foster homes, group homes, or child welfate custody and subsequent trafficking cases. Missing episodes within the child welfare system are strongly correlated with trafficking victimization, yet these disappearances are often treated as routine placement disruptions rather than high-risk exploitation alerts. The failure to respond missing-from-care events as active trafficking cases represents a gap in protective response.

THE CASE FOR CSEC-SPECIFIC CARE MODELS OVER TRADITIONAL GROUP HOMES:

- Standard security and supervision measures are insufficient to prevent recruitment or elopement
- Youth with complex trauma histories may not receive adequately resourced, trauma-informed care
- Elopement prevention and rapid response protocols are inconsistent
- Traffickers target youth in congregate care environments
- High staff turnover and limited trafficking-specific training reduce identification and intervention capacity
- Some programs rely on punitive behavior management rather than therapeutic, relationship-centered approaches

WHEN YOUTH RETURN TO TRAFFICKING OVER THE 'PROTECTIVE' CUSTODY OF GROUP HOMES, WE NEED TO ASK OURSELVES: WHAT HAVE WE DONE TO MAKE EXPLOITATION FEEL SAFER THAN OUR CARE?

CRITICAL FINDING: MULTIPLE SYSTEM TOUCHPOINTS

27.7% of child welfare–involved trafficking cases show youth engaged with more than one system at the same time.

When involvement expands across systems without strong coordination and continuity, instability can increase rather than decrease.

MOST COMMON OVERLAPPING SYSTEM PATTERNS

Group Home / RTC + Legal Guardianship
- Youth under guardianship while simultaneously placed in residential care.
- Indicates fragmented responsibility and unclear protective authority.

Group Home / RTC + Kinship Care
- Movement between relative placements and congregate care
- Fragmented caregiving environments and inconsistent supervision

Custody Disruption + Kinship Care
- Removal from parents followed by placement with relatives
- Trafficking occurring despite family-based placement
- Suggests that kinship care alone does not eliminate vulnerability

Foster Care + Group Home / RTC
- Transition from foster care into congregate settings
- Often associated with placement disruption or escalating support needs

Group Home / RTC + Missing Person Reports
- Youth reported missing from residential placements
- Strong overlap between missing episodes and trafficking victimization
- Indicates gaps in supervision, response protocols, or elopement prevention systems

"The day you turn 18 in foster care is the day you lose everything — housing, support, family. Traffickers know this. They're waiting at the exit door."- JJ

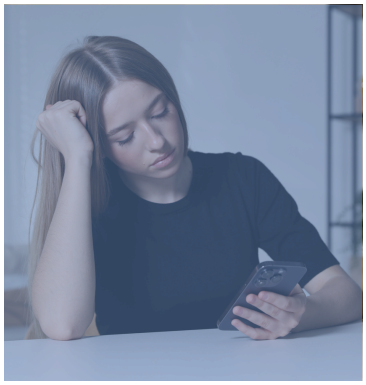
Residences dominates child welfare related trafficking venues at 37.2%
- Youth taken to private homes
- Traffickers' residences
- "Safe" place offered to youth running away
- Facilitates isolation and control

Hotels are second at 11.5%
- Youth leaving placements are frequently exploited in hotel settings
- Commercial sexual exploitation often occurs shortly after departure from care
- Hotels function as transitional locations between placement instability and active trafficking

Kids Run To...	% of Cases
Private Residence	37.20%
Hotel/Motel	11.50%
Street	6.10%
Bar/Club	5.90%

ONE CASE DOCUMENTED SEVEN DISTINCT CHILD WELFARE TOUCHPOINTS: ELOPEMENT, FOSTER CARE, CUSTODY DISRUPTION, GUARDIANSHIP INVOLVEMENT, MISSING PERSON REPORTING, GROUP HOME/RTC PLACEMENT, AND ACTIVE CW SUPERVISION. DESPITE EXTENSIVE SYSTEM INVOLVEMENT AND MULTIPLE DOCUMENTED RISK FLAGS, TRAFFICKING STILL OCCURRED.

"KIDS ARE JUMPING FENCES FROM GROUP HOMES DIRECTLY INTO TRAFFICKERS' HANDS."



Patterns across cases indicate that elopement often reflects unmet needs and system instability rather than individual defiance.

Contributing Factors to Elopement:

- Trauma insufficiently addressed within placements
- Abuse or harm occurring within care settings
- Strong attachment to or pressure to return to family systems
- Active grooming by traffickers promising autonomy or stability
- Unmanaged mental health crises
- Substance use vulnerability
- Conflict with caregivers or staff within under-resourced environments

These individual circumstances occur within broader systemic conditions:

- Limited integration of trafficking-informed and trauma-informed practice
- Placement of youth with complex trauma histories in non-therapeutic or under-resourced settings
- Reliance on punitive behavioral models rather than relational, healing-centered approaches
- Insufficient specialized training among frontline staff
- Re-traumatization due to instability, restraint practices, or lack of trust-building
- High caseloads limit meaningful supervision and follow-up
- Inconsistent risk assessment and monitoring protocols
- Repeated placement transitions disrupting continuity of care

System Pattern:

- Protective system contact alone does not ensure safety. Without trauma-responsive practice, continuity, and coordinated oversight, involvement can fail to mitigate exploitation risk.

RECOMMENDATIONS

1. WHEN YOUTH ELOPE: IMMEDIATE RESPONSE

Elopement must be treated as a trafficking risk event, not a disciplinary issue.

- Activate a 72-hour rapid response protocol
- File an immediate missing person report
- Designate trafficking risk in law enforcement notification
- Presume exploitation risk until ruled out
- Screen for trafficking upon return
- Do not impose punitive consequences
- Reassess placement before return
- Maintain therapeutic placements

2. PREVENTING ELOPEMENT

Prevention requires relational safety and early identification.

- 24/7 crisis access
- Direct trusted contact for youth
- Individualized safety planning for high-risk youth
- Peer support structures
- Trafficking risk screening at intake and during transitions

3. ADDRESSING ROOT CAUSES

Elopement often reflects instability within care.

- Embed trauma-informed practice across placements
- Ensure immediate access to mental health services
- Integrate substance use treatment
- Reduce placement disruption
- Prioritize family preservation when safe

4. STRUCTURAL REFORM

Security alone is insufficient.

- Conduct safety audits of congregate care settings
- Require trafficking-specific staff training
- Establish 24/7 trained staffing minimums
- Develop CSEC-focused residential models
- Shift from punitive compliance models to relational, trauma-responsive care

Containment does not equal protection. Stability, clinical alignment, and relational safety reduce trafficking risk.

COMPREHENSIVE RECOMMENDATIONS

Universal Screening & Assessment
All children in Child Welfare custody must receive mandatory trafficking screening at three critical junctures: intake, every placement change, and every caseworker visit. This screening should be integrated into standard safety assessments rather than treated as a separate process. Child Welfare workers need trafficking-informed training that enables them to recognize grooming patterns, understand coercion dynamics, and respond appropriately. Consider establishing specialized trafficking caseworkers who can provide consultation on complex cases and direct intervention when needed.

Caseload Management Reform
Reduce maximum caseloads to 12 cases per worker to enable actual monitoring and relationship-building with youth. The current system makes it nearly impossible for workers to maintain the frequent, meaningful contact necessary to identify warning signs or build the trust that allows youth to disclose exploitation. More frequent contact means earlier intervention and better outcomes.

Foster Parent Capacity Building
Require mandatory trafficking training for all foster parents covering recognition of grooming behaviors, online safety monitoring, warning signs of exploitation, and response protocols. Provide ongoing support through a 24/7 hotline, monthly check-ins, and access to trafficking specialists.

Digital Safety Protocols
Implement digital safety plans for all youth that include age-appropriate device oversight, social media education, gaming safety awareness, and education about dating app dangers. Avoid surveillance—implement appropriate supportive adult awareness of whom the youth are communicating with online and recognition of red flags.

Kinship Care Enhancement
Apply consistent vetting standards to kinship caregivers, including background checks, home studies, and trafficking risk assessment. Provide adequate financial support, training, respite care, and access to services. Ensure appropriate oversight in traditional foster care through regular caseworker visits and youth check-ins.

Specialized Placement Development
Partner with existing programs for out-of-home placements and contracts with specialized programs, including out-of-state placements when necessary and in the best interest of the youth. Develop new options, including secure residential programs for high-risk youth (therapeutic and trauma-informed, not punitive detention) and host homes with trained foster parents providing intensive support at lower ratios (1-2 youth per home). Avoid placing youth with trafficking history in general population group homes, juvenile detention, or long-term psychiatric hospitals without genuine need.

Implementation Priority
These recommendations must be implemented systemically, not piecemeal. Screening without proper training yields false negatives. Training without caseload reform means workers can't act on what they learn. Identification without appropriate placements means youth return to situations where they can be re-exploited. The system must address prevention, identification, and response simultaneously to protect this vulnerable population.

THE IMMIGRATION NEXUS

Addressing immigration concerns is essential to providing effective, trauma-informed care to trafficking survivors. These are not "immigration cases" that happen to involve trafficking - they are trafficking cases where immigration status is leveraged against survivors.

Out of 3,605 total cases analyzed (2,869 adults, 222 minors, 514 TAY), **only 153 cases (4.2%)** show clear immigration-related concerns that create additional barriers to safety and services for trafficking survivors.

Adults: 3.8% of all adult cases

Minors: 9.5% of all minor cases

TAY: 4.5% of TAY all cases

Victims of human trafficking follow several common patterns of exploitation. Many are brought to the country by family members who subsequently exploit them for labor or commercial sex, while others are lured with promises of legitimate work or opportunity only to be forced into labor or sex trafficking upon arrival. Domestic servitude situations represent another significant pattern, where individuals are isolated in private homes and subjected to forced labor. Unaccompanied minors face particular vulnerability after being discharged from Office of Refugee Resettlement (ORR) custody, as they lack stable support systems and become easy targets for traffickers. Additionally, organized international trafficking rings systematically move victims across borders, operating sophisticated networks that exploit vulnerable populations through coordinated criminal enterprises.

COMMON TRENDS AMONG THOSE WITH IMMIGRATION CONCERNS

DOCUMENTATION ISSUES 33%

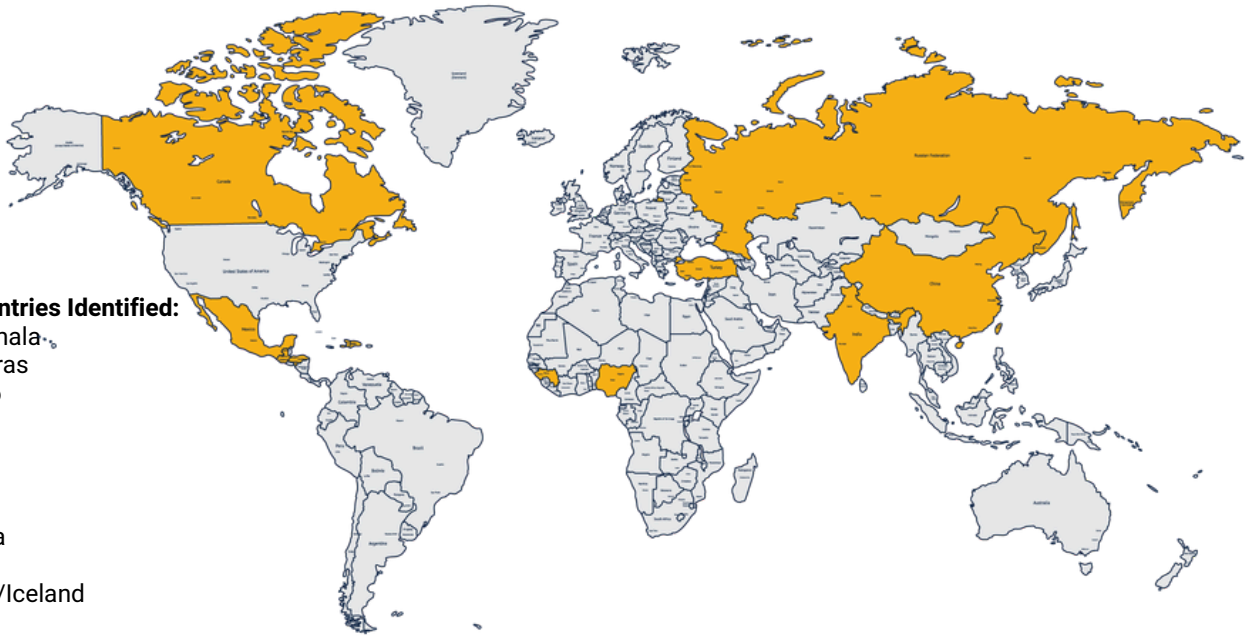
Common Scenarios:

- Traffickers withholding passports, birth certificates, and IDs
- Fake citizenship papers or identification documents provided by traffickers
- Complete lack of identifying documents

Impact on Services:

- Cannot access housing programs requiring ID
- Unable to apply for employment
- Barriers to healthcare enrollment
- Difficulty accessing emergency shelter
- Cannot obtain driver's licenses or state benefits

"I AM CURRENTLY WORKING TO SUBMIT A T-VISA APPLICATION, BUT I DON'T HAVE ANY SERVICES. I HAVE RECEIVED AN EVICTION NOTICE AND HAVE NOWHERE TO LIVE." - CH



Origin Countries Identified:

1. Guatemala
2. Honduras
3. Mexico
4. Nigeria
5. Haiti
6. Guinea
7. India
8. Canada
9. China
10. Russia/Iceland
11. Turkey
12. Dominican Republic

FEDERAL AGENCY INVOLVEMENT 16.3%

Cases involving Homeland Security Investigations (HSI), FBI or immigration enforcement

Types of Involvement:

- HSI victim assistance referrals
- Active federal trafficking investigations
- Homeland Security witness protection
- Federal prosecution cases

Key Challenges:

- Complexity of coordinating with federal agencies
- Need for specialized immigration legal support
- Support in understanding and navigating U.S. legal systems

"CLIENT WAS DISCHARGED FROM ORR SHELTER ON HER 18TH BIRTHDAY. HOTEL ROOM IS PAID FOR THROUGH MID-MONTH. CLIENT IS SEEKING ASYLUM AND HAS WORK PERMIT APPROVAL PENDING, BUT NEEDS SERVICES ASAP." - VICTIM ADVOCATE

VISA & WORK AUTHORIZATION 9%

Visa Types Mentioned:

- T-Visa applications in process (trafficking victims)
- U-Visa (crime victims)
- Work permits/authorization
- Tourist visas expired
- Green card issues
- Asylum cases

Common Challenges:

- Lengthy T-Visa processing times (18+ months typical)
- Cannot work legally while waiting
- Fear of deportation preventing service access
- Traffickers using immigration status as control mechanism
- Loss of documentation during trafficking

SERVICE GAPS & BARRIERS IDENTIFIED FOR IMMIGRATION RELATED CASES

AGE SPECIFIC VULNERABILITIES IDENTIFIED AMONG CASES WITH DOCUMENTED IMMIGRATION CONCERNS

Minors (14%)

- Unaccompanied minors aging out at 18 without documentation or support
- Family-based trafficking by relatives who brought them to the U.S.
- Language barriers preventing disclosure in schools and hospitals
- Deportation threats used as a control mechanism
- Foreign national minors without a legal guardian in the U.S.

Adults (71%)

- Document withholding as a primary control mechanism
- Labor exploitation combined with immigration fraud
- Domestic servitude of foreign nationals
- Gang or cartel threats tied to immigration status
- Complex cases involving both t**rafficking and immigration violations**

Transitional-Age Youth (15%)

- ORR discharge at 18 into homelessness or instability
- Work authorization gaps create economic vulnerability
- Transition from unaccompanied minor to adulthood without support
- Mixed-status family dynamics
- Educational access barriers due to a lack of documentation

1. Housing and Shelter

- Many shelters are unable or unwilling to accept undocumented survivors
- Predominance of short-term emergency shelter models (30–90 days) insufficient for long-term stabilization
- Limited capacity to serve non-English-speaking survivors
- Fear of ICE encounters deters survivors from seeking shelter
- Documentation requirements restrict access to voucher-based housing programs

2. Legal Services

- Limited availability of qualified immigration attorneys; services often cost-prohibitive
- T-Visa adjudication timelines frequently exceed 18 months
- Complex coordination required between immigration relief and trafficking case documentation
- Limited pro bono immigration representation
- Asylum cases backlogged two to three years

3. Healthcare

- Undocumented survivors ineligible for Medicaid in many states
- Language barriers in clinical settings
- Limited availability of mental health services in native languages
- Prenatal and pregnancy care complicated by documentation barriers
- Restricted access to prescription medications

4. Employment

- Inability to work legally without authorization
- Work authorization gaps exploited by traffickers
- Credential and educational recognition barriers
- Language limitations reducing employment opportunities
- Fear of employer discrimination

5. Safety Planning

- Immigration status used as a coercive control mechanism
- Fear of deportation discouraging law enforcement reporting
- Delays in federal case coordination impacting protective measures
- Transnational tracking by trafficking networks
- Threats to family members across borders

HEALTH INSURANCE

Survivors requiring the most intensive medical care are simultaneously least likely to have health insurance, forcing them to cycle through emergency departments, go without essential medications, and wait months to establish care.

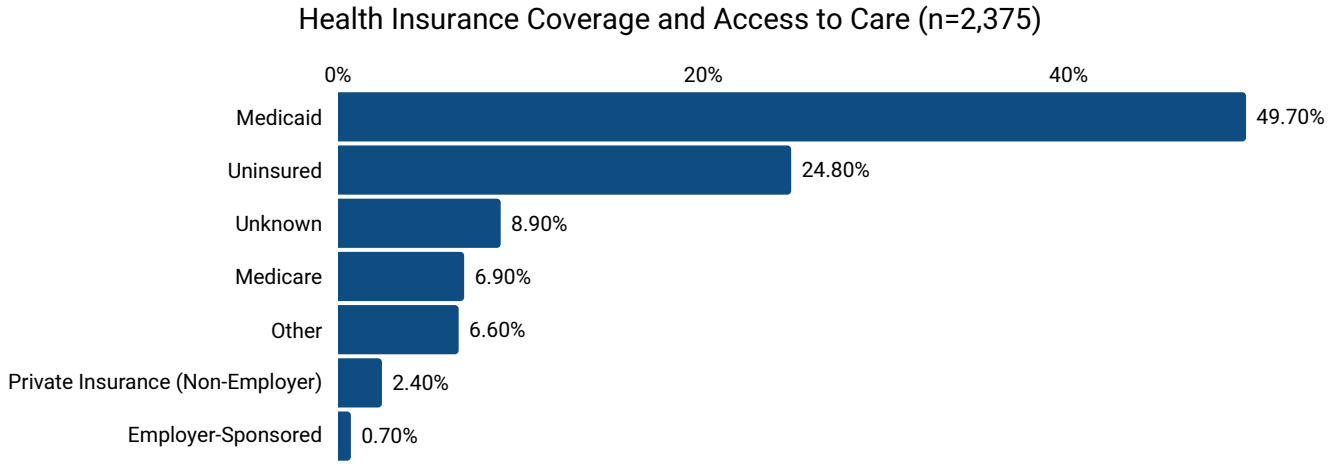
PLACEMENT CONSIDERATIONS AND THE ROLE OF INSURANCE ACCESS

An analysis of 2,375 placement considerations across adults, minors, and transitional-age youth demonstrates the significant clinical, logistical, and accessibility needs among individuals seeking services. These needs must be understood within the context of the population's limited access to private or employer-sponsored health insurance.

More than two-thirds of individuals (66.3%) rely on publicly funded insurance, including Medicaid (49.7%) and Medicare (6.9%). This level of reliance places significant demands on survivor-serving programs to navigate complex public insurance systems, manage coverage gaps, and coordinate care within networks that are often overburdened and difficult to access—particularly for trauma-informed, specialized providers.

At the same time, nearly one in four individuals (24.8%) are uninsured, creating immediate barriers to basic medical care, behavioral health treatment, and medication continuity. For survivors, lack of insurance often translates into delayed treatment, unmanaged mental health conditions, and increased reliance on emergency services, all of which undermine stabilization and recovery efforts.

Access to private or employer-sponsored insurance is extremely limited, with only 3.1% reporting such coverage. Additionally, 8.9% of individuals are unsure of their insurance status, pointing to gaps in healthcare literacy and system navigation that further restrict access to timely, appropriate care.



INSURANCE AS GATEKEEPER: HOW COVERAGE GAPS DRIVE SURVIVORS INTO CRISIS SYSTEMS AND MULTIPLY PUBLIC COSTS

Insurance status, not clinical need, determines whether survivors access appropriate care—and when coverage gaps force survivors out of stabilizing placements and into emergency departments, psychiatric hospitals, and jails, taxpayers fund the most expensive interventions while achieving the worst outcomes.

Survivors present with complex, intersecting needs that require specialized placements, yet access to appropriate care settings is fundamentally determined by insurance status rather than clinical necessity. Beyond the psychiatric and medical complexity already documented, survivors require accommodations for intellectual or cognitive disabilities (7%), wheelchair accessibility or physical modifications (3.9%), and deaf or sensory-access needs (1%)—all of which increase placement costs and narrow the pool of viable programs. When combined with family factors including custody of children (14.5%), pets in care (7.2%), and pregnancy (4.1%), the need for integrated, multi-service placements becomes clear, yet insurance coverage—or lack thereof—determines whether such placements are financially feasible for programs operating on narrow margins.

The challenge intensifies for survivors with high-acuity needs: 18.6% present with severe mental health conditions, 10.4% require detox services for active substance use, 6.3% have recent suicide attempts or active suicidality, and 3.8% have active eating disorders—all conditions requiring clinical services that programs can only provide if they can bill Medicaid or private insurance for behavioral health and medical care. For uninsured or underinsured survivors, accessing these high-acuity placements becomes significantly more challenging, with many programs unable to absorb the cost of intensive psychiatric care, 24/7 supervision, or medical monitoring without reimbursement streams. The result is not that survivors' needs disappear, but that they manifest in exponentially more expensive crisis-driven systems: emergency department visits for behavioral health crises costing thousands of dollars per episode without producing lasting stabilization, inpatient psychiatric admissions and involuntary holds representing the most expensive interventions particularly when repeat admissions occur due to absent follow-up placement, and detox admissions without step-down care increasing the likelihood of relapse and repeated crisis utilization.

This creates a predictable and costly cascade across multiple public systems. Survivors with severe mental health conditions, suicidality, and active substance use—when unable to access appropriate placements—cycle through emergency departments, inpatient psychiatric facilities, medical detox centers, and criminal justice systems rather than receiving stabilized community-based care. Parents unable to access timely mental health or substance use treatment face child welfare involvement, with 14.5% instances of custody considerations in this dataset representing potential child welfare system escalation and family separation that appropriate treatment could prevent. Justice system costs rise when untreated behavioral health needs result in probation violations or incarceration despite being clinically manageable conditions. Survivors requiring physical or cognitive accommodations face institutionalization when community placements lack the financial capacity to provide necessary modifications. Each of these system responses—emergency care, hospitalization, child welfare intervention, incarceration, institutionalization—carries substantially higher per-episode costs than proactive, coordinated placement into appropriate care settings.

REDUCING CROSS-SYSTEM COSTS

Investment in flexible, insurance-aware placement capacity represents cost avoidance rather than expense, enabling a shift from reactive crisis response to preventive stabilization that yields measurable savings by reducing emergency department and inpatient utilization, shortening lengths of stay through faster appropriate placement, preventing repeat detox and psychiatric admissions, minimizing child welfare escalation, and reducing justice system contact driven by unmet health needs. These savings accrue not only to healthcare systems but to state and local governments, Medicaid programs, hospital systems, child welfare agencies, and public safety networks—making placement access an issue of fiscal efficiency as much as humanitarian imperative. Without targeted investment in programs capable of serving survivors regardless of insurance status, individuals with complex needs will continue defaulting into more restrictive, higher-cost, and less effective systems of care, generating avoidable expenses across multiple public systems while failing to achieve the stabilization that appropriate, timely placement would provide.

PUBLIC FISCAL IMPACT OF INVESTING INTO HUMAN TRAFFICKING SERVICE PROVIDERS:

Funding programs that provide comprehensive services for human trafficking creates a shift from reactive crisis response to preventive, stabilization-focused care, yielding measurable cost avoidance by:

- Reducing emergency department and inpatient utilization
- Shortening lengths of stay through faster placement into qualified service providers
- Preventing repeat detox and psychiatric admissions
- Minimizing child welfare escalation
- Reducing justice system contact driven by unmet health needs

Critically, these savings accrue not only to healthcare systems, but also to state and local governments, Medicaid programs, hospital systems, and community safety networks.

"They told me I needed inpatient treatment for my mental health, but the program couldn't take me without Medicaid. So I waited a month to get enrolled while things got worse. By the time I finally got placed, I'd been to the ER four times and spent 72 hours on a psych hold..." - Cindy

RECOMMENDATIONS FOR PROGRAM DESIGN AND FUNDING

The data demonstrates that insurance access is not a peripheral concern but a central determinant of placement success. Programs serving this population must be equipped to:

- Provide insurance navigation and enrollment support, particularly for Medicaid
- Maintain capacity to serve uninsured individuals, preventing exclusion from care due to coverage gaps
- Sustain high-acuity, trauma-informed placements capable of addressing complex mental health, substance use, and disability-related needs
- Absorb short-term financial risk associated with serving individuals who cannot immediately generate reimbursable services
- Provide health literacy support to ensure individuals understand, access, and effectively utilize available coverage and services

IMMEDIATE NEEDS:

☐ Comprehensive medical evaluation upon intake
☐ Medication reconciliation and refills
☐ Trauma-informed medical providers
☐ Mental health crisis assessment
☐ Dental screening
☐ Vision/hearing checks

ONGOING CARE:

☐ Care coordination across specialists
☐ Medication management
☐ Physical therapy/rehabilitation
☐ Mental health counseling
☐ Substance use treatment
☐ Case management for appointments

ACCOMMODATION PLANNING:

☐ Assess mobility needs
☐ Identify service animal requirements
☐ Plan for medical equipment
☐ Consider dietary restrictions
☐ Arrange accessible housing
☐ Coordinate transportation

DOCUMENTATION:

☐ Obtain consent for medical records
☐ Document all visible injuries
☐ Photograph injuries (with consent)
☐ Complete forensic exams if recent assault
☐ Track medication history
☐ Monitor treatment adherence

Key Considerations for Serving:

The medical needs of individuals who have experienced human trafficking are:

- **Complex**, with multiple co-occurring conditions
- **Severe**, often involving life-threatening or disabling impacts
- **Chronic**, requiring sustained, long-term management rather than episodic care
- **Trauma-related**, directly resulting from prolonged exploitation and violence
- **Undertreated**, due to systemic barriers and fragmented access to care
- **Specialized**, requiring trauma-informed, survivor-centered approaches

Success in serving requires:

- Multi-disciplinary care teams
- Trauma-informed practices at all levels
- Patience with complex medical histories
- Flexibility in treatment approaches
- Long-term commitment to healing
- Understanding of trafficking dynamics
- Cultural competency
- Sensitivity to perceived power dynamics

Targeted investment in this infrastructure directly addresses structural barriers to healthcare access, strengthens recovery outcomes, and reduces long-term public costs by stabilizing individuals earlier in their healing process rather than responding after crises escalate.

OVERALL HEALTH

The medical needs of trafficking survivors reflect the profound and multi-layered toll of exploitation, requiring comprehensive healthcare responses that address immediate trauma, chronic conditions, and complex co-occurring disorders.

Physical violence is pervasive, with nearly two-thirds of survivors reported documented injuries ranging from broken bones to traumatic brain injuries and sexual trauma requiring medical intervention. The psychological impact is even more universal, with 88.6% of survivors reporting at least one mental health diagnosis—a testament to the devastating emotional and psychological harm inflicted through exploitation.

Beyond acute injuries, trafficking creates or exacerbates chronic health conditions, with 45% of survivors reporting at least one chronic disease and over a third reporting chronic pain, back problems, or neuropathy—often resulting from forced labor, prolonged physical abuse, or lack of medical care during exploitation. Substance use disorders was reported by more than one-third of survivors, frequently stemming from trafficker-forced drug use as a means of control, creating an additional layer of medical complexity that requires specialized, trauma-informed treatment approaches.

The data underscores that effective anti-trafficking responses must integrate robust medical partnerships and survivor-centered healthcare access as foundational elements of identification, stabilization, and long-term recovery.

MEDICAL NEEDS STATISTICAL ANALYSIS (n=1,264)	
CONDITION	**PERCENT**
REPORTED MENTAL HEALTH CONDITIONS	
PTSD/Complex Trauma	59.3%
Depression	51.4%
Anxiety Disorders	53.8%
Suicidal Ideation/Self-Harm	33.2%
Bipolar/Mood Disorders	22.2%
Psychotic Disorders	14.2%
Dissociative Disorders	6.7%
Eating Disorders	7.3%

CONDITION	PERCENT
REPORTED PHYSICAL TRAUMA	
Physical Assault Injuries	45.9%
Broken Bones/Fractures	25.3%
Traumatic Brain Injury	22.9%
Sexual Trauma/Injuries	19.0%
Strangulation Injuries	8.7%
REPORTED NEUROLOGICAL CONDITIONS	
Seizure Disorder/Epilepsy	14.6%
Memory/Cognitive Issues	15.4%
REPORTED DEVELOPMENTAL CONDITIONS	
ADHD	10.7%
Autism Spectrum	3.8%
Intellectual/Developmental Disability	8.3%
REPORTED CHRONIC DISEASES	
Diabetes	7.5%
Asthma	9.9%
Heart Conditions	6.2%
HIV/AIDS	3.3%
Cancer	3.0%
Lupus	1.7%
Fibromyalgia	2.8%
Thyroid Conditions	4.1%
Hepatitis	2.2%
REPORTED SUBSTANCE USE	
Substance Use	38.4%
Medication-Assisted Treatment	9.9%

CONDITION	PERCENT
REPORTED PAIN CONDITIONS	
Back/Spine Injury	33.2%
Chronic Pain/Neuropathy	23.3%
Arthritis/Joint Problems	13.8%
Migraines/Headaches	11.1%
REPORTED FUNCTIONAL LIMITATIONS	
Mobility Limitations	17.0%
Vision Issues	9.3%
Hearing Issues	2.8%
Dental Needs	15.4%
OTHER	
Pregnancy	9.4%
Service/Support Animal	3.6%
No Specialized Needs Documented	4.0%

As seen in the overall health data, survivors report many healthcare considerations when they exit a trafficking situation. For instance, survivors report substantial functional limitations that affect daily living: 17% report mobility limitations requiring wheelchair access or other accommodations, 15.4% report pressing dental needs causing pain and affecting nutrition, 9.3% report vision impairments, and 2.8% report hearing issues—all barriers to employment, housing access, and basic quality of life that programs rarely account for in their design.

Medical complexity is the norm, not the exception: only 11.5% of survivors report having a single medical condition, while 88.5% report managing multiple co-occurring conditions and 58.4% report simultaneously navigating four or more health issues, with the **average survivor juggling 4.2 conditions requiring coordinated care across multiple providers and specialists**. Care gaps are severe and pervasive—58.5% of survivors report having untreated or undertreated conditions, 55% carry the consequences of medical neglect or abuse that occurred during trafficking, 41.1% report conditions serious enough to require hospitalization, and nearly one-third (32.4%) need surgical intervention.

These are not survivors who need occasional medical referrals; they require intensive healthcare navigation, care coordination, insurance advocacy, and programs built around the assumption that medical appointments, treatment adherence, and health crises will be constants in their recovery journey, not occasional disruptions to the "real work" of employment and life skills training.

PREGNANCY NEEDS

1 in 10 survivors requesting services are pregnant, with nearly 1 in 5 Transitional Aged Youth survivors being pregnant, including minors. These are not planned pregnancies in supportive circumstances—they are the result of trafficking exploitation.

All Age Groups: 9.4%

- Adults: 7%
- Minors: 11%
- Transitional Aged Youth (18-24): 19%

Of the 1,264 survivors analyzed, 9.4% are pregnant. Most of these pregnancies are occurring without prenatal care while survivors are still being trafficked or immediately after escape. Survivors enter services managing high-risk pregnancies complicated by trauma, substance use disorders, untreated STIs, malnutrition, and the absence of any medical support during gestation. Yet few anti-trafficking programs account for the reality that a significant portion of survivors—particularly young survivors—are navigating recovery from trafficking while pregnant or caring for infants, requiring coordinated obstetric care, pediatric support, trauma-informed parenting resources, safe housing for families, and advocacy with child welfare systems that may not distinguish between trafficking and voluntary parenting choices.

SURVIVOR SUPPORT CONSIDERATIONS

The 9-19% pregnancy rate means that almost 1 in 10 survivors (and nearly 1 in 5 Transitional Age Youth) require:

- Immediate prenatal care
- OB/GYN services
- Trauma-informed maternity and birth care
- Potentially high-risk pregnancy management
- Decisions about pregnancy continuation
- Parenting support or adoption planning

Beyond pregnancy related information, many survivors reference severe reproductive coercion as a trafficker control mechanism, including forced abortions. The intersection of forced abortion with other traumas underscores the complexity of survivor needs. Medical emergencies, like a septic abortion, highlight life-threatening risks when reproductive healthcare is inaccessible or delayed.

Critical Action Items:

- Integrate a human trafficking screening into pregnancy help organizations & abortion providers
- Develop abortion survivor support groups
- Advocate for healthcare access regardless of ID/insurance status to avoid blackmarket abortions
- Train staff on trauma-informed reproductive health discussions

These cases represent survivors who experienced profound violations of bodily autonomy within trafficking exploitation. Each case demands comprehensive, survivor-centered response addressing immediate safety, medical care, and long-term healing.

MENTAL HEALTH

The psychological impact of trafficking is widespread and clinically significant. Among survivors served, 86.9% have at least one documented mental health diagnosis, while only 13.1% have no identified condition at intake.

A consistent trauma-related clustering pattern emerges in the data analyzing 4,338 survivors. Approximately 10.9% of survivors report a three-condition trauma profile simultaneously, and 22.5% experience this triad alongside additional diagnoses. This pattern reflects the cumulative psychological effects of prolonged coercion, instability, and abuse.

These reports indicate a level of psychiatric acuity that exceeds standard outpatient counseling models. Effective response systems require access to licensed mental health professionals, psychiatric medication management, and long-term therapeutic continuity capable of addressing complex, trauma-related mental illness.

Universal Impact: 86.9% Report Mental Health Diagnoses

Only **13.1%** have no reported diagnosed mental health condition

- **86.9%** report at least one diagnosis
- **65.8% report** multiple diagnoses

Average: 2.8 diagnoses reported per survivor

Severe Mental Illness Indicators:

- Bipolar: 20.3%
- Borderline Personality Disorder: 10.4%
- Dissociative Identity Disorder: 5.4%
- Schizophrenia: 5.4%
- Bipolar + Schizophrenia: 1.6%

THE "TRAUMA TRIAD" - The Core Pattern

Top 3 Diagnoses:

- **Anxiety**: 63.5%
- **Depression**: 54.3%
- **C-PTSD**: 51.6%

The exact combination "Anxiety + C-PTSD + Depression":

- Most common pattern: 1 in 9 survivors
- With additional diagnoses: 22.5%

Count of Diagnoses	Percent
0 diagnoses	13.10%
1 diagnosis	21.10%
2 diagnoses	21.70%
3 diagnoses	20.30%
4 diagnoses	14.10%
5 diagnoses	6.70%
6+ diagnoses	3.10%

The "Dissociative Cluster" (DID* Cases):
When Dissociative Identity Disorder is present:

- Average of 5.2 diagnoses (highest complexity)
- 94% also report Anxiety
- 91% also report Depression
- 89% also report C-PTSD
- 43% also report BPD
- DID* indicates chronic, severe childhood trauma.

The "Psychosis Cluster" (Schizophrenia):
When Schizophrenia is reported:

- 82% also report Anxiety
- 76% also report Depression
- 71% also report C-PTSD
- 45% also report Bipolar
- Note: Some may be severe trauma cases or other conditions with psychotic features misdiagnosed as schizophrenia.

Bipolar Disorder

- Often co-occurs with anxiety and depression
- Concern: May be complex PTSD with mood dysregulation misdiagnosed as bipolar

Borderline Personality Disorder

- Significant symptom overlap with C-PTSD (both trauma-based)
- When BPD is reported, average increases to 4.2 diagnoses
- BPD + Bipolar combination: 89 cases (clinically complex)
- Concern: May be complex PTSD or survival-based behaviors misdiagnosed as BPD

URGENCY INDICATORS:

- Recent hospitalizations
- Emergency surgeries needed
- Active medical crises
- Untreated serious conditions
- Medication running out
- Withdrawal symptoms

KEY IMPLICATIONS | PSYCHIATRIC CARE AS CORE INFRASTRUCTURE

Psychiatric care is foundational to effective survivor services. The prevalence of multiple, co-occurring mental health conditions requires integrated treatment approaches that address PTSD, depression, anxiety, and related disorders concurrently rather than in isolation.

Trauma-focused therapy provides the clinical base upon which stabilization, employment readiness, housing support, and life skills development depend. Without addressing the neurobiological and psychological impacts of exploitation, other interventions often fail to gain sustained traction.

Medication management is frequently necessary to support emotional regulation, sleep, and cognitive stability, enabling meaningful participation in therapy and case planning. For many survivors, psychiatric support is not short-term; it involves ongoing management beyond the 6–12 month timelines typical of many programs.

These findings support care models in which psychiatric providers, therapists, medical professionals, and case managers operate in coordinated systems rather than fragmented silos. Integrated, multidisciplinary approaches are better aligned with the complexity and duration of trauma recovery.

Reasons for Hospitalization:

Based on analysis of 1,264 Survivors.
Among those who report hospitalization:

- Mental health crisis: **33.1%**
- Physical assault injuries: **27.6%**
- Suicide attempt/ideation: **22.0%**
- Medical emergency: **14.2%**
- Sexual assault: **11.8%**
- Overdose: **9.4%**
- Pregnancy/childbirth: **6.3%**

BARRIERS TO CARE:

- Insurance issues (lack of coverage, expired, transitioning between states)
- Medical records inaccessible or falsified by traffickers
- Missed appointments due to trafficking situation
- Interrupted treatment/medication
- Difficulty accessing specialists
- Transportation barriers

FREQUENCY IN WHICH INPATIENT MENTAL HEALTH OR MEDICAL CARE IS REQUIRED

AGE GROUP	% OF AGE GROUP
Adults	**11%**
Minors	**28%**
Transitional Age Youth	**12%**

Minors are 2–3× more likely to require in-patient care

- Acute psychiatric needs
- Developmental crises
- System failure prior to identification
- Reinforces the need for licensed clinical integration in Transitional Age Youth programs

NEEDS OF MINORS REQUIRING INPATIENT CARE (UNDER 18)

- Developmental conditions care (ADHD, autism)
- Behavioral health treatment
- Services for serious physical injuries
- Pediatric specialists
- Educational accommodations
- Family involvement in care

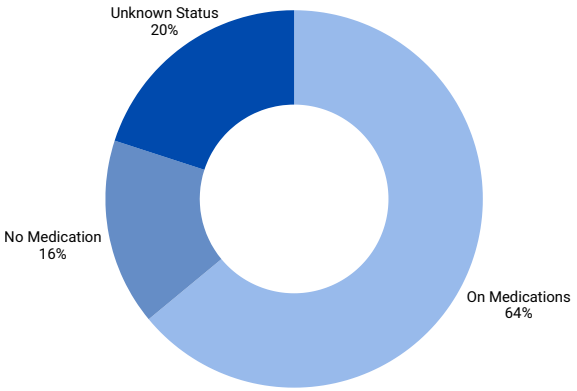
NEEDS OF TRANSITIONAL AGE YOUTH REQUIRING INPATIENT CARE (18-24)

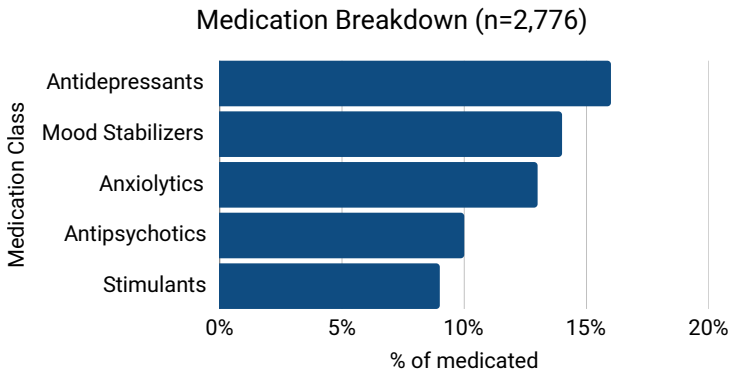
- Care for mental health crises
- Substance use treatment
- Pregnancy considerations
- Assistance transitioning to adult care
- Independence in care management
- Need for age-appropriate services

NEEDS OF ADULTS REQUIRING INPATIENT CARE (25+)

- Most complex medical presentations
- Chronic disease burden is highest
- Care for long-term untreated conditions
- High rates of permanent disability
- Cardiovascular disease common

MEDICATION STATUS OVERVIEW (N=4,338)





MEDICATION COMPLEXITY (POLYPHARMACY)

- **4+ medication classes:** 7% — high clinical acuity requiring intensive management
- **3 medication classes:** 12% — significant psychiatric comorbidity
- **2 medication classes:** 21% — common dual-diagnosis patterns

Most common complex regimen:

- Mood stabilizer + antipsychotic + anti-anxiety + antidepressant, typically associated with severe mood dysregulation and layered trauma-related symptoms.

ADDITIONAL MEDICAL CONCERNS

- **Substance Use Disorder**: 5% report Suboxone/Methadone for opioid addiction treatment
- **Physical Health Medications**: 14% report diabetes, chronic pain, or hormones.
- **Youth & Minors**: 17% report psychiatric medications, many on complex multi-drug regimens

The finding that **60% of survivors report use of psychiatric medication**, with **40% on multiple medications** and **10% prescribed antipsychotics,** reflects significant clinical acuity within the population served. These prescriptions are commonly associated with PTSD, depression, bipolar disorder, and other serious mental health conditions linked to prolonged trauma and instability.

Many service models prioritize rapid employment or short timelines, yet survivors frequently manage:

- Medication side effects affecting daily functioning
- Ongoing medical and psychiatric appointments
- Periods of destabilization
- Chronic conditions requiring long-term care

Additionally, **269 survivors reported "Other" for physical health conditions**, suggesting that medical complexity may be under-captured in traditional reporting structures.

Stability requires:

- Integrated medical and behavioral health partnerships
- Ongoing healthcare access and care coordination
- Program flexibility to accommodate clinical realities

Service systems must align expectations with the documented medical complexity of the population served rather than relying solely on time-limited or employment-based benchmarks.

REPORTED MEDICATION OVERVIEW BY AGE & TYPE				
Medication Type	**Adult**	**Transitional Age Youth**	**Minor**	**Total**
Anti-Anxiety	15.50%	14.50%	12.90%	15.10%
Anti-Depressant	14.70%	14.50%	16.10%	14.80%
Sleep Aids	7.00%	7.50%	7.50%	7.10%
Mood Stabilizer	6.00%	8.80%	4.30%	6.30%
Anti-Psychotic	5.70%	6.30%	5.40%	5.80%
Stimulants	5.30%	7.50%	0%	5.20%
Pain Killers	5.20%	5.00%	8.60%	5.50%
Cannabis	4.10%	1.30%	3.20%	3.60%
Benzos	3.00%	4.40%	1.10%	3.10%
Suboxone	2.70%	1.90%	3.20%	2.60%
Injectable	2.30%	1.30%	2.20%	2.10%
Narcotics	1.30%	0.60%	2.20%	1.30%
Methadone	0.90%	1.90%	1.10%	1.10%
Hormones	0.90%	0.60%	0%	0.80%
None	25.50%	23.90%	32.30%	25.90%
n	788	159	93	1,040

The psychiatric diagnoses in this dataset were self reported by the survivors themselves or their referring advocate and therefore may not fully reflect trauma-informed assessment. Research shows significant overlap between complex trauma responses and conditions such as borderline personality disorder, schizophrenia, and bipolar disorder. Many survivors were diagnosed before their trafficking history was known or within systems unfamiliar with trafficking's neurobiological impact.

This does not invalidate survivors' reported diagnoses or their need for psychiatric care. However, it highlights the importance of trauma-informed evaluation to distinguish primary psychiatric disorders from trauma responses. Accurate assessment can improve treatment alignment and reduce unnecessary polypharmacy while maintaining appropriate medication support where needed.

TRAFFICKERS MOTIVATIONS

Every control tactic a trafficker uses is an indictment of a support system that should have been there first. Traffickers use an average of 2.3 control tactics per victim—layering psychological manipulation, economic coercion, and physical threats to trap individuals in exploitation.

Human trafficking is a calculated business model that weaponizes human survival needs. Yes, human traffickers must be held accountable, but there is also the harsh reality that they didn't create the vulnerability that made exploitation possible. Society did. Through housing instability, family separation, economic desperation, and failed systems of care. Trafficking exists because society creates the conditions that traffickers profit from. Real solutions require us to address root causes, protect victims, and prosecute traffickers and buyers, and must reinforced by policy and partnership.

Of the 4,338 cases analyzed, 2,540 (58.8%) documented the traffickers' motivations and control mechanisms as reported by the victim or advocate.

Exploitation Mechanism (n=2,540)	Percent	What It Tells Us
Housing or survival coercion	53.40%	Homelessness is the primary vulnerability exploited
Violence or threats of harm	38.30%	Fear sustains control after dependency is established
Financial control or monetary coercion	23.00%	Profit is the central motive
Familial trafficking involvement	22.30%	Trust is weaponized through relational manipulation
Substance use coercion	18.90%	Substance dependency reinforces control
Debt bondage	11.90%	Debt coercion (“you owe me”) creates ongoing entrapment
Romantic Manipulation	11.40%	The “Romeo” model remains a common recruitment strategy

Note: traffickers use an average of 2.3 control mechanisms per victim, so cases align to multiple exploitation mechanisms.

What this data reveals is that traffickers are strategic, not opportunistic. They identify existing vulnerabilities—homelessness, substance use disorders, prior trauma, immigration status, family instability—and systematically exploit them for profit. The documented control mechanisms show calculated patterns: offering housing to the unhoused, providing drugs to those with addiction, promising family to those separated from loved ones, and threatening deportation to undocumented individuals. These aren't random acts of violence. They're business strategies built on the gaps in our social infrastructure. When 58.8% of cases clearly document these patterns, we're not looking at isolated criminal behavior—we're looking at a model that thrives because we've left people without alternatives. Disrupting trafficking means disrupting the conditions that make these control mechanisms effective.

A TRAFFICKER'S CALCULAITON: THE BUSINESS MODEL

FIND: Person experiencing homelessness / Youth who has runaway / Person experiencing addiction / Person recovering from abuse
OFFER: Housing / Drugs / "Love" / Protection
CREATE: Dependency (can't leave without losing survival need)
ENFORCE: Violence + Isolation + Threats
PROFIT: $200-1,000/day per victim × 365 days = $73,000-365,000/year
SCALE: Multiple victims = Exponential profit

OVERHEAD: Near zero (victim's own survival pays costs)
RISK: Low (victim fear, low enforcement, stigma)
REWARD: Massive financial gain

= SUSTAINABLE, SCALABLE BUSINESS

THE MULTI-TACTIC SOPHISTICATION:

Most Common Combinations:
1. Housing + Violence - Offer shelter, use force to control
2. Financial + Housing - Economic coercion
3. Drugs + Housing - Layered dependency
4. Financial + Housing + Violence - Complete control system

Why multiple tactics:
- Redundancy - If victim resists one, another activates
- Compounding - Each makes others more effective
- Customization - Different victims, different vulnerabilities
- Escalation - Start soft (romance), end hard (violence)

TRAFFICKING EXISTS BECAUSE SOCIETY CREATES VULNERABILITY, AND TRAFFICKERS EXPLOIT IT FOR PROFIT.

THE "WHY" IS SIMPLE: IT WORKS. UNTIL WE MAKE IT NOT WORK, IT WILL CONTINUE.

For transitional age youth, the top reported areas of need and vulnerability include housing (58.1%), violence (33.2%), family instability (24.9%), financial insecurity (19.4%), and substance use (16.2%). A critical inflection point occurs at age 18, when foster care support often ends— leading to homelessness and significantly increasing the risk of trafficking. Youth aging out face immediate vulnerability, often without credit history, rental history, or consistent family support to help them secure stable housing or employment. This lack of support creates conditions that traffickers readily exploit.

For adults, the top reported vulnerabilities include housing (58.2%), violence (41.5%), financial instability (24.6%), substance use (19.5%), and family instability (19.1%). Chronic homelessness combined with domestic violence significantly increases susceptibility to exploitation, with survival sex often evolving into trafficking. Often, an individual presents as a "helper" by offering housing or financial support, ultimately becoming the trafficker, leveraging that dependency for control and exploitation.

System Changes to End Trafficking:
- **Eliminate vulnerability** → Housing, economic support, family stability
- **Interrupt exploitation** → Early identification, rapid intervention
- **Break control systems** → Comprehensive wraparound services
- **Stop victim-blaming** → Understand coercion mechanics
- **Increase consequences** → Prosecute traffickers, not victims
- **Reduce profit** → Seize assets, reduce demand

WHY VICTIMS SAY THEY CAN'T "JUST LEAVE":

HOUSING DEPENDENCY	VIOLENCE THREATS	DRUG ADDICTION	FAMILY BETRAYAL	ISOLATION	"DEBT" THEY "OWE"
53.4%	38.3%	18.9%	73.9% OF MINORS	5.6%	11.9%

LEAVING = Homelessness + Violence + Withdrawal + Isolation + Debt collection + Unknown danger
STAYING = At least have shelter + Known danger + Can survive another day
RESULT: Stay (not a "choice" - survival math under duress)

TOP 5 RECOMMENDATIONS TO REDUCE TRAFFICKERS' CONTROL

1 Housing first = trafficking prevention

- Homelessness prevention IS trafficking prevention
- Rapid rehousing programs essential
- No one should need to trade sex for shelter

2 Family reunification requires careful, individualized assessment

- Safety planning must include screening family members for potential involvement, coercion, or facilitation, rather than assuming harm or safety.
- Ongoing family connection may be possible and appropriate in some cases, even when returning to the home environment is not immediately safe.
- For a subset of survivors, reunification is not possible without significant risk, requiring alternative long-term care arrangements.

3 Integrated SUD+ Trafficking Treatment

- Irresponsible to address trafficking without addressing addiction
- Medication-assisted treatment is a critical option
- Harm reduction must be an option, not abstinence-only

4 Multi-system response required

- Average of 2.3 control tactics per victim
- Single intervention = failure
- Need: Housing + Mental health + SUD + Legal + Safety + Economic+ Community

5 Economic Empowerment Prevents Trafficking

- Jobs, education, financial literacy
- Living wage employment
- Economic independence = freedom

TRAFFICKERS MOTIVATIONS: FAMILIAL TRAFFICKING

Victims of familial trafficking being referred into residential safe house programs have complex needs due to the interpersonal trauma experienced at the hands of someone who should have protected them.

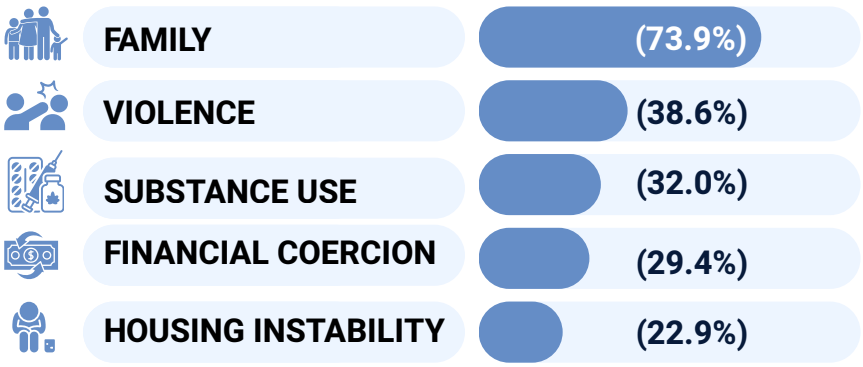
Nearly 3 in 4 minor trafficking cases being referred for residential care in our data set involve family members exploiting their own children.

This isn't the stranger danger narrative we've been conditioned to fear. The greatest threat comes from inside the home—from parents, guardians, and relatives who should be sources of safety and protection. Familial trafficking represents the ultimate betrayal: caregivers commodifying childhood, selling access to their own children for money, drugs, or to satisfy debt.

This statistic demolishes our comfortable assumptions about who traffickers are and where exploitation happens. It means a child can be trafficked without ever leaving home. It means the adults mandated to protect them are the ones profiting from their abuse. It means our child welfare systems, law enforcement, and healthcare providers must rethink how we identify and respond to trafficking.

When family is the threat, where does a child turn? Traditional interventions assume there's a safe adult to return to, a home to escape from, a clear line between perpetrator and protector. Familial trafficking erases those lines entirely. It requires us to build new frameworks—ones that recognize exploitation can look like "normal" family dysfunction, that escape might mean removing a child from everyone they know, and that long-term healing requires addressing intergenerational trauma, poverty, and the systemic failures that allow parents to see their children as commodities rather than people worthy of protection.

MINORS TOP 5:



"I WAS SOLD FOR SEX BEFORE I CAN REMEMBER BY MY GRANDPA, AND MY MOM PIMPED ME OUT AND HAD PEOPLE MOLEST AND RAPE ME MY WHOLE LIFE..."

Minor Data Disclaimer: The minor data reflects individuals referred for out-of-home or safe home placement. As a result, the dataset skews toward cases involving familial trafficking or unsafe home environments. In situations where parents or caregivers are not involved in the exploitation and maintain custody, youth often have lower acuity needs and may be appropriately supported through community-based or in-home services rather than residential placement. These cases are therefore underrepresented in this dataset.

DIGITAL RECRUITMENT & ONLINE EXPLOITATION

Today's predators hunt online and exploit in homes. Minors face 70% higher risk—yet private residences remain our blindest spot in the fight against trafficking.

12.6% of victims shared they were groomed online

Key Insights Regarding Kids:

- 13.5% of minor cases involve elopement after online contact from a predator
- School Chromebooks are being used to access dating apps despite age restrictions

Highest-Risk Platforms (n = 915)

- Instagram: 78.2%
- Snapchat: 33.3% minor involvement
- Dating applications: 33.3% minor involvement, indicating age-verification vulnerabilities
- Facebook: 18.9% minor involvement
- Gaming platforms (Discord, Roblox, Fortnite): 14.3% minor involvement, representing exposure pathways

Age-Based Risk Differentials

- Minors are 3× more likely than adults to have online exploitation transition into in-person meetings
- Minors are 2.2× more likely to be groomed online
- Minors are 1.9× more likely to experience sextortion

Grooming Patterns:

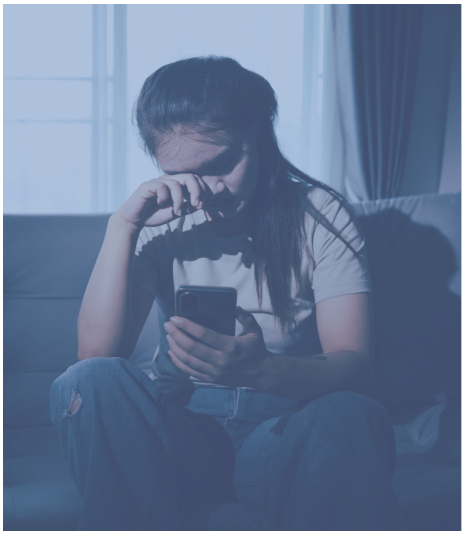
- Sextortion to blackmail to threats
- Recruitment to enticement language (job offers, modeling, “promised money,” etc.
- Online ads to “selling content.”

Sex Trafficking Patterns:

- Online ads to “selling content.”
- Tech-enabled control to monitoring to account access

Common Payment Types:

- CashApp
- Venmo/PayPal/Zelle/
- Crypto
- Gift Cards



Sextortion Escalation | Primary Grooming Pathway

This progression appears consistently in minor cases:

- Initial contact: Direct message, often via Instagram, from a peer-presenting account
- Grooming phase: Compliments, attention, and trust-building
- Image solicitation: Escalation to requests for explicit photos
- Sextortion: Threats to distribute images unless additional content is provided
- In-person meeting: Coercion into a physical meet-up
- Exploitation location: Private residence or hotel setting

23.4% OF MINOR CASES EXPLICITLY MENTION ONLINE PLATFORMS, YET THE ACTUAL DIGITAL FOOTPRINT IS MUCH HIGHER. DIGITAL SAFETY IS CRITICAL TO PROTECTING KIDS.

GANGS & ORGANIZED CRIME

Human trafficking can manifest through distinct organizational structures, including gang-controlled trafficking operations, organized crime networks that operate illicit massage businesses, and religious or occult-based trafficking patterns. Out of 3,605 total cases analyzed, 22.9% have intersection with such criminal enterprises.

KEY FINDINGS AGAINST ALL CASES:

- Organized Crime Indicators are the most prevalent pattern across the data, present in 16.84% of all cases
- Gang-Controlled Trafficking affects 2.69% of all cases, with highest prevalence among minors 4.05%
- Religious/Occult Trafficking represents 3.36% of all cases
- Illicit Massage Businesses are minimally represented in this dataset at only 0.06%, which aligns with victims recovered from IMBs often choosing not to pursue placement into residential care programs.

BREAKDOWN OF TYPE BY CASES WITH KNOWN ORGANIZED CRIME INVOLVEMENT

BREAKDOWN BY CONCERN TYPE

1. Gang-Controlled Trafficking
Direct trafficking operations controlled or facilitated by gang-affiliated individuals

Key Characteristics:

- Traffickers with active gang affiliation
- Recruitment through established gang networks
- Multiple victims trafficked within the same network
- Territory-based control and enforcement

Impact on Survivors:

- Inability to safely return to specific neighborhoods or cities
- Elevated risk of retaliation
- Exposure to multiple traffickers within a hierarchical structure
- Witnessing or experiencing gang-related violence

	ADULT (N685)	TAY (N112)	MINOR (N30)	ALL (N827)
GANG-CONTROLLED	10.95%	11.61%	30.00%	11.73%
ILLICIT MASSAGE	10.95%	0.00%	0.00%	0.24%
ORGANIZED CRIME	74.01%	75.00%	53.33%	73.40%
RELIGIOUS/OCCULT	10.02%	9.12%	11.51%	9.95%

2. ORGANIZED CRIME NETWORKS
Trafficking linked to structured criminal enterprises operating beyond individual actors

Structure Types

- Multi-state trafficking operations
- International organized crime networks
- Crime families or syndicates
- Complex, multi-layered criminal enterprises

Common Elements

- Connections extending into formal systems or institutions
- Sophisticated tracking and surveillance methods
- Multi-generational involvement
- Money laundering activity

Gangs and Criminal Organizations Identified
The following groups were referenced in case documentation:

- Mexican cartel-affiliated operations (unspecified)
- Sinaloa Cartel
- Jalisco Cartel
- MS-13
- Bloods
- Crips
- Aryan Brotherhood
- Folk Nation
- Mongols
- G-Unit Riders

Note: References reflect survivor-reported or case-documented affiliations and do not constitute verified organizational attribution in all instances.

MINORS AND TRANSITIONAL-AGE YOUTH: KEY PATTERNS

- Recruitment through social media platforms and peer networks
- Family gang involvement creating pressure or normalization, including parental coercion
- Immigration status leveraged in combination with gang threats
- Juvenile justice system involvement
- Movement from detention settings into gang recruitment pathways

Adults: Key Patterns

Long-Term Gang Entrenchment

- Deep integration within gang-controlled operations
- Multiple relocation attempts unsuccessful

Elevated Protection Needs

- FBI or federal case involvement
- Active threats to life
- Multi-state pursuit
- Inability to safely return to multiple states

Coordinated Tracking and Surveillance

- Survivors located repeatedly across state lines
- Use of sophisticated monitoring methods, including:
  - Compromised phones or email accounts
  - GPS tracking
  - Social media monitoring

Organized Crime Integration

- Multi-state or international operational reach
- Allegations of institutional or law enforcement corruption in select cases

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Major Barriers

Safety and Shelter Constraints

- Limited staff training in gang-related threat assessment
- Lack of secure or confidential placement options
- Inability to remain safely within the same city or state

Law Enforcement Complications

- Fear of retaliation for reporting gang involvement
- Distrust stemming from perceived corruption or past negative interactions
- Coordination challenges between federal and local law enforcement
- Allegations of gang connections within local enforcement structures in select cases

Relocation Barriers

- Inability to return safely to entire cities or regions
- Gang territorial reach spanning multiple states
- Limited placement options that meet safety criteria

Long-Term Program Gaps

- Few residential or long-term programs equipped to manage gang-level threat risk
- Limited availability of gang-specialized, trauma-informed therapy
- Absence of long-term protection mechanisms for non-federal cases

Technology and Digital Safety Concerns

- Compromised phones, devices, or online accounts
- GPS tracking devices placed on vehicles or belongings
- Limited digital safety and cybersecurity training for survivors

HUMAN TRAFFICKING VENUES

Survivors reveal exactly where trafficking occurs and enable targeted industry intervention, staff training, and technology deployment where exploitation actually happens rather than where assumptions suggest it might.

The following data reflects the venues where survivors reported trafficking occurred at time of intake. Of the cases analyzed, 1,983 cases reported primary sex trafficking venues and 210 identified primary labor trafficking venues.

PRIMARY Venue for Sex Trafficking

Venue Type	% of Total
Hotel/Motel	49.06%
Private Residence (including vacation rentals)	34.10%
Street or Public Space	29.81%
Online/Digital Platforms	8.92%
Adult Entertainment Venue	2.87%
Truck Stop or Rest Area	1.06%
Escort Service or Agency	0.66%
Massage Parlor	0.23%

PRIMARY Venue for Labor Trafficking

Venue Type	% of Total
Domestic Work	70.95%
Retail	13.81%
Agriculture	8.10%
Restaurant or Food Service	3.33%
Factory or Manufacturing	1.43%
Nail Salon	0.95%
Construction	0.95%
Landscaping	0.48%

SEX TRAFFICKING KEY INSIGHTS

Hotel/Motel Sector Dominate

- Hotels are a less common venue for minor trafficking, reporting 35.2% of cases where the location is known.
- Reinforces the importance of sustained hotel industry training and partnerships
- Confirms Simply Report integration with the hospitality sector as a critical intervention point

Residential Settings Show Consistent Risk

- Disproportionately impact minors cases due to familial trafficking
- Reflect a shift toward private, harder-to-detect locations
- Point to the need for community-level awareness and neighbor-based reporting mechanisms

Street "Blade" Trafficking Remains a Significant Venue

- Often associated with survival-based coercion and gang-controlled trafficking
- Suggests overlap with housing instability and public-space vulnerability
- Indicates the continued importance of street outreach, law enforcement coordination, and community-based intervention strategies

LABOR TRAFFICKING KEY INSIGHTS

Enhanced Labor Trafficking Detection Required:
Labor trafficking is significantly underidentified within residential referral datasets, with only 2.9% of cases documented.

- Develop labor trafficking-specific identification and screening protocols for healthcare systems, specifically free and charitable clinics.
- Conduct outreach focused on domestic work and informal labor settings
- Partner with labor departments, worker advocacy organizations, and regulatory agencies
- Develop multilingual identification and reporting materials
- Expand training for labor inspectors, workplace safety officials, and frontline employment regulators

MULTI-VENUE SEX TRAFFICKING OPERATIONS ANALYSIS

- **RESIDENCE + STREET: 42.8%**
  - Suggests deliberate risk balancing — public exploitation generates revenue; private settings reduce detection.
  - Implies enforcement pressure in one environment may displace activity into the other rather than stop it.
- **HOTEL/MOTEL + RESIDENCE: 19.8%**
  - Hotels likely serve as high-volume transaction sites.
  - Residences provide privacy and reduced third-party oversight.
  - This pattern suggests deliberate logistical coordination rather than opportunistic exploitation.
- **ONLINE/DIGITAL + RESIDENCE: 9.4% (CONSISTENT WITH PREVIOUS 9%)**
  - CRITICAL: 32.1% of Minor multi-venue cases
  - Minors are 4x more likely than adults to show this pattern
  - Recruitment and coordination occur online.
  - Exploitation occurs in private residential spaces.
  - This reduces public visibility and bypasses traditional street-level detection.

Data Limitations:

- Findings must be interpreted within the context of a dataset limited to individuals referred for residential services
- Venue identification is based on case narrative descriptions, which were not included in all cases
- Sex trafficking survivors are more likely to be referred for residential placement due to higher-acuity safety, medical, and stabilization needs, increasing documentation
- Labor trafficking survivors are more often served through non-residential or employment-focused interventions
- As a result, the low identification rate likely reflects limits in the data rather than true prevalence
- Digital and online venues are likely underidentified, as they are inconsistently captured in case narratives that tend to prioritize physical locations.
- Data reflect self-reported and advocate-reported information, which may vary in completeness and specificity

HUMAN TRAFFICKING IN HOSPITALITY

Two-thirds of adult sex trafficking and 17% of minor sex trafficking occur in hotels. It's happening in their rooms, on their shifts, under their roofs. It is a critical place for intervention.

- **Adults (67%)** show patterns consistent with hotel-based commercial sexual exploitation,
- **Minors (17%)** show patterns where hospitality functions as a temporary containment and movement tool, especially before system intervention.
- **n = 4,338**

HOSPITALITY - ADULT PATTERNS

Adult trafficking associated with the hospitality sector typically involves:

- Repeated short hotel stays, with properties used as rotating venues for trafficking
- Consistent movement across cities or state lines to evade detection
- In-Call venue for commercial sexual exploitation

HOSPITALITY - MINOR PATTERNS

For minors, hotels are used in materially different ways than in adult contexts. The data indicates that hotels most frequently function as:

- Holding locations for out-call exploitation in residential settings, including short-term rentals
- Transition points rather than primary exploitation venues
- Lodging during elopement or missing episodes

Comparison Area	Adults	Minors / Youth
Primary hospitality role	Venue for exploitation	Holding or transition space
Connection to commercial sex	Direct and ongoing	Present, often at earlier stage
Pattern of hotel stays	Repeated, cyclical use	Short-term, pre-identification
Visibility to hotel staff	Mid-Low (normalized behavior)	Very low (controlled movement)
Identification point	Self-referral, outreach	Hospitals, systems
Data visibility	Indirect	Highly masked

Hotels are critical places for:

- Exploitation sites where commercial sex occurred
- Housing paid for by traffickers or buyers
- Connecting victims with exploiters
- **Intervention by law enforcement**

Hotel Types Most Frequently Involved:

- Budget/economy chains
- Extended-stay facilities
- Interstate exit properties
- Airport-adjacent hotels

Geographic Hotspots:

- Charlotte, NC: Concentrated activity along the I-85 corridor
- Los Angeles, CA: Figueroa Street motels and transit-adjacent hotels
- Interstate corridors: Exit hotels along I-85, I-95, I-10, and I-40
- Major metropolitan areas: Dallas, Atlanta, Houston, and Orlando, particularly near tourism and theme park zones

Mechanism	How It Works
Anonymous Transactions	Cash payments, no questions asked, short-term stays appear routine
Geographic Mobility	Interstate chains facilitate moving victims between cities/states
Physical Isolation	Removes youth from schools, neighbors, community oversight
Digital Facilitation	Online ads list hotel locations; rooms become transaction sites
Financial Invisibility	Cash economy prevents paper trail linking adults to minors
Training Gaps	High turnover, minimal trafficking awareness, no reporting protocols

SYSTEM FAILURES:

- **Profit over protection:** Revenue concerns discourage scrutiny of paying guests
- **Lack of reporting protocols:** Staff lack clear guidance on how to respond to indicators
- **Liability concerns:** Misperception that avoiding knowledge reduces legal risk
- **Corporate–franchise disconnect:** National policies inconsistently implemented at property level
- **Normalized desensitization:** Repeated exposure in high-traffic areas reduces sensitivity to patterns

RECOMMENDED INVESTMENT

- Comprehensive identification and reporting training for all staff
- Clear, enforceable reporting protocols for employees and guests
- Early-identification technology to detect patterns across properties

FINANCIAL IMPACT

- A single avoided civil lawsuit can exceed the total cost of implementation, significantly reducing long-term liability exposure

COSTS OF INACTION:

- **Civil liability:** Increasing survivor lawsuits resulting in multi-million-dollar settlements
- **Criminal exposure:** Risk of charges for benefiting from trafficking activity
- **Reputational damage:** Public exposure erodes brand trust and corporate credibility
- **Lost revenue:** Consumers avoid properties associated with trafficking

HUMAN TRAFFICKING IN TRANSPORTATION

Transportation sector involvement affects roughly 22% of survivors overall, but the transportation methods, risk dynamics, and intervention opportunities vary markedly by age group.

The data indicate a clear need for age-differentiated transportation intervention strategies implemented in parallel, alongside a coordinated aviation protocol applicable across all age groups. Rather than applying a uniform model, effective anti-trafficking efforts in the transportation sector must be calibrated to reflect distinct exposure patterns across age groups.

Type	Minors (under 18)	Transitional Aged Youth	Adults (25+)	Primary Risk Group
All Forms	21.98%	22.03%	22.13%	All
Aviation	20.72%	16.93%	16.97%	Minors (+22% higher)
Trucking	0%	0%	1.80%	Adults only
Public Transit Hubs	6.76%	9.14%	8.61%	TAY (highest visibility)
Rideshare	1.80%	0.19%	0.52%	Minors (3.5x higher)
Highway/Interstate	low	low	significant	Adults (68% higher)
n = 3,605	222	514	2,869	

For minors, intervention priorities should center on aviation sector coordination, recognizing their disproportionately high exposure to air travel within trafficking operations. This must be paired with rideshare platform engagement and the development of safety mechanisms to address the documented pattern of digital recruitment followed by rideshare transport to exploitation sites. Additional focus should include airport-adjacent hospitality oversight and strengthened federal and interstate collaboration, given the organized, cross-jurisdictional nature of minor trafficking involving air travel.

Transitional-age youth require a strategy built around public transit system partnerships, reflecting their heightened visibility and independent mobility patterns in urban transit environments. Effective intervention demands urban service integration and coordination with homeless response systems, recognizing the intersection between transit-based trafficking exposure and housing instability. Age-transition stabilization supports represent a critical component, addressing the unique vulnerabilities faced by young adults navigating the shift from youth to adult service systems.

7 adult trafficking cases explicitly identified truck drivers as the traffickers themselves. These cases demonstrate how individuals within the trucking industry leverage their professional access, mobility, and isolation inherent to long-haul routes to facilitate trafficking operations.

Adult-focused strategies must prioritize trucking industry engagement and highway corridor interventions, given the documented involvement of truck drivers as traffickers and the use of interstate routes to facilitate control and isolation. Interstate Enhanced Collaborative Model coordination becomes essential for addressing the cross-jurisdictional movement patterns observed in adult cases. Monitoring of workforce housing and "man camp" environments represents an additional priority, particularly in regions with temporary industrial or extraction-related housing where trafficking to these sites has been documented.

Across all age groups, aviation sector coordination should remain a universal intervention point. The consistent exposure rates—approximately 17-21% across minors, transitional-age youth, and adults—combined with the interstate and international movement patterns associated with air travel, establish airports and airline partnerships as critical detection and intervention infrastructure regardless of survivor age. Transportation-sector anti-trafficking strategies must ultimately be evidence-informed and targeted rather than universally applied, with parallel age-specific approaches supported by coordinated cross-age protocols where exposure patterns warrant such integration.

Industry Patterns for Adult Cases:

Direct trafficker involvement

- Truck drivers use their occupation to transport survivors across state lines
- Coordinated networks of drivers transferring victims between routes

“Man camp” linkage

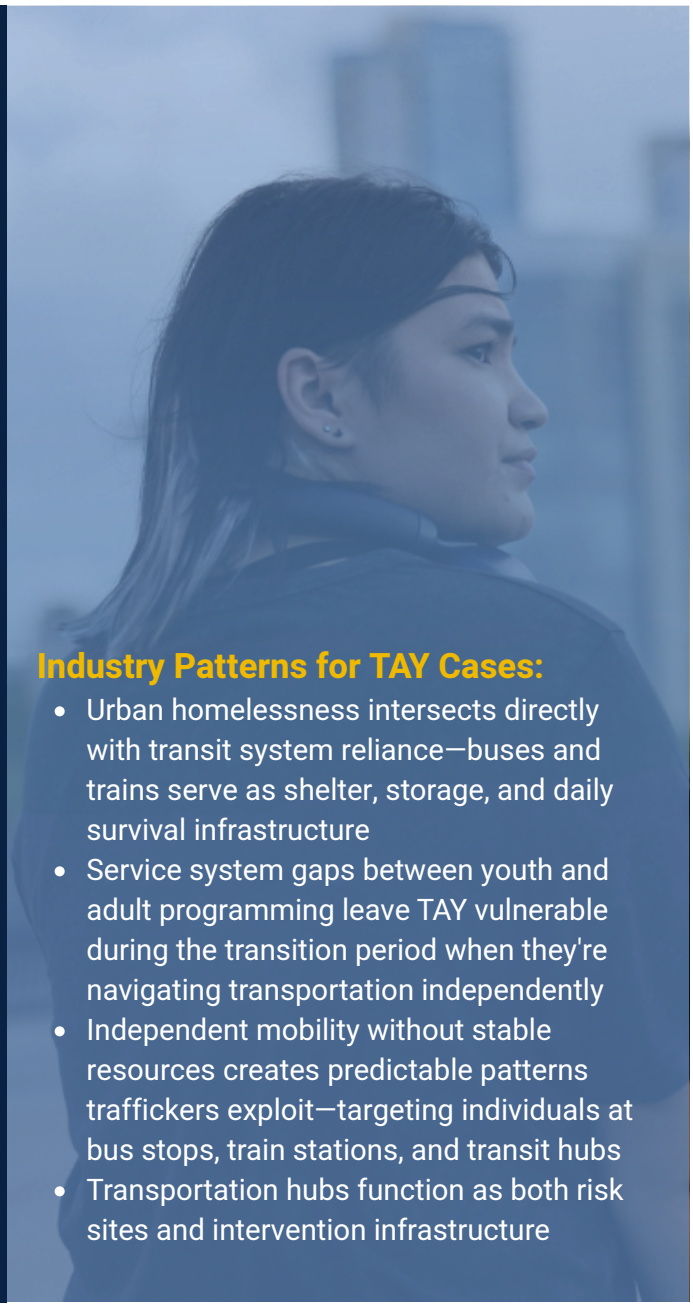
- Multiple cases reference trafficking to temporary workforce housing associated with industrial or extraction sites

Interstate pursuit and control

- Traffickers using semi-trucks to follow or monitor survivors
- Long-haul trucking routes facilitate prolonged isolation and control

Industry Patterns for Minor Cases:

- Trafficked through rideshare platforms rather than using rideshare independently—adults or traffickers coordinate transport, not the minors themselves
- Clear exploitation sequence: digital recruitment (social media, gaming platforms) → rideshare transport → hotel-based exploitation.
- Airport-adjacent hospitality becomes a critical intervention point where air travel and commercial lodging intersect
- Cross-jurisdictional movement triggers federal jurisdiction, requiring coordination between local, state, and federal agencies



Industry Patterns for TAY Cases:

- Urban homelessness intersects directly with transit system reliance—buses and trains serve as shelter, storage, and daily survival infrastructure
- Service system gaps between youth and adult programming leave TAY vulnerable during the transition period when they're navigating transportation independently
- Independent mobility without stable resources creates predictable patterns traffickers exploit—targeting individuals at bus stops, train stations, and transit hubs
- Transportation hubs function as both risk sites and intervention infrastructure

SAFETY-DRIVEN LOCATION RESTRICTIONS

Survivors can face geographic restrictions that limit service options due to safety concerns, legal constraints, or trafficker proximity.

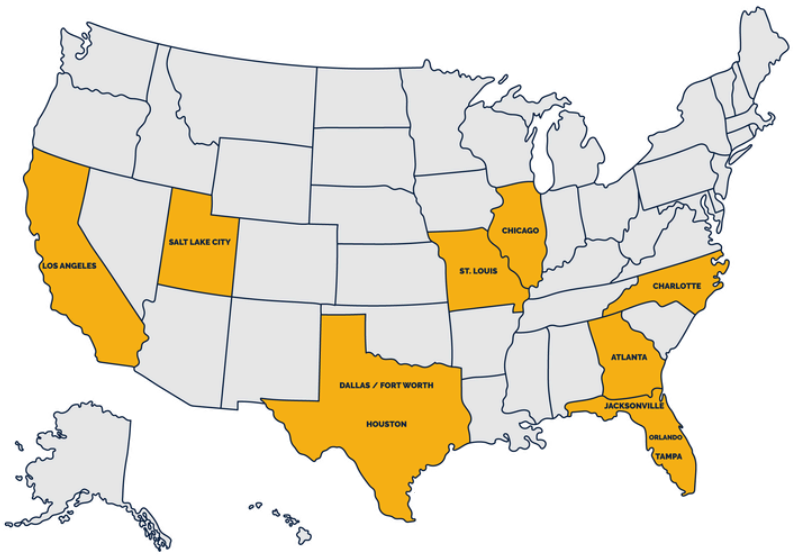
Geographic restrictions exist as a critical safety measure to protect survivors from active threats—keeping them beyond the reach of their traffickers, distancing them from areas where they remain vulnerable to re-exploitation, or shielding them from locations where trauma-triggering encounters could undermine their recovery and stability. Among the 4,338 cases analyzed, 90.3% had no geographic restrictions while 9.7% had geographic restrictions in place.

Rank	State	Percent
1	Texas	37.00%
2	California	34.10%
3	Florida	31.80%
4	Georgia	26.30%
5	New York	24.60%
6	North Carolina	23.00%
7	Ohio	22.00%
8	Illinois	21.10%
9	Nevada	19.90%
10	Washington	18.50%
11	Oklahoma	18.00%
12	Tennessee	17.80%
13	Pennsylvania	17.30%
14	Michigan	16.60%
15	Alabama	16.10%
16	Missouri	15.60%
17	Kentucky	15.60%
18	Virginia	15.40%
19	Arizona	15.40%
20	Kansas	14.90%
21	South Carolina	14.70%
22	Washington DC	14.50%
23	Indiana	13.70%
24	Utah	13.70%
25	Oregon	13.50%

Number of States Restricted (n=422)

- 1 state only: 41.5%
- 2–5 states: 22.5%
- 6–10 states: 10.7%
- 11–20 states: 8.3%
- 21–40 states: 5.9%

TOP CITIES TO AVOIDED



1. Atlanta
2. Charlotte
3. Jacksonville
4. Dallas / Fort Worth
5. Houston
6. Los Angeles
7. Salt Lake City
8. Chicago
9. St. Louis
10. Tampa
11. Orlando

Survivors avoid known trafficking corridors, not just states.

Cannot Leave (Legal / Financial Constraints)

- On probation/parole
- Pending criminal charges
- Court-ordered visitation
- Immigration or ID barriers
- Methadone clinic proximity
- Medical insurance limitations

These survivors are geographically limited, not resistant.

Cannot Go (Safety-Based Refusal)

- Known trafficker presence
- Prior exploitation occurring in the area
- Community-level collusion or enabling environments
- Family involvement in trafficking activity

MACRO TREND: "UNSAFE BY SYSTEM, NOT PREFERENCE"

The dominant theme is systemic unsafety, not personal preference.

Survivors are not saying "I don't like this place" — they are saying:

- I will be found
- I will be criminalized
- I will be medically harmed
- I will be erased (identity, gender, autonomy)

This is critical: placement failures are structural, not logistical.

REASON 1: Legal & State Power Risks

Survivors explicitly avoid states that:

- Restrict name changes / identity recognition
- Limit cross-state mobility

REASON 2: LGBTQ+ Non-Affirming Jurisdictions

Survivors report prior experiences in certain jurisdictions that include:

- Re-traumatization within service systems
- Denial of services
- Forced misgendering

Some survivors decline otherwise available placements if the program is not affirming.

REASON 3: Climate & Medical Unsafety

Survivors cite:

- Heat intolerance
- Humidity-triggered breathing issues
- Thermal dysregulation from injuries
- Inability to manage chronic illness in hot climates

Climate is a medical placement factor, not comfort.

SURVIVOR SERVICES

Data in this report is drawn from two sources. Field-wide figures — including disqualification criteria, specialized population access, medication policies, and housing configurations — are drawn from self-reported data from 557 open, anti-trafficking programs in the Safe House Project database as of February 2026. All programs indicated Sex Trafficking Specific Programming (99.6%) or closely related program types. Data was collected via intake forms completed by program representatives.

Program-level data on length of stay, completion rates, evidence-based model use, therapy provision, and lived experience integration are drawn from the 68 programs that applied to Safe House Project's 2025 housing grant cycle. Where figures are sourced, the dataset is noted.

The 68 programs in Safe House Project's 2025 grant applicant cohort are self-selected — they sought SHP funding, which means they were already aware of SHP, aligned with its mission, and motivated to pursue certification. This cohort likely skews toward more survivor-centered, LEE-engaged programs than the field at large. Comparisons between applicant data and Service Landscape Report data should be read with that in mind.

PROGRAM DESIGN: AGE BREAKDOWN

Three out of four residential programs are designed to serve adult female sex trafficking survivors, revealing significant unmet need across other victim profiles.

Programs were asked which age groups they serve. A single program may serve multiple age groups. The table below shows how programs break across three primary age categories.

Age Category	Programs	% of All (n=557)
Adults (18+)	425	76.30%
Minors (under 18)	140	25.10%
TAY (Transitional Age Youth 18–24)	83	14.90%

- 35 programs serve both adults and minors.
- TAY programs overlap substantially with adult-serving programs.

Adult Program Sub-Types	% of Adult-Serving (n=425)
Adults without dependents	97.90%
Adults with dependent toddlers (newborn to 3)	4.20%
Adults with dependent children within specified age ranges (newborn through program specific upper age limit)	5.90%

Minor Program Sub-Types by Custodial Status	% of Minor-Serving (n=140)
Minors currently in foster care	97.90%
Minors not in foster care (no program fees required)	35.70%
Minors not in foster care (program fees required)	16.40%

*Programs can fall into multiple categories above.

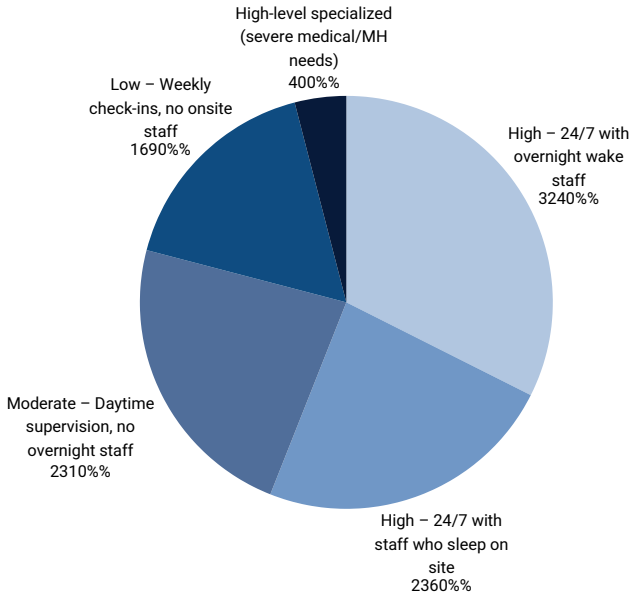
Key Finding: Minor Access Barriers
Nearly all minor-serving programs accept youth in state care (97.9%), but only 35.7% accept minors outside the foster system without charge. For non-state-care minors without financial resources, the available programming drops sharply.

PROGRAM DESIGN: ACCESSIBILITY & SUPERVISION

Program design elements reflect how and for whom a program is intentionally structured, including the population served, physical accommodations available, and the level of staffing and oversight provided.

Room Configuration	% of Reported (n=302)
Roommates (shared bedroom & spaces)	56.00%
Single occupancy (own room)	45.70%
Independent living support (rapid rehousing, rent assistance)	17.20%
Apartments / townhouses / houses	9.90%
Hotel vouchers offered	6.00%
Family apartments / townhouses / houses	5.60%
Home-like environment	5.60%
Non-residential services only	2.60%
Communal living (no bedrooms)	2.60%

Staff Supervision Level (n=320)



Source: 2025 Safe House Project Program Survey

SUPPORT STRUCTURE

Residential structure and supervision models together define the lived experience of care. Room configuration, level of privacy, housing type, and degree of on-site oversight collectively shape safety, autonomy, therapeutic stability, and daily functioning. The physical environment and supervision intensity signal how a program is designed to balance structure with independence, and determine which survivors it is best equipped to support at different stages of stabilization and recovery.

SPECIALIZED POPULATIONS & ACCESSIBILITY

Programs were asked which specialized populations and accessibility features they support.
Adult-serving programs (n=374) | Minor-serving programs (n=108)

Specialized Service / Population	Adult	Minor
Pregnant Survivors	43.90%	50.90%
Wheelchair Accessible Facilities	30.70%	28.70%
Labor Trafficking	29.40%	25%
Survivors with Personal Vehicles	31.60%	20.40%
Survivors with Intellectual or Developmental Disabilities	25.90%	30.60%
Survivors with Active Eating Disorders	24.60%	28.70%
Service animal–friendly programs	27.50%	21.30%
Survivors with severe mental health needs	21.90%	30.60%
Emotional support animal–friendly programs	19.50%	15.70%
Survivors of organized or ritualized abuse	18.20%	15.70%
Deaf or hard of hearing survivors	18.40%	12%
LGBTQ+ Specialization	13.10%	17.60%
Pet-friendly (dogs permitted)	16.60%	8.30%

Specialized Service / Population	Adult	Minor
Pet-friendly (cats permitted)	15.80%	8.30%
Survivors of cult-based exploitation	13.40%	13%
Parents with three or more children	15.80%	14.80%
High-risk youth not formally identified as trafficking victims	5.30%	41.70%
Non-English Speaking Survivors	9.40%	9.30%
Pet-friendly programs (other animals permitted)	10.40%	7.40%
Survivors with dependent adults or multi-generational families	7.50%	3.70%
Couples or spouses accepted	6.70%	3.70%
Specializes in Native American Populations	5.30%	5.60%
Accepts survivors with PICA	4.80%	3.70%
Programs operating under a harm reduction model	2.90%	7.40%
Secure Youth Program (Lock Down)	0.50%	9.30%

Source: 2025 Safe House Project Program Survey

PROGRAM DESIGN: DISQUALIFIERS FOR SERVICES

Program design elements related to disqualifiers for services reflect the eligibility criteria that determine which survivors a program is unable or unwilling to admit based on clinical, behavioral, legal, or operational limitations.

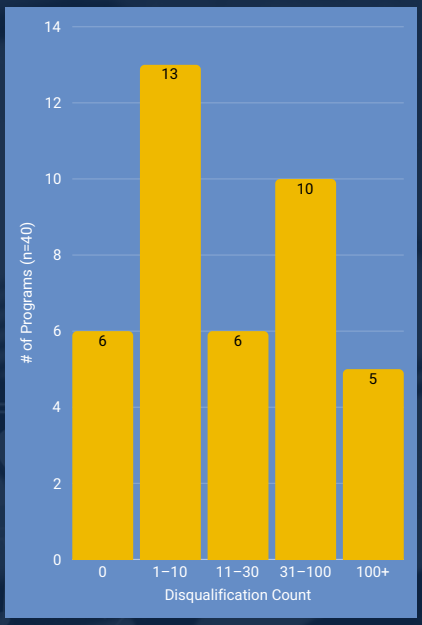
Two separate questions in the grant application addressed how programs handle survivors who cannot be admitted. Together they reveal both the scale of exclusion and the reasons behind it — which, when compared against the broader service landscape, point to one of the most consequential gaps in the field

How Many Survivors Were Turned Away

QUESTION ASKED: How many survivors were disqualified from services in your existing housing component last year?

This question was asked of all 68 applicants, though many programs noted they did not yet have an operational housing component or had not served survivors in 2024. Among the 40 programs that reported an active program and provided a number, the range was striking: from zero disqualifications to 250.

The median was approximately 5 disqualifications, but the mean was pulled sharply upward by a cluster of large, established programs. Five programs alone reported turning away a combined 868 survivors in 2024 — a figure that does not appear in the Service Landscape data, which does not collect this information at all. For referral partners and funders, this is not a footnote: it is a direct measure of how many people sought help and were told no.



MOST COMMON REASONS SURVIVORS WERE DISQUALIFIED

QUESTION ASKED: What were the three most common reasons survivors were unable to access or were disqualified from your housing services in 2024?

This question asked programs to name their three most common disqualification reasons from a defined list. It is important to read this data carefully: because programs self-selected their top three, the counts below represent how frequently each reason appeared among those three choices — not the total number of survivors excluded for each reason. A reason appearing in 28 programs' top three is a signal that it is a pervasive structural barrier, not simply an occasional occurrence.

The reasons cluster into three distinct categories, and understanding those categories separately matters as much as understanding the individual items.

Clinical & Medical Barriers
Detox needed was the single most frequently cited reason, appearing in more than half. Mental health conditions appeared in 57%. Active self-harm or suicidality appeared in 17%. These are not fringe or unusual presentations among trafficking survivors. They are among the most common co-occurring realities, and they are functioning as top disqualifiers.

Capacity & Operational Barriers
"We were full" or "No availability" appeared in 48% responses, and staff shortages in 15%. These are not eligibility-based exclusions — they are structural. A survivor who meets every intake criterion can still be turned away because a program simply has no room or no staff. This distinction matters for funders: capacity expansion and workforce investment directly address these barriers in ways that training and policy change cannot.

Survivors Willingness to Participate at Time of In-Take
Willingness to participate was cited 39% of the time. But "Willingness to participate" can mean different things — in trauma-informed programs, it may reflect a genuine fit assessment; in more compliance-based programs, it can function as a behavior screening that favors the most resourced or compliant survivors.

FIELD FINDING
The conditions that most commonly accompany trafficking victimization — substance dependence, severe mental health conditions, active suicidality — are also the most common reasons programs will not admit survivors. The system is structurally misaligned with the population it exists to serve.

"After being told I didn't qualify, I finally found a program. I came in broken and convinced I was unfixable. But the other survivors around me, the staff who remembered my name, the walls that held our stories — they showed me that healing isn't something you do alone. Belonging to something safe was the first step to becoming someone free." - Breighanna

What were the three most common reasons survivors were unable to access or were disqualified from your housing services?

Reason	Category	Programs (n=46)
Detox needed	Clinical	61%
Mental health condition	Clinical	57%
We were full / no availability	Capacity	48%
Willingness to participate	Policy/Fit	39%
Active self-harm / suicidality	Clinical	17%
Physical health concerns	Clinical	15%
Staff shortages	Capacity	15%
Survivor had custody of children	Eligibility	15%
Not the gender we serve	Eligibility	13%
Trafficking not verified	Verification	11%
Criminal background	Eligibility	11%
Survivor was not the age we serve	Eligibility	11%
Disability accommodation needed	Access	9%

"Every door I knocked on told me I was too much. Too unstable. Too sick. Too complicated. I needed detox. I had trauma.
I had charges from things I did to survive. I had kids. Everything that made me vulnerable, everything that happened to me, became the reason I was turned away. The very things I needed help for were the reasons I couldn't get it." - Cookie

CONSIDERATION FOR DISQUALIFICATION AS PART OF IN-TAKE PROCEDURE

Programs were asked what conditions would disqualify a potential resident at the point of application. Residential programs operate within defined eligibility criteria that determine who they are able to admit at the point of application. These disqualifiers are typically shaped by clinical capacity, staffing levels, safety considerations, funding requirements, and organizational policy. While often intended to protect program stability and resident safety, such criteria can significantly influence which survivors are able to access care and which are redirected elsewhere.

Because many survivors present with complex medical, mental health, substance use, legal, or family-related needs, these eligibility boundaries can disproportionately affect those with the highest levels of vulnerability. As a result, the factors most closely tied to exploitation and instability may also become barriers to immediate access to residential support.

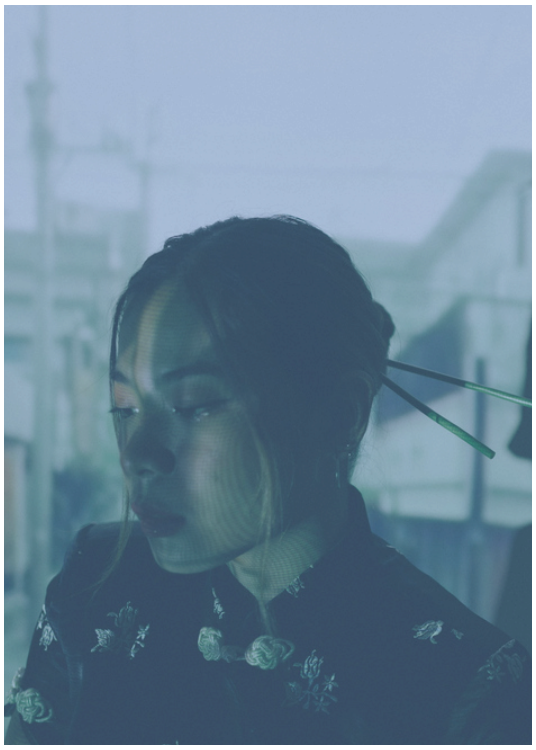
Consideration for Disqualification	Adult (n=263)	Minor (n=76)
Requires Medical Detoxification at Intake	55.50%	61.80%
Unwilling to Participate in Program	46%	53.90%
Registered Sex Offender History	47.10%	43.40%
Declines to Part with Cell Phone	39.20%	46.10%
Active Self-Harm or Suicidal Behavior	38.40%	26.30%
Severe Mental Health Presentation	36.90%	35.50%
Actively Using Substances	34.20%	25%
Significant Physical Health Concerns	28.50%	19.70%
History of Violent Offenses	22.40%	28.90%
Less Than 30 Days of Sobriety	24.30%	18.40%
Requires Disability Accommodation Beyond Program Capacity	20.90%	14.50%
Unmanaged or Unstabilized Mental Health Needs	17.90%	11.80%
Declines to Quit Smoking	12.50%	15.80%
Declines to Participate in Faith Activities	11.40%	3.90%
Experiences Seizures	11%	5.30%

Source: 2025 Safe House Project Program Survey

Consideration for Disqualification (continued)	Adult (n=263)	Minor (n=76)
Mobility issues	12.20%	3.90%
History of Recruitment	7.60%	15.80%
Active Eating Disorder	5.70%	9.20%
Lack of Government-Issued Identification Documentation	3.80%	9.20%
History of Leaving Programs Without Completion	4.20%	3.90%
Criminal History	1.50%	5.30%

WHO IS MOST LIKELY TO BE SERVED

Synthesizing the data above, the following profile represents the survivor most likely to find available programming across the current landscape. This is not a statement about who needs services — it is a statement about who the system is currently built to serve.



Survivor Most Likely to Be Serveds are:	Adult (18+) — 76.3% of programs
Sex trafficking — 99.6% of programs	No active substance use, no detox needed, 30+ days sober
Stable, medicated, no active self-harm or suicidality	No significant health concerns, no disability accommodations needed
No sex offense, no violent crime history	Has ID, SSN, and/or birth certificate
Willing to participate in faith activities (opens 43.3% more programs)	Willing to surrender cell phone

Each condition a survivor presents with that deviates from this profile narrows the number of programs available to them, often dramatically. A survivor who is actively using substances, has a severe mental health condition, and needs disability accommodations may find fewer than 10% of reporting programs willing to accept them.

Source: 2025 Safe House Project Program Survey

INTAKE TIMELINE & LENGTH OF STAY

Intake timelines vary significantly across the network — and for the most vulnerable survivors, the gap between need and placement can be the difference between safety and ongoing harm.

Timeline	% of Reported (n=218)
24 hours	26.60%
3 days	27.50%
7 days	17.40%
Two weeks	17.40%
Three weeks	3.20%
1 month	4.60%
2 months	0.90%
3+ months	2.30%

AMONG REPORTING PROGRAMS

- **54.1%** can place a survivor within 3 days or less.
- **71.6%** can place within a week.
- The remaining **28.4%** require two weeks or longer, with **7.8%** taking a month or more.

These delays carry significant consequences. Survivors awaiting placement often remain in unstable or unsafe environments, including emergency shelters, hospitals, temporary housing, or, in some cases, ongoing exploitation. Extended intake timelines increase the risk of trafficking, program disengagement, mental health destabilization, and loss of identification momentum. When safe placement is not rapidly available, the window of intervention narrows.

Intake timelines also correlate with complexity. Survivors with higher-acuity needs—such as active substance use requiring detox, severe mental health conditions, medical complexity, pregnancy, parenting children, mobility limitations, or elevated security risk, require additional screening, staffing coordination, and clinical review prior to admission. Programs equipped to serve these populations often operate with more structured assessment protocols and limited bed availability, extending intake timelines.

In practice, the more complex the survivor's clinical, medical, legal, or safety profile, the longer it typically takes to secure appropriate placement. This creates a structural paradox: the survivors at highest risk and with the most urgent needs frequently face the longest delays in accessing specialized care.

Source: 2025 Safe House Project Program Survey

INTENDED LENGTH OF STAY IN RESIDENTIAL CARE

QUESTION ASKED: What is the intended length of stay for participants in this housing program?
The distribution of intended stays is dominated by long-term housing models. Nearly a third of all applicants described an intended stay of one year or more. Another 16% programs intended 9 to 12 months. In total, approximately 50% of this cohort is designed around stays of nine months or longer.

A smaller but notable cluster of programs operates under short-term models: 4 programs intended stays of 2 to 4 weeks, 2 programs intended 1 to 2 weeks, and one program intended stays of less than a week. These short-stay programs appear to function as crisis stabilization or bridge housing rather than long-term recovery housing. Several used the word "other" or "variable" to describe their intended stay, indicating flexible or individualized timelines that don't fit standard categories.

Intended Length of Stay	% of Cohort (n=68)
1+ years	34%
9–12 months	16%
6–9 months	4%
2–3 months	7%
1–2 months	4%
2–4 weeks	6%
1–2 weeks	3%
Less than 1 week	1%
Other / variable	15%
Not yet operational	9%

"I needed space to stabilize, to sleep without fear of how I was going to pay rent, to figure out who I was without someone controlling me. When programs are built around timelines instead of people like me, it feels like you're racing your trauma instead of recovering from it."
-Noelle

WHEN SURVIVORS STAY LONGER THAN THE PROGRAM PLANNED

Programs where actual stay exceeds intended duration are not necessarily failing — they may be responding to reality. If a survivor intended for a 9-to-12-month program is still in housing at 18 months, it may reflect that the program extended its timeline to prevent a harmful transition. Several programs in this cohort with a 1+ year intended stay also reported actual stays exceeding that, which may indicate that for complex-needs survivors, even long-term housing is sometimes not long enough.

When Survivors Stay for Less TIme Than the Program Planned

Programs where actual stays fall significantly below intended duration present more concern. Two programs designed for 9 to 12 months reported actual average stays of 1 to 2 months. One program with a 9-to-12-month model reported actual stays averaging 3 to 4 months. Whether this reflects survivors leaving voluntarily, being discharged, or losing housing for other reasons cannot be determined from this data — but the pattern correlates meaningfully with the completion rate data in the next section.

ACTUAL LENGTH OF STAY (2024)

QUESTION ASKED: In 2024, what was the average length of stay for participants in this housing program?

Among the 42 programs that reported serving survivors in 2024, actual length of stay data produces a more complex picture than intended stay alone. When intended and actual stay are compared directly, three patterns emerge:

Match: Actual stay falls within the same range as intended stay.
Exceeded: Survivors stayed longer than intended, suggesting the program extended stays to meet need.
Shorter: Actual stays were significantly below intended, suggesting early exits, program attrition, or structured discharges.

37% of active programs showed aligned actual and intended stays.
35% showed actual stays that exceeded intended duration.
28% showed actual stays significantly shorter than intended.

Source: 2025 SHP Housing Grant Applications

PROGRAM DESIGN: ADDITIONAL CONSIDERATIONS

The following reflects average weekly therapy hours, engagement with lived experience experts, and program needs — surfacing gaps in operational capacity that shape survivor outcomes across the network.

QUESTION ASKED: How many hours of individual therapy or sessions do you or will you provide to survivors each week?

This question asked programs to report the weekly volume of individual therapy offered to residents. The answers reveal significant variation in clinical intensity across the cohort — and, when cross-referenced with completion rate data, suggest that clinical dosage may be one of the more consequential predictors of program outcome.

Weekly Therapy Hours	% of Respondents (n=49)
Zero / none reported	2%
1–2 hours/week	37%
2–3 hours/week	27%
3–4 hours/week	16%
4+ hours/week	18%

The majority of programs offer 1 to 2 hours of individual therapy per week. For survivors managing complex trauma, PTSD, co-occurring substance use, and the psychological aftermath of trafficking — including the effects of coercive control, exploitation, and often a lifetime of compounding adversity — this represents a relatively modest clinical presence.

Programs offering 4 or more hours of individual therapy weekly reported average completion rates roughly 30 percentage points higher than programs offering 1 to 2 hours (approximately 70% vs. 38%). This correlation is not causal — programs with more clinical capacity may also differ in intake criteria and population served. But the pattern is consistent enough to warrant attention.

The clinical intensity gap connects directly to the staffing theme that emerges throughout this cohort's "other needs" responses. Therapist and clinical staff vacancies are among the most frequently cited non-funding barriers to program readiness. More funding alone will not increase therapy hours if qualified clinical staff cannot be recruited and retained.

Source: 2025 SHP Housing Grant Applications

INTEGRATION OF LIVED EXPERIENCE EXPERTS

QUESTION ASKED: In the last 24 months, how has your organization engaged Lived Experience Experts in the development, delivery, or evaluation of your residential program?
Almost all programs in the cohort reported engaging people with lived experience in some form — 97%. But modes of engagement vary significantly, and the distinction between consultative and structural engagement is consequential.

Mode of Engagement	% of Cohort (n=68)
Consulted with LEE during program development	71%
LEE reviewed program-related documents	62%
LEE has spoken at organization's events	56%
Input from past residents	53%
LEE as direct care staff	32%
Survivor leaders as mentors to current residents	29%
Advisory board with LEE representation	26%
LEE as paid consultant (non-advisory)	25%
Trainings led by LEE	21%
LEE as board member(s)	**18%**
LEE as executive leadership	**13%**
LEE as volunteer consultant	12%

Consultative vs. Structural Engagement
The most common forms of LEE engagement — consulting during development, reviewing documents, speaking at events, providing input as past residents — are meaningful but fundamentally consultative. In these roles, people with lived experience inform decisions made by others. The least common forms — board membership and executive leadership — represent structural inclusion: roles where lived experience holders have decision-making authority, not just advisory input.

Only 12 programs listed LEE as board members and only 9 listed LEE in executive leadership. In a cohort of 68 programs that collectively represent some of the most survivor-centered applicants in the field, fewer than 15% have placed people with lived experience in governance roles. This is consistent with broader field trends but represents a significant gap given the evidence that survivor leadership correlates with more responsive, survivor-centered program design.

Why governance matters
Consultative engagement places the burden of advocacy on the lived experience expert without giving them authority to act on what they know. Governance-level inclusion — board seats, executive roles, voting authority — changes who decides, not just who is asked. SHP's certification standards and funding criteria represent a direct lever for moving the field from consultation toward structural integration

Source: 2025 SHP Housing Grant Applications

WHAT PROGRAMS NEED BEYOND FUNDING

QUESTION ASKED: Besides funding, what are your other needs before launching this project?

This open-ended question was answered by 46 of 68 applicants. The remaining programs either indicated they had no additional needs or were already operational and used this space to provide program notes rather than needs statements. The responses to this question are among the richest qualitative data in the application — and they reveal a set of systemic pressures that funding alone cannot resolve.

Staffing Is the Dominant Non-Funding Need

Staffing was mentioned in 31 of 46 responses — in some cases as the entire answer, in others as one of several needs. The roles named most frequently were: qualified advocates and case managers, overnight and residential staff, peer support navigators, clinical staff and therapists, and program coordinators. Several programs noted that finding staff who are both clinically qualified and aligned with survivor-centered practice is the specific challenge — not simply that positions exist unfilled.

Investing in People

The staffing crisis named across this cohort is not unique to these 68 programs. It reflects a field-wide shortage of qualified, LEE-aligned, trauma-informed staff trained in anti-trafficking residential care. SHP is positioned to address this through shared training resources, peer support certification pathways, or network-level hiring pipelines that serve multiple grantees simultaneously.

Partnerships, Referral Networks, and Navigation

12 programs identified partnerships and referral networks as critical needs — specifically, connections to detox and step-down services, mental health providers, legal advocates, and post-program housing navigation. This is particularly notable given the disqualification data in Section 1: programs that cannot accept survivors who need detox or clinical step-down services are, in many cases, explicitly aware of this gap and naming the need for external partners to fill it.

Training and Certification

9 programs named specific training needs: trauma-informed care, motivational interviewing, TBRI (Trust-Based Relational Intervention), and trauma-focused cognitive behavioral therapy. Several programs launching new initiatives described needing to train their entire incoming staff cohort before opening. This suggests that training access — not just training content — is a barrier, particularly for smaller or more rural organizations.

Source: 2025 SHP Housing Grant Applications

7 KEY FINDINGS & INVESTMENT OPPORTUNITIES

1. The Substance Use and Mental Health Exclusion
Among programs that disclosed disqualification criteria, 55.5% of adult programs and 61.8% of minor programs exclude survivors needing detox. Severe mental health conditions are a disqualifier for 36.9% of adult programs and 35.5% of minor programs. Active self-harm/suicidality excludes at 38.4% of adult programs but only 26.3% of minor programs. These are among the most common co-occurring realities for trafficking survivors. Programs designed to serve survivors with active substance use, co-occurring mental health conditions, and self-harm represent a critical investment opportunity.

2. The Minor Access Funnel
While 140 programs serve minors, 97.9% are structured for youth in foster care. Only 35.7% accept minors outside the foster system without charge, and only 15.7% serve children under 12. The system is built around a foster-care pipeline that does not reflect how all minors enter services.

3. The Cell Phone Policy Paradox
39.2% of adult programs and 46.1% of minor programs disqualify survivors unwilling to part with their cell phone. For survivors whose phone is their primary connection to safety networks, legal advocates, employment, and children, this policy creates a meaningful barrier. It also raises questions about trauma-informed practice, given that control over personal communication is a hallmark of trafficking itself.

4. Specialized Population Gaps
Only 2.9–7.4% of programs operate under a harm reduction model. Under 10% serve non-English speaking survivors. Only 5.3–5.6% specialize in Native American populations. Only 5.0% accept multi-generational families. Each represents a population with documented vulnerability and virtually no dedicated programming.

6. Data Collection and Transparency
40.6% of programs did not disclose disqualification criteria. 51.5% did not disclose medication policies. 47.2% report housing and community-based data in combined form. Referral partners making placement decisions often work without knowing who a program will accept, what it offers, or what medications are permitted. Improving transparency in program self-reporting is itself a field-level need.

7. Emergency vs. Long-Term Structural Differences
Emergency programs are more likely to keep requirements optional (50.5% for adults), reflecting the crisis nature of the placement. Long-term programs impose significantly more structure: 60.5% require chores, 31.1% require part-time employment, and physical exercise, community service, and education requirements all increase substantially. These differences matter for survivors transitioning between levels of care.

Source: 2025 Safe House Project Program Survey

IDENTIFICATION TRENDS & SURVIVOR SUPPORT GAPS BY STATE

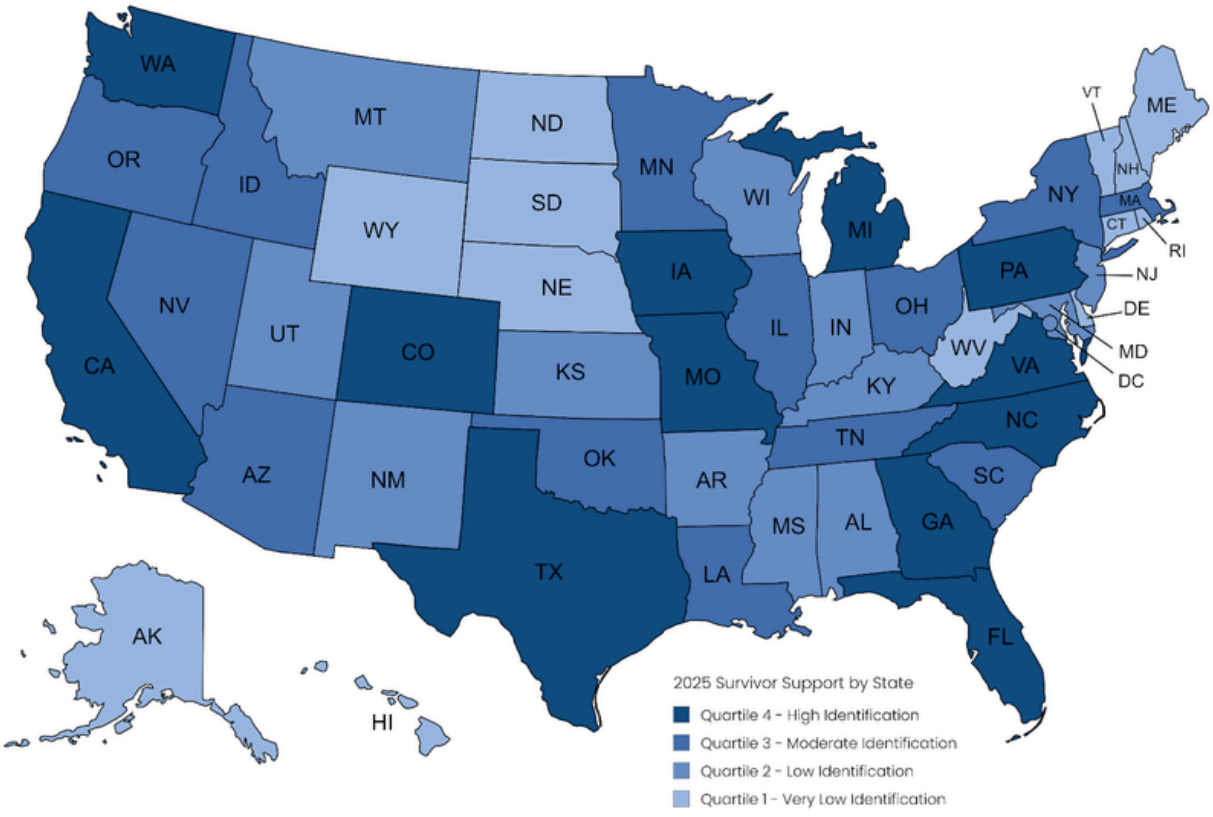
The data that follows captures identification trends and survivor support gaps across the country — but geographic concentration should not be mistaken for prevalence. A state with high identification rates may not have more trafficking; it may have stronger training, better intervention policy, more robust referral networks, and frontline partners who know what to look for. Conversely, states with lower case volume are not safer — they may simply have fewer systems in place to recognize and report what is already happening. With victim identification estimated at just 1% nationally, every data point in this section represents a fraction of the actual landscape. No state is exempt from this reality, and every state has room to strengthen its response through education, training, reporting, and prevention — because the victims and survivors not yet counted are still out there.

NATIONWIDE REFERRAL INFORAMTION BY STATE

The following pages illuminate critical national trends, drawing directly from the voices of victims to reveal the persistent gaps in services that leave too many survivors without the support they need and deserve.

VICTIM IDENTIFICATION DENSITY BY STATE IN 2025

excludes unknown locations(n=2,360)



"1,163 RESIDENCE BASED TRAFFICKING CASES MEANS IT'S HAPPENING IN YOUR NEIGHBORHOOD. ON YOUR STREET. BEHIND DOORS YOU WALK PAST EVERY DAY."

PERCENT OF SURVIVORS SERVED BY STATE IN 2025 BY SAFE HOUSE PROJECT

excludes unknown locations (n=2,360)

	% of total
California	10.50%
Texas	8.80%
North Carolina	7.80%
Georgia	5.50%
Florida	4.70%
Washington	3.90%
Pennsylvania	3.50%
Colorado	3.30%
Iowa	3.30%
Virginia	3.30%
Michigan	3.20%
Missouri	3.00%
New York	2.40%
Idaho	2.30%
Illinois	2.30%
Ohio	2.10%
Tennessee	2.10%
Oklahoma	2.00%
Nevada	1.90%
Arizona	1.80%
South Carolina	1.70%
Kansas	1.50%
Louisiana	1.50%
Minnesota	1.40%
Massachusetts	1.30%
Oregon	1.30%
Alabama	1.20%
Wisconsin	1.10%
Maryland	1.10%
Mississippi	1.00%
Kentucky	0.90%
Indiana	0.90%
Utah	0.90%
Montana	0.80%
New Jersey	0.70%
Washington, D.C.	0.70%
Arkansas	0.70%
New Mexico	0.50%
South Dakota	0.50%
Connecticut	0.40%
Maine	0.30%
West Virginia	0.30%
New Hampshire	0.30%
Nebraska	0.20%
Rhode Island	0.20%
Delaware	0.20%
North Dakota	0.20%
Alaska	0.10%
Hawaii	0.10%
Wyoming	0.10%
Vermont	0.05%

GEOGRAPHIC DISTRIBUTION: KEY CONCLUSIONS

Service Demand Is Concentrated in a Limited Number of States
Five states account for a disproportionate share of individuals served:

- California (10.5%)
- Texas (8.8%)
- North Carolina (7.8%)
- Georgia (5.5%)
- Florida (4.7%)

Together, these states represent a substantial concentration of placement demand.

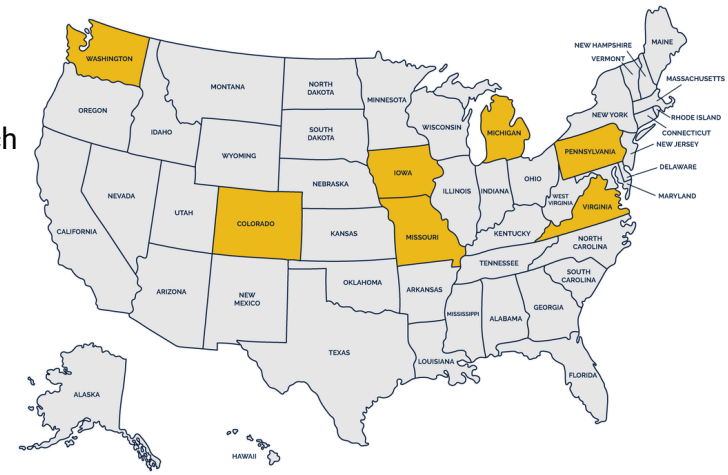
HIGH-VOLUME STATES REFLECT ACCESS POINTS — NOT PREVALENCE

Referral concentration should not be interpreted as trafficking prevalence. Volume may be influenced by:

- Referral partner density
- Transportation corridors
- State-level identification capacity
- Existing service infrastructure

Mid-Tier States Demonstrate Broad National Reach
States in the 2–4% range reflect consistent but distributed demand, including:

- Washington (3.9%)
- Pennsylvania (3.5%)
- Colorado (3.3%)
- Iowa (3.3%)
- Virginia (3.3%)
- Michigan (3.2%)
- Missouri (3.0%)



This distribution reinforces that need is not isolated to a small number of states.

LOWER-VOLUME STATES DO NOT INDICATE LOWER NEED
REDUCED REPRESENTATION MAY REFLECT:

- Under-identification
- Limited referral networks
- Variability in awareness of placement options
- Survivor relocation prior to service engagement

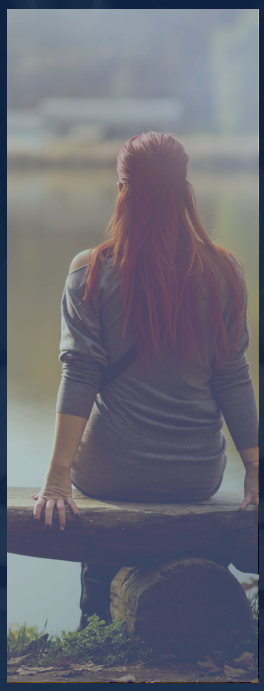
NATIONWIDE REFERRAL TRENDS & GAPS

The following pages illuminate critical national trends, drawing directly from the voices of victims to reveal the persistent gaps in services that leave too many survivors without the support they need and deserve.

The service gaps outlined in the following section reflects perceived barriers to access as reported directly by survivors of trafficking and the agencies referring them for services. These gaps are grounded in lived experience: whether a survivor or referring partner was able to locate, access, and successfully engage with support at the moment it was needed.

This data is not intended to function as a comprehensive inventory of all services that may exist; rather, it highlights points of friction in the system where survivors encounter delays, denials, or dead ends, even in jurisdictions where programs operate. In many cases, resources may exist but remain unknown to frontline partners, have eligibility restrictions that limit access, lack capacity, or be inaccessible due to factors such as geography, language, acuity, or program design.

By centering survivor-reported experience and referral outcomes, these findings surface the difference between theoretical availability and practical access. Identified gaps should therefore be understood as indicators of system performance from the perspective of those navigating it, not as definitive statements about the absence of services. This framing allows states, funders, and providers to move beyond counting programs and instead examine whether existing resources are truly reachable, responsive, and aligned with survivor needs.



TREND 1: TECHNOLOGY & MODERN TACTICS

- Digital Exploitation: Survivors report online ads with their photos, social media harassment, phone hacking, tracking via technology.
- Isolation via Control: Phone monitoring, social media control, location tracking by traffickers maintains power even after physical separation.

TREND 2: TRAFFICKING TYPOLOGY

- Duration: Trafficking experiences range from days to decades. Many report childhood onset (as young as 3-5 years old) with exploitation continuing as an adult.
- Complexity of Networks: References to gangs, cartels, organized rings, multiple perpetrators. Some cases involve law enforcement or other authority figures.
- Labor Trafficking Underrepresented: Overwhelming majority of narratives describe sex trafficking. Labor trafficking present but seems underidentified/underserved.
- "Boyfriend" Trafficking Model: Frequent pattern of relationship that becomes trafficking ("boyfriend" becomes trafficker).

TREND 3: FINANCIAL EXPLOITATION

- Economic Control: Survivors report all money taken, no access to own funds, forced to work without pay, bank accounts stolen/drained.
- No Resources for Exit: Common barrier - no money for transportation, temporary housing, basic needs upon leaving.

GAP 1: HOUSING & PLACEMENT SHORTAGES

- **Shelter Scarcity:** Constant theme of "all shelters full," "no beds available," "waitlists," creating dangerous delays in crisis moments.
- **Program Mismatch:** Many survivors placed in domestic violence shelters are not equipped for trafficking-specific trauma. General homeless shelters are also inadequate.
- **Phone/Independence Restrictions:** Significant barrier - many programs require surrendering phones or have strict communication limits. Survivors with children, jobs, or court obligations cannot comply.
- **Pet/Service Animal Barrier:** Frequent mentions of survivors having service animals or pets they won't leave without. Most programs can't accommodate, forcing impossible choices.

GAP 2: CRITICAL SAFETY & URGENT NEEDS

- **Immediate Danger:** High frequency of "ASAP," "today," "emergency" language. Survivors report active pursuit by traffickers, death threats, and imminent homelessness, creating crisis-level need for immediate placement.
- **Geographic Safety:** Survivors are repeatedly unable to stay in their current locations due to traffickers knowing their whereabouts. Pattern of needing to relocate to entirely different states/regions for safety.
- **Re-victimization Risk:** Cycle of survivors leaving programs → returning to streets/trafficking → attempting to exit again. High vulnerability to re-exploitation during gaps between services.

GAP 3: NEEDS DUE TO SUBSTANCE USE

- **Coerced/Forced Use:** High prevalence of forced drug use by traffickers (especially meth, fentanyl) as control mechanism. Survivors often don't identify as having addiction but withdrawal concerns exist.
- **MAT/Methadone Needs:** Multiple survivors on Medication-Assisted Treatment being turned away from programs that don't allow MAT, creating barrier to care.
- **Recent Sobriety:** Many report days to weeks of sobriety and express motivation to stay clean with proper support.

GAP 4: ACCESS TO MENTAL HEALTH & TRAUMA SERVICES

- **Complex Trauma Presentations:** High rates of PTSD, dissociation, DID, psychosis symptoms. Many survivors describe symptoms consistent with severe trauma but lack formal diagnoses.
- **Suicidal Ideation:** Frequent mentions of current or recent suicidal thoughts, hospitalizations for mental health crises.
- **Paranoia/Hypervigilance:** Survivors report being followed, tracked, surveilled - sometimes grounded in reality (traffickers actively pursuing), sometimes potentially trauma responses.

GAP 5: CHILDREN & FAMILY DYNAMICS

- **Mothers Seeking Safety:** A large number of survivors with children (infants to teenagers) needing placement together. Few programs accommodate families.
- **CPS Involvement:** Pattern of concurrent trafficking and child welfare cases. Some children in care, survivors working toward reunification.
- **Familial Trafficking:** Disturbing frequency of trafficking by family members (parents, stepparents, relatives), complicating safety planning and support systems.

GAP 6: LEGAL & DOCUMENTATION BARRIERS

- **Lack of ID/Documents:** Traffickers commonly confiscate identification, birth certificates, and social security cards. Creates barriers to accessing virtually all services.
- **Active Legal Cases:** Many survivors have pending charges (often from activities while being trafficked), probation requirements, or need to testify as witnesses.
- **Immigration Status:** Undocumented survivors face additional barriers. Some trafficking victims are brought from other countries.