Reducing Barriers to Treatment and Support Services for Drug-Addicted Survivors of Human Sex Trafficking

by

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Abstract

Human sex trafficking is prevalent problem across the globe and is considered a form of modern-day slavery (ILO, 2024; United Nations Office on Drugs and Crime, 2009). Canada is a transit, destination, and origin location for human sex trafficking exploitation (Brooks & Heaslip, 2019; Public Safety Canada 2023). This capstone aimed to examine barriers to survivors accessing support services due to addiction and other variables and to investigate the relationship between drug use and human sex trafficking. Examination of present research finds that there are numerous barriers that survivors face in accessing support services due to addiction or other factors. Addiction is identified as a common effect of exploitation and other previous survivor traumas, substance use that is voluntary and involuntary is prevalent during human sex trafficking exploitation and is a risk factor in recruitment and exploitation (Hammond & McGlone, 2014; Robertson, 2017; Michaelis et al., 2022; Marburger & Pickover, 2020). Despite research demonstrating a closely emmeshed relationship between addiction and human sex trafficking exploitation, most human trafficking organizations and other community services maintain sobriety requirements as a condition to receive support and services. This capstone addresses barriers and gaps in service access by recommending the utilization of a harm reduction model of care in direct opposition to abstinence-based models, as well as the use of the trauma-informed care and specific therapist skills. Recommendations are made for counsellors, service providers, organizations, and systems to support the closing of gaps and reduction of barriers. This contributes to the field as little research discusses use of harm reduction and trauma informed approaches to reduce barriers to service access.

Keywords: human sex trafficking, trauma-informed care, harm reduction model of care, addiction

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Dedication

I dedicate this capstone to my friends in Victim Services, who make continuous efforts to reduce barriers in service access and support the safety of vulnerable folks in the community, with genuine kindness and passion for the work.

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Chapter One: Introduction

Overview of the Topic

Human trafficking is a prevalent problem that occurs worldwide (United Nations Office on Drugs and Crime [UNODC], 2009). Labour and sex trafficking are the two best known forms of human trafficking (Heidinger, 2023). Labour trafficking can take the form of domestic servitude (such as child or elder care, house cleaning, laundry or other domestic tasks), forced drug transportation, and forced hard labour (Canadian Human Trafficking Hotline, n.d.; Public Safety Canada, 2022). Forced labour can occur in the industries of farming, construction, hospitality, restaurants, and manufacturing plants (Canadian Human Trafficking Hotline, n.d.; Public Safety Canada, 2022). Human sex trafficking takes many forms, including sexual acts, sexual tourism, stripping, exotic dancing, live sex shows, pornography, forced marriages, and mail-order brides (Deshpande & Nour, 2013; Litam, 2017). Other less known forms of human trafficking include organ removal, illegal adoption and selling of infants, and exploitative begging (UNODC, 2021; cited in Heidinger, 2023). This capstone focuses specifically on human sex trafficking. Human sex trafficking is not to be confused with sex work, as those engaging in sex work earn funds to live and work without the influences of force, fraud, and coercion (Brooks & Heaslip, 2019; George et al., 2010). While these influences are not present, sex workers report experiencing both physical and sexual violence from clients and partners and are vulnerable to protentional trafficking and exploitation (Martín-Romo et al., 2023). According to the International Labour Organization (ILO) (2022), as of 2021 approximately 49.6 million people are trafficked for forced labour or sex each year. This is a significant increase from the 2012 report, which found that approximately 20.9 million people were trafficked each year (ILO, 2012). Approximately 22-27% of trafficked persons are sex trafficked (ILO, 2012). While human trafficking has a reputation of moving survivors great distances to be exploited, most survivors

share the same nationality and country as the trafficker (UNODC, 2009). Forced movement is not required to be considered human trafficking, as most survivors are exploited within their own region and country (Litam, 2017; UNODC, 2009).

Billions of dollars in profit are made by traffickers exploiting individuals for labour and sexual acts (ILO, 2024). Despite human sex trafficking accounting for the minority of human trafficking, it generates more profit than forced labour or other types of trafficking, accounting for 73% of all profits (ILO, 2024). Human sex trafficking alone is estimated to yield 99 billion dollars a year in profit (ILO, 2014). The ILO (2024) estimates that traffickers make $27,252 USD in profit for each person who is sexually exploited. This demonstrates the high working demands of workers and the significance of their exploitation, as survivors see next to no funds. The frequency and magnitude of human trafficking makes it the second and third most profitable criminal enterprise worldwide (Greenberg, 2016; cited in Robertson, 2017). The high rate of victimization and profits lead human trafficking to be considered as modern-day slavery (Ernewein & Nieves, 2015; Hamond & McGlone, 2014). Every continent, including North America, has been identified as an origin place, transit spot, and destination location for exploitation (Brooks & Heaslip, 2019). While individuals may believe that trafficking does not happen in this country, Canada is not immune to human trafficking. From 2012-2022, 3,996 cases of forced labour and human sex trafficking were reported to Canadian law enforcement agencies (Public Safety Canada, 2024). These statistics do not specify the specific numbers of sex trafficking versus forced labour cases in Canada, however human sex trafficking has been reported to be the most identified form of human trafficking (Heidinger, 2024). The Canadian Centre to End Human Trafficking (2023), a confidential hotline which provides support and resourcing to survivors of human trafficking, identified 1,500 cases from 2019-2022, 1,029 of

those cases involved human sex trafficking exploitation. UNODC (2022) reported that in Canada, unofficial brothels are the most common locations where survivors are exploited (53%), followed by hotels (24%) and apartments provided by the trafficker (11%). It is difficult to know the true estimates of human sex trafficking victimization, as it tends to be underreported for a variety of reasons (Gerassi & Nichols, 2017; Government of British Columbia, 2023; UNDOC, 2009). Survivors may fear arrest, criminal charges, and deportation by police (Gonzalez et al., 2019; Howarth, 2023). Police may misidentify survivors as sex workers or as criminals for drug possession, due to bias and or lack of knowledge for screening suspected trafficking, leading to arrests and criminal charges (Gonzalez et al., 2019; Howarth, 2023; Robertson, 2017). Given traumatic and oppressive histories between law enforcement, specific racial groups, and LGBTQIA2S people, LGBTQIA2S people and people of colour tend to underreport their experiences due to fear of harm and mistrust of police (Gerassi & Nichols, 2017). Keep in mind that there is a lack of statistics for these groups, as well as statistics specific to indigenous peoples and non-citizens (Gerassi & Nichols, 2017). UNODC (2022) estimates about 2% of survivors in the United States are transgender, however further information about statistics of gender queer and non-binary survivors globally and within Canada are absent. Previous UNODC research operates on a gender binary and does not provide in-depth analysis on race within victim categories. Researchers in the field assert that people of colour and LGBTQIA2S are disproportionately victimized and that statistics are not reflective of this, which emphasizes the need for more inclusive statistics and human trafficking services (Gerassi & Nichols, 2017). Survivors can also be misidentified by hospital workers due to lack of knowledge and training to screen for possible trafficking (Gonzalez et al., 2019; Roberson, 2017). For instance, when under

the influence of drugs, health care workers see their surface as addicted and unwell, not considering circumstances that may lie beneath (Roberson, 2017).

People of all gender identities, races, sexes, and ages can be victims of human trafficking (Ernewein & Nieves, 2015; Litam, 2017; Public Safety Canada, 2024). Statistics demonstrate that women account for most trafficking victims (UNODC, 2022; UNODC, 2009; UNDOC, 2006). Amongst all types of trafficking, including forced labour and sex trafficking, they account for 79% of total victims worldwide (United Nations Office of Drugs and Crime, 2006). In Canada, 94-96% of human trafficking survivors are women and girls (Conroy & Sutton, 2022; Public Safety Canada, 2024). In Canada, nearly 25% of human trafficking survivors are youth (Heidinger, 2023; in Public Safety Canada, 2024). This percentile can depend on how young survivors were lured into trafficking. For example, youth are frequently exploited through survival trafficking, which occurs when traffickers take advantage of their dependency and need to survive (Duncan & DeHart, 2019; Gerassi & Nichols, 2017). Those experiencing homelessness, are in foster care, poverty, abuse, neglect, lack of parental involvement, and rejection are at higher risk of exploitation (Gerassi & Nichols, 2017; Michaelis et al., 2022). Addicted parents of youth can end up allowing their child to be exploited so they can access drugs as reward (Marburger & Pickover, 2020; Michaelis et al., 2022). One study found that 80% of survivors who were exploited by violent/gang affiliated traffickers were youth (Michaelis et al., 2022). Ultimately, most adult survivors report first being trafficked as youth (Ernewein & Nieves, 2015; Hammond & McGlone, 2014; Howarth, 2023). Certain life circumstances and specific vulnerabilities place an individual at a higher risk of being exploited. Risk factors for human sex trafficking include unstable living environment, sexual abuse/victimization, lack of

safety, abuse, poverty, unemployment, addiction, selling drugs, being unhoused, neglect, lack of support, and isolation (Gerassi & Nichols, 2017; Hammond & McGlone, 2014; Litam, 2017).

Research finds that most traffickers across the world are men and boys (Heidinger, 2023). Heidinger (for Statistics Canada) (2023) reports that males account for 81% of those accused in human trafficking cases (cited in Public Safety Canada, 2024). 77% of male traffickers are aged 18-34 years old (Statistics Canada, 2023; cited in Public Safety Canada, 2024). In some areas, however, women have disproportionate involvement in trafficking. There areas include eastern Europe, Central Asia, East Asia, Pacific and Central America (UNODC, 2009). There are outlier areas in Central America where women account for an equal or greater percentage of traffickers compared to men (UNODC, 2009). Traffickers can be known or unknown to survivors. Those known can be friends, family, and partners who traffic survivors or have affiliations with traffickers. Those unknowns are gang members and pimps (Duncan & DeHart, 2019; Litam, 2017; Marburger & Pickover, 2020; Michaelis et al., 2022).

Traffickers use these various strategies to target the vulnerabilities of survivors. There are 4 ways that youth and adults are lured and recruited into sex trafficking; coercion and force by people close to the survivor, boyfriend pimping, bait and switching, and Guerilla pimping.

Coercion and force can come from family members, intimate partners, friends and others close to the survivor or these individuals can be affiliated with traffickers (Duncan & DeHart, 2019; Litam, 2017; Marburger & Pickover, 2020; Michaelis et al., 2022). Heidinger (for Statistics Canada) (2023) finds that 91% of survivors were trafficked by a person known to them. Of this 91%, 34% are intimate partners (Heidinger, 2023). As noted above, children can be exploited by addicted parents in exchange for drugs (Marburger & Pickover, 2020; Michaelis et al., 2022).

Survivors are targeted by traffickers who use grooming strategies that resemble romantic relationships. This is known as boyfriend or finesse pimping, which is when traffickers mimic a relationship or relationship qualities with the survivor to gain their trust and compliance (Deshpande & Nour, 2013; Gerassi & Nichols, 2017; Michaelis et al., 2022). Litam (2017) identifies four common stages of grooming. The first is ensnaring, which is the stage where trust and a sense of safety are built. The survivor believes that being with the trafficker is a good thing, as they believe they will be taken care of, will help make their dreams come true, and love them (Litam, 2017). They may buy gifts for survivors to draw them in and manipulate their emotions (Gerassi & Nichols, 2017; Michaelis et al., 2022). They make survivors feel loved and taken care of, but for selfish reasons. The second stage is creating dependence. As a bond and trust has been built with the survivor, controlling behaviour begins and the trafficker begins to isolate the survivor from others (Litam, 2017). As dependency is formed, the trafficker coerces the survivor to use drugs and convinces them that they are all that they need (Deshpande & Nour, 2013; Shelley, 2012). They begin to act controlling and possessive of the survivor (Contreras et al., 2017; Litam, 2017). The third stage is taking control. The controlling behaviour escalates, survivors' movements are extremely limited, drug use moves from casual to forced, and violent behaviour emerges (Litam, 2017). The survivors access to the outside world, other supports, and options are restricted and the trafficker manipulates the survivor to believe that they need them to survive (Hammond & McGlone, 2014; Litam, 2017). The fourth and final stage is total dominance, where the survivor has been manipulated and coerced to a point where they cannot see alternatives to their situation (Litam, 2017). Finesse pimping and the stages of grooming demonstrate the way in which trafficker-survivor dynamics exhibit similarities to cycles of abuse in intimate partner relationships, both of which are difficult to escape.

Survivors can be lured by the 'bait and switch' technique (Hammond & McGlone, 2014). Survivors are lured in by a false opportunity advertised by the trafficker that will better themselves, allow them to work independently, make good money, and ultimately live a good life (Hammond & McGlone, 2014). As soon as they agree, the trafficker immediately subjects them to exploitation, switching from 'great opportunity' to their true intention to exploit. This practice is also done by traffickers who engage in finesse pimping (Duncan & DeHart, 2019).

Traffickers may opt for more violent and forceful recruitment, known as Guerrilla pimping (Hammond & McGlone, 2014; Michaelis et al., 2022). Frequent abuse, forced drug use, and threats are common actions by traffickers to subdue survivors into compliance (Michaelis et al., 2022). Some utilize abduction to maintain control over survivors' movements (Michaelis et al., 2022).

Force, fraud and coercion are core qualities presented in all forms of human trafficking, including human sex trafficking exploitation. Regardless of the strategy used by traffickers to lure and recruit survivors, elements of force, fraud, and coercion are involved in the recruitment and maintaining of survivors (De Shalit et al., 2021; Deshpande & Nour, 2013; Ernewein & Nieves, 2015; Judge et al., 2018). The common denominator is control. In force, violence, physical force or restraint, forced drug use, and intimidation make survivors compliant due to fear of harm, or they are compliant because they cannot physically escape due to the method of force used (Litam, 2017; Michaelis et al., 2022). In fraud, survivors are lured with false promises of a good life, which turn out to be a fraudulent claim (Deshpande & Nour, 2013; Litam, 2017). Traffickers utilize substances to foster/maintain addiction in survivors, so they become dependent on the trafficker for drugs (Roberson, 2017). As traffickers also restrict the movements of survivors, they come to depend on them to provide food, shelter, and condoms

(Litam, 2017). The trafficker provides drugs, food and condoms in exchange for the survivor to engage in sexual acts with buyers or the traffickers themselves (Litam, 2017). As the need for drugs grows along with the addiction and the need for food is always present, survivors continue to endure suffering to get their addiction and survival needs met (Roberson, 2017; Stoklosa et al., 2017). There is never truly a paid off debt, it is a cycle of debt controlled by the trafficker to maintain control of survivors (Michaelis et al., 2022; Shelley, 2012). In coercion, traffickers influence and control survivor behaviour and emotions using threats and manipulation (Contreras et al., 2017; Gonzalez et al., 2019; Litam, 2017). For example, they can threaten to harm the survivor or their loved ones if the survivor does not comply or manipulate the survivor to believe that only the trafficker is trustworthy, leading them to disconnect from their support systems (Hammond & McGlone, 2014; Marburger & Pickover, 2020; Michaelis et al., 2022; Roberson, 2017). Such manipulation can be used to destroy a survivor's self-worth, and they may even feel that they are lucky to not be harmed and feel grateful toward the trafficker (Litam, 2017).

Purpose Statements

This capstone aims to:

1) Investigate the relationship between drug use and human sex trafficking
2) Examine barriers to survivors accessing support services
3) Examine addiction as a particular barrier in accessing support services
4) Make recommendations to reduce barriers in service access through the implementation of trauma-informed and harm reduction approaches by counsellors and service organizations.

Theoretical/Conceptual Framework

There are four theoretical and conceptual frameworks that guide the analysis of the present literature: empiricism, first-person accounts, trauma-informed care, and a harm reduction model of care.

This capstone relies significantly on statistics and peer reviewed literature and research to inform understanding and knowledge of the relationship between human trafficking and substance use, and to understand the barriers faced by survivors due to drugs or other reasons (Collins Dictionary, n.d.). As someone who has not personally been affected by human sex trafficking nor is an expert in the field, it is essential to rely on literature and research from reliable sources to gain an accurate understanding of human sex trafficking (such as prevalence, risk factors, impacts to well-being), addiction, and barriers to services in order to assess structural and organizational shortcomings and make appropriate recommendations for counsellors supporting survivors and structural change.

First-person accounts are highly valued as the voices of survivors and service providers are heard. Reading about survivors' lived experiences of exploitation, addiction, facing of barriers, and resilience add valuable context and breathe life into theories and terms. Literature and research are highly valuable, however, first-person accounts provide real world context to research and concepts that foster greater understanding of the subject (Tenny et al., 2022). First-hand accounts are a form of qualitative research that provide great insight in understanding the experiences of survivors and service providers. They are the experts of their own lives, and much can be learned from their shared experiences (Tenny et al., 2022). For example, without these accounts, less would be known about the use of drugs in sex trafficking, the effect of service provider biases and stigmas in service provision, and the challenges survivors face accessing

services due to addiction. Thus, less would be known about how to support clients and where to advocate for change.

A trauma-informed lens is maintained throughout the research and analysis of the literature. In examining the frequent pre-existing addictions, utilization of drugs in trafficking, and impact of trauma on the well-being of survivors, I hold understanding and empathy around their substance use. I understand when a survivor leaves their trafficker they are faced with many needs, challenges, and often lowered capacities because of trauma. I understand that trying to stop using substances may not be feasible or a priority for the survivor in that moment. Both trauma-informed care and a harm reduction approach empower the survivor to be the expert in their own life and supports their agency to make their own decisions (Hopper, 2017; Marburger & Pickover, 2000). I hold a critical lens toward human trafficking organizations with sobriety requirements and a lack of treatment service options. From a trauma-informed and harm reduction lens, I see these organizations as taking away their opportunity to choose, denying meeting a client where they are, and agency by assuming the role of expert. This is not trauma-informed, not a part of harm reduction, nor is it client-centred. It does not make sense to operate in such a way given research findings demonstrating the way that human sex trafficking and drug use are interconnected (De Shalit et al., 2021; Shelley, 2012; Stoklosa et al., 2017). Trauma-informed care recognizes that having strict rules and schedules can be retraumatizing for survivors as they have lost agency and their behaviours and whereabouts are again controlled by someone else (Canadian Centre to End Human Trafficking, 2023). This relates to harm reduction frameworks, which aim to reduce potential harm when participating in risk behaviours by offering the client choice, unlike programs with sobriety policies that assume what is best for the survivor. This approach is trauma-informed, as it supports survivors' agency to be actively

involved in making their own decisions, meets survivors where they are (whether it is sober or not sober), and offers options to support and prioritize their safety. For example, for those using substances it could be provision or clean needles for those who are not able or do not want to quit or it could be a detox site that provides a safe place for those wishing to take the first steps to sobriety.

Contribution to the Field

This capstone brings to awareness the interconnected relationships between addiction and human sex trafficking exploitation. The research consistently demonstrates that most survivors who have been exploited experience addiction (Koegler et al., 2022; Michaelis et al., 2022; Robertson, 2017; Shelley, 2012). Psychological theories, specifically the stages of change model, sees relapses as an anticipated part of the journey of change (Hopper, 2017). The harm reduction model is known to be successful in reducing risk behaviours, including substance use and engagement in trafficking, and increasing social service engagement (Chambers et al., 2024; Open Society Institute, 2015; cited in Preble, 2018). Despite research and theory, many human trafficking specific organizations will not provide services, including immediate shelter, if a survivor is not sober or has not detoxed, and will retract services if a survivor relapses (Gerassi, 2018; Preble et al., 2022). This capstone demonstrates the disconnect between research about human sex trafficking and substance use, and the practices of human trafficking organizations.

This capstone contributes to the field in two main ways. First, by challenging the sobriety requirements held by many human trafficking services. I contribute recommendations for human trafficking specific services to shift from a ‘hard on drugs’ approach to a harm reduction, trauma-informed approach. Enforcing abstinence for a service that is supposed to serve survivors, who statistically have a high rate of addiction and likely will attend the service presenting with

addiction, exerts a narrative that those with addiction are not worthy of care until they 'fix' themselves. It is restrictive, stigmatizing, and places the service providers/organization in the position of the expert or rescuer, rather than supporting survivors in exercising their own strengths and agency. It appears that many service providers are unaware of their own biases toward addiction; in most of the research where service providers discuss their organizations and provision of services, they speak to their strong desire to help survivors and discuss barriers that prevent survivors from accessing their services. However, they address sobriety requirements as necessary in doing so, even though it is a barrier to survivors accessing support. I challenge service providers reading this capstone to reflect on their current biases and to be open to alternatives. Trauma-informed and harm reduction approaches reduce barriers to services access due to sobriety requirements and will provide a host of other benefits for survivors. This will be expanded on in chapter three. Second, it provides information about human trafficking, the risks and harms associated, and addiction that will help aid counsellors who may work with survivor populations. There is limited research defining a specific approach to working with survivors of human sex trafficking. This capstone makes recommendations for counsellors working with survivors, including implementation of trauma-informed practices along with interventions to support client recovery. Effective work with survivors can reduce personal barriers to accessing services. Given the knowledge of barriers in service access acquired through this capstone, counsellors are encouraged to act as advocates for their clients and to use their platform to advocate for structural change.

Reflectivity and Positionality Statement

I became inspired to understand the nature of drug use in human sex trafficking and the barriers survivors face due to addiction when my Victim Services colleagues and I hit barriers of

our own while trying to resource for a survivor who was potentially being trafficked. Victim Services Caseworkers provide emotional support, practical assistance, information and referrals, and information about the criminal justice system to victims, witnesses, and families who have experienced crime or trauma. Caseworkers work with either police or community agencies. My colleagues and I were made aware that an individual, who was suspected to have been a trafficked person, was taken to hospital and would need supports when they are released. My colleague liaised with a hospital social worker who advised that this person needs a safe place to stay as they are not local. The hospital social worker also advised that they had been off substances for the past few days while in hospital. My colleague contacted a local anti-human trafficking organization that supports survivors of human trafficking, as they had a safe house designed for survivors fleeing and provided continued support and resourcing specific to the needs of survivors. While waiting to hear back from this organization, the other caseworkers and I began contacting transition houses as a backup option for immediate shelter. Many houses were full and the few that may have had a bed could not take this individual because of their recent substance use and the individual's situation did not fit their intake parameters of domestic violence. Later, my colleague was in contact with a worker from the anti-human trafficking organization who advised that they could not take this client until they are one week sober from drugs. They offered to assist in future with transportation to detoxification treatments so the survivor can later engage with their services. My colleagues and I were in disbelief that this vulnerable individual, who was believed to have fled and was at immediate risk of homelessness, was denied immediate shelter and safety because of using substances a few days ago. We discussed our beliefs about drug use and human trafficking, and how many survivors have addiction problems due to intentional or forced use. I was not familiar with human sex

trafficking. While I learned through undergraduate studies that sex work occurs in Canada, I did not know that human sex trafficking occurred as well. I am a white, middle class, cisgender female who grew up in a home in the suburbs. While I had my own adverse experiences, no one in my family used drugs (to the best of my knowledge) and I have never known someone who had been trafficked. Though I knew little about the subject, my coworkers' beliefs and hypotheses did not sound unreasonable, given that being trafficked would be extremely traumatic and drugs are a known method of coping with pain. I knew less about the use of drugs by traffickers but imagined that it could be possible that they use drugs to inebriate survivors. I wondered if beliefs and hypotheses of these colleagues are true, that addiction is prevalent in human trafficking, and queried how an organization who would surely be aware of such expect clients to be sober immediately after fleeing? I was surprised that harm reduction was not utilized. This experience brought to awareness the barriers faced by survivors seeking services because of their addictions. It also brought to awareness that there are limited services specific to survivors of human trafficking, as this organization was the only option in the lower mainland. I decided that I wished to gain a thorough understanding of the relationship between substance use and human trafficking, such as prevalence of addiction and how drugs are used. I wanted to know if sobriety requirements are a common barrier in accessing human trafficking specific services as well as others, or if this experience was an outlier. I also wanted to explore other barriers faced by survivors in accessing services. My belief that all people deserve to access services regardless of addiction drove me to research into harm reduction as opposed to sobriety requirements, as well as trauma-informed approaches, to reduce barriers to service access and adequately support clients as they begin to heal from extensive traumas.

Definition of Terms

Boyfriend Pimping

Also known as Romeo pimping, is a strategy used by traffickers to groom and lure survivors into the trade by preying on desires for love, safety, and connection (Deshpande & Nour, 2013; Duncan & DeHart, 2019; Litam, 2017). It is known as boyfriend pimping because the dynamics between trafficker and survivor resemble a romantic relationship (Duncan & DeHart, 2019; Michaelis et al., 2022). The trafficker acts in ways that are imitative of romantic relationships, including gift giving, showing affection, care, kindness, acting charming, and promising to give the survivor the best life possible, to foster survivor feelings of love, safety, and connection so they become romantically attached and loyal to the trafficker (Deshpande & Nour, 2013; Duncan & DeHart, 2019; Litam, 2017).

Coercion

A core strategy used by traffickers to manipulate or control a survivor's actions using physical force, fraud, or threats (Gonzalez et al, 2019; Litam, 2017).

Ensnaring

A stage of the grooming process where the trafficker seeks to build trust, safety, and loyalty (to the trafficker) with the survivor (Litam, 2017). Ensnaring often occurs as the first stage of grooming, however it can occur at different points in the grooming process (Litam, 2017).

Fraud

A core strategy used by traffickers to maintain control over survivors through accumulation of debts. Survivors engage in sex acts to repay their debts for food, substances, and condoms (Litam, 2017; Michaelis et al., 2022; Shelley, 2012). However, survivors find themselves trapped in a cycle, as they will continue to need food to survive and those addicted continue to need

drugs to avoid withdrawal and cope with pain, leading to constant and inescapable re-accumulations of debt (Michaelis et al., 2022; Shelley, 2012; Stoklosa et al., 2017).

Force

A core strategy used by traffickers to control survivors by using physical violence, sexual violence, intimidation, confinement, abduction. and forced substance use (Deshpande & Nour, 2013; Litam, 2017; Marburger & Pickover, 2020).

Guerilla Pimping

Also known as gang affiliated or violent trafficking, is a strategy used by traffickers to bring survivors into the trade through use of force, coercion, and provision of drugs (Hammond & McGlone; Michaelis et al., 2022). It is also known as gang affiliated trafficking because it is often current or former gang members who utilize violence in the recruitment and control of survivors (Michaelis et al., 2022).

Harm Reduction Model of Care

A model that aims to “reduce negative outcomes associated with certain activities which typically are criminalized and involve health risk” (Chambers et al., 2024, p. 45). This model supports an individual’s agency and freedom to engage risk behaviours (such as substance use or engagement with a trafficker), collaborating with the individual to promote personal safety and minimalizing risk of harm. The approach essentially provides an unconditional support and care to individuals, regardless of addiction, substance use, and decisions. This approach is in direct opposition to abstinence-based models, where maintaining sobriety is a condition to receive care and support.

Human Sex Trafficking

Defined by the Trafficking Victims Protection Act as "the recruitment, harbouring, transportation, provision, or obtaining of a person for commercial sex through force, fraud, or coercion, or in which the person induced to perform a sex act is under 18 years of age" (US Department of State, 2000; cited in Litam, 2017, p. 46).

Human Trafficking

Defined by the United Nations Office on Drugs and Crime (2004) as:

> The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force, or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments of benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. (p. 42).

Human trafficking commonly refers to sexual exploitation, forced labour, but it can also include organ removal, illegal adoption and selling of infants, and exploitative begging (Ernewein & Nieves, 2015; ILO, 2017; UNODC, 2021; cited in Heidinger, 2023).

Labour Trafficking

The use of force, fraud, and coercion to exploit individuals into doing any work the trafficker desires (Public Safety Canada, 2022).

LGBTQIA2S+

The acronym for lesbian, gay, bisexual, transgender, queer and questioning, asexual or agender, and two-spirit (Michigan State University, n.d.)

Pimp

A person who controls the survivor and promotes or solicits buyers. They can work for traffickers and profit from the trafficked person's exploitation (Merriam-Webster, n.d.)

Sex Work

When an individual voluntarily engages in sex acts in exchange for money (George et al., 2010; Merriam-Webster, n.d.)

Survival Trafficking

Survivors who are lured into the trade through the promise of meeting basic needs or addiction needs that they are unable to meet on their own (Duncan & DeHart, 2019). The trafficker acts as a provider, however they exploit the survivor's desperation to survive by providing food, shelter, and substances in exchange for sexual acts (Contreras et al., 2017). Sexual acts to meet the survivor's needs are known as 'survival sex' (Duncan & DeHart, 2019; Gerassi & Nichols, 2017). Trafficker provision or withholding of basic needs is a method used to coerce and control survivors (Contreras et al., 2017).

Trafficker

An individual who engages in the exploitation and illegal buying and selling of services, goods, or people (Britannica, 2024).

Transition House

Also known as a 'safe house', a shelter designated for women and children fleeing from domestic and family violence.

Trauma-Informed Care

Care guided by the understanding of the social, emotional, physical, behavioural and psychological impacts of trauma on individuals (Gerassi & Nichols, 2017; Judge et al., 2018).

Outline of the Capstone Project Chapters

The present chapter provided background information to understand fundamentals of human sex trafficking. It clearly defines the broad range of acts that fall within the category of sex trafficking. Human sex trafficking is identified as one of the most profitable criminal enterprises. It is a pervasive problem across the globe, with millions trafficked each year for criminal profit. Research demonstrates that Canada is not immune to human sex trafficking, with hundreds to thousands reporting to police or human trafficking hotlines annually (Canadian Centre to End Human Trafficking, 2023; Public Safety Canada, 2024). This chapter raises awareness of human sex trafficking as a problem in Canada that warrants attention and awareness. While women and girls tend to make up the greatest numbers of survivors, any person can be trafficked and exploited (Ernewein & Nieves, 2015; Litam, 2017; Public Safety Canada, 2024; UNODC, 2009). The chapter identified social, environmental, psychological, and behavioural factors that make an individual more vulnerable to being trafficked. Many risk factors are rooted in past trauma, abuse, poverty, lack of social supports, and addiction. The methods used by traffickers to recruit survivors are discussed. They often involve preying on vulnerabilities by presenting themselves as able to meet the survivor's unfulfilled needs to build trust and gradually become more forceful and controlling, while some immediately utilize violence to control survivors and force them into exploitation. Force, fraud, and coercion are identified as core components in the recruitment and entrapment of survivors. They function as methods for traffickers to maintain physical and financial control over survivors, as well as dependence to survive. The background information about the process of trafficking and the harm to survivors through the uses of force, fraud, and coercion provides foundational knowledge for the reader. Empiricism, first person accounts, trauma informed care, and a harm

reduction model of care are introduced as theoretical lenses that I am examining the present research through and make recommendations from.

Chapter two builds on the foundational knowledge gained in chapter 1 by providing detailed information about the health consequences of human sex trafficking for survivors. The chapter demonstrates the significant, negative effects that human sex trafficking exploitation has on the physical, psychological, emotional, and behavioural well-being of survivors. The chapter introduces addiction as a significant factor in the recruitment, force, fraud, and coercion of survivors. It examines the types of substances used, the side effects of their use, and the purposes of substance use by traffickers and survivors. The chapter brings forward the issue of survivors being unable to access necessary services, such as shelter, housing, specialized treatments, and services specific to human sex trafficking. This is identified as a significant problem because statistics reveal that under half of survivors report accessing services. The chapter discusses eight main barriers to service access, including a separate section dedicated to the discussion of addiction as a particular barrier to accessing housing, shelter, and human trafficking specific supports. It also discusses the challenges that individuals face in accessing addiction treatment services, demonstrating that even those who choose to seek sobriety still experience barriers in accessing services due to sobriety requirements.

Chapter three builds on chapter two by making best practice recommendations for counsellors, service providers, and organizations while calling for systemic change. The recommended best practice for counsellors and service providers are trauma informed care, as well as drawing on strength-based approaches, harm reduction approaches, and resourcing for clients. These practices aim to reduce barriers to service access by; mitigating the effects of internalized stigma and shame, improving well-being and trauma symptoms which help clients to

be in a state where they can assess their needs and access services, bringing awareness to and understanding of available resources/services to the survivors attention, and providing referrals services where necessary. These approaches support safety, wellbeing, and agency of clients by making them the centre of the change process. Recommendations to organizations include proper training and education about trauma informed care, harm reduction practices, and human sex trafficking exploitation to reduce stigmas and provide care that is ethical, empowering, non-judgemental, and accessible to all survivors. I call for systemic change by providing greater funding for service provision and detoxification/addiction supports on site at human trafficking organizations to help close gaps in service provision.

Chapter Two: Literature Review

The Effects of Human Sex Trafficking

Physical

According to the research, most survivors (about 83.3%) have experienced physical violence while being trafficked (Deshpande & Nour, 2013; Muftić & Nieves, 2015). Violence ranges from moderate to severe and the sources of violence are from traffickers, pimps, or those paying for services. Since violence is a component of force used by traffickers to maintain control, it is no surprise the most survivors experience physical harm. Survivors are subject to physical and sexual violence and abuse that has detrimental effects on their physical well-being. Various studies on the impact of trafficking on survivors found the following as commonly reported physical injuries: broken bones, scars, dental and jaw injuries, internal and genital injuries, chronic pain, head trauma, and burns (Hammond & McGlone, 2014; Marburger & Pickover, 2020; Powell et al., 2018). Other health issues reported by survivors and health professionals due to their exploitation include sexually transmitted infections (STI) (including AIDS, and HIV), Hepatitis C, reproductive health problems stemming from unsafe abortions, hypertension, and increased risk of diabetes (Deshpande & Nour, 2013; Marburger & Pickover, 2020; Powell et al., 2018). States of malnutrition and dehydration are reported (Hammond & McGlone, 2014; Marburger & Pickover, 2020). It is important to reduce barriers to survivor access to health care services so they can begin to heal physical wounds from their victimization and promote the best health outcomes.

Emotional & Psychological

Research finds that human trafficking has a profound impact on the emotional and psychological well-being of survivors. Survivors report experiencing high rates of trauma,

anxiety, eating disorders, and depressive disorders. The disorders include post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder, complex trauma, obsessive compulsive disorders (OCD), generalized anxiety disorder (GAD), major depressive disorder, suicidal ideation, suicide attempts, specific phobias, anorexia nervosa, bulimia nervosa, and substance use disorders (Deshpande & Nour, 2013; Gerassi & Nichols, 2017; Hammond & McGlone, 2014; Marburger & Pickover, 2020; Powell et al., 2018; Stoklosa et al., 2017). Survivors report high rates of suicidal ideation and attempts, feeling fearful, dysregulated, in 'fight or flight', shameful, guilty, and hopeless (Hemmings et al., 2016; Judge et al., 2018; \ Marburger & Pickover, 2020; Powell et al., 2018; Stoklosa et al., 2017). Survivors remain in a survival state for extended periods of time. A frequent survival state is a common reaction to trauma, as well as amplified fear, nightmares, and avoidance of places and stimuli that are a reminder of the traumatic event. Dysregulation makes it difficult for survivors to cope. Survivors experience intrusive thoughts, self-blame, dissociation, and nightmares (Gerassi & Nichols, 2017; Powell et al., 2018). Multiple traumatic events and abuses in human trafficking make it complex and highly traumatic. This is further compounded for those who have experienced previous trauma, with the numerous predisposing factors that place the client at even greater risk for further abuse, coercion, and trauma by traffickers (Recknor et al., 2020). Experiences of complex trauma are found to be common and some literature suggests it dates back to childhood (Chambers et al., 2024). There is a risk of comorbid disorders, and there is a high risk of comorbidities such as depression and addiction, especially when there is pre-existing PTSD and physical injury (Marburger & Pickover, 2020).

Behavioural

Survivors reportedly experience several behavioural impacts from human sex trafficking due to complex trauma. Lack of trust due to trauma is a focal point of many of the behavioural challenges (Gerassi & Nicols, 2017; Judge et al., 2018). For many prior to trafficking, people who were supposed to protect them and be trustworthy caused harm. Now a survivor may be recruited by a pimp or trafficker who promises safety and love, things that they longed for. They trust again and are harmed again. Some may have been arrested by police for drug charges rather than protected from their trafficker (Contreras et al., 2017). For those who leave trafficking that have family remaining, they strongly fear judgement, stigma, and rejection. Survivors experiencing marginalization and discrimination from medical professionals and systems naturally have a difficult time trusting (Contreras et al., 2017; Duncan & DeHart, 2019; Gerassi & Nichols, 2017). The literature finds avoidance behaviours a common behavioural response by traumatized survivors. For example, avoidance of people, places, and stimuli that trigger emotions and memories of their victimizations (Gonzalez et al., 2019; Powell et al., 2018). Avoidance also presents in survivor views of the world: viewing the world as unsafe and other people (including care providers) as untrustworthy, thus it is best to avoid people and places to protect the self (Gerassi & Nichols, 2017). Human sex trafficking impacts relationships and connection with others. Survivors report struggling with connecting and relating with others and fearing rejection (Judge et al., 2018). The struggle with connection contributes to feelings of disconnection and low satisfaction in relationships (Judge et al., 2018). They may flee from those who are trying to support them or anyone who is trying to connect with them, fearful of potential rejection and harm. Psychological impacts affect the ability to self-regulate, which can lead to difficulty controlling emotions, impulses and intense fear (Deshpande & Nour, 2013; Judge et

al., 2018). Remaining in a state of fear, or fight/flight, can make it difficult to feel safe while navigating the world and lead to them fleeing from people and places who are trying to help (Gerassi & Nichols, 2017). Survivors who develop substance use disorders turn to substances in part to try to regulate themselves and cope with the emotional and psychological impacts of trauma (Michaelis et al., 2022; Roberson, 2017; Powell et al., 2018; Stoklosa et al., 2017).

Drug Use

Prevalence of Addiction

It is well established in research and literature that human sex trafficking, victimization, and addiction are closely intertwined (De Shalit et al., 2021; Shelley, 2012; Stokolsa et al., 2017). Addiction is amongst the risk factors for human trafficking and is most often the major factor in the recruitment, coercion, and control of survivors, fosters dependency on traffickers, and is a barrier to survivors exiting (Hammond & McGlone, 2014; Marburger & Pickover, 2020; Michaelis et al., 2022; Roberson, 2017). The vast majority of survivors experience addiction and substance use during their victimization, by force or choice. According to available research on substance abuse and addiction, between 60-100% of adult survivors reported using substances during their exploitation (Roberson, 2017; Shelley, 2012). Limited research examines the prevalence of addiction in youth survivors of human sex trafficking. In one study, 75% of youth survivors disclosed drug use or addiction during their exploitation (Roberson, 2017). It is possible that the variance in drug use/addiction amongst adults in part may be due to a confounding variable: force and coercion. Those who report the highest rates of addiction and substance use identified as being ‘gang-controlled’ (Roberson, 2017). Gang traffickers tend to use high rates of violence and force toward survivors (Roberson, 2017). The next highest rates of drug use and addiction came from those whose traffickers were controlled by pimps, who also

use violence and force to maintain control of survivors. (Roberson, 2017). Forced drug use and coercion are strategies utilized by gang and pimp-controlled traffickers to maintain control and compliance of survivors (Deshpande & Nour, 2013; McGlone, 2014; Michaelis et al., 2022; Stoklosa et al., 2017). Both groups also tend to target individuals with substance use addictions for exploitation as they use their addiction to control them. This includes withholding drugs as punishment or making survivors endure abuse in exchange for drugs (Michaelis et al., 2022). Some research indicates that many drug-addicted survivors began using as youth (Koegler et al., 2022). "Survivors often find themselves in a seemingly inescapable cycle of trauma, abuse, and self-harm" (UNODC, 2016; cited in Roberson, 2017, p. 361). Further research would be beneficial to inform a mean rate of survivor substance use.

Types of Substances and their Effects

The literature finds that various types of drugs/substances are used by survivors. Two main factors that influence which substances are used: the desired effect and substance accessibility. Five drug types are found to be utilized by either traffickers, survivors, or both. These are opioids, stimulants, alcohol, marijuana, and synthetics (Hopper, 2017; Koegler et al., 2022; Shelley, 2012). All drugs cause varying degrees of withdrawal symptoms if a survivor tries to quit use, depending on the frequency and duration of use and dosage. Withdrawal symptoms will be discussed later in chapter two. It is essential to keep in mind that individuals can be using multiple substances at one time (polysubstance use) which increase, decrease, or completely change the known effects of each drug (U.S. Centers for Disease Control and Prevention, 2024).

Opioids are an extremely addictive and popular drug used in human trafficking (Koegler et al., 2022; Roberson, 2017). Opioids can take the form of pharmaceutical and non-pharmaceutical drugs (Australian Government Department of Health and Aged Care, 2021).

Heroin was identified as the most used opioid, with 25% of survivors using it (Roberson, 2017; Shelley, 2012). In addition to heroin, fentanyl and prescription opioid drugs have reported use by survivors (Koegler et al., 2022; Roberson, 2017). The research does not detail which specific opioids are included in the identified prescription drug use. For reference, some commonly used prescription opioids include codeine, morphine, oxycodone, and fentanyl (Canada, 2024). Opioids' side effects can vary by the type of opioid used. Effects can include pain relief, euphoria (feeling good), dizziness, confusion, sedated state, drowsiness, headaches, and constipation (Australian Government Department of Health and Aged Care, 2021; Canadian Centre on Substance Use and Addiction, 2022; Government of Canada, 2024). Their addictive nature leads users to develop high physical dependence on them, experiencing withdrawal symptoms if they do not continue to use (Government of Canada, 2024). Withdrawal symptoms can range from severe to minor, depending on frequency and duration of use and dosage (Government of Canada, 2024).

Stimulants are another drug utilized in human trafficking. Stimulants can take the form of pharmaceutical or non-pharmaceutical drugs (Government of Canada, 2022). The reported stimulant use by survivors includes cocaine and methamphetamine, however cocaine was more commonly reported (Koegler et al., 2022). Effects of stimulant use include feelings of euphoria, increase in energy, alertness, attention, confidence, dizziness, wakefulness, sleep difficulty, anxiety, paranoia, and aggression (Australian Government Department of Health and Aged Care, 2021; Government of Canada, 2022). Some effects, such as paranoia, anxiety, and aggression, can build over time, while other effects occur after a short time (Government of Canada, 2022).

The research found that alcohol is also a commonly used substance, in part due to alcohol being legal and easily accessible (Hopper, 2017; Koegler et al., 2022). Effects of alcohol use

include increased relaxation, calmness, drowsiness, skin flushing, nausea and vomiting, depression, anxiety, infertility, memory problems (memory loss and blackouts), slurred speech, lowered inhibitions, impulsive behaviour, impaired concentration, decision making and judgement, slow reaction time, difficulty sleeping, and unconsciousness (Government of Canada, 2022). The research does not elaborate on the types of alcohol used in human sex trafficking.

Like alcohol, marijuana is an easily accessible and legal substance (in Canada and other countries) that is a commonly used substance among human trafficking survivors (Hopper, 2017; Koegler et al., 2022). Marijuana contains tetrahydrocannabinol (THC), a cannabinoid that is responsible for the physical and psychological effects experienced by users (Canadian Centre on Substance Use and Addiction, n.d.; National Center for Complementary and Integrative Health, 2019). Impaired memory, concentration, reaction times and reflexes are staple effects of marijuana (Government of Canada, 2024). Marijuana can cause a wide array of effects on users: some experience a relaxed effect, with increased euphoria, sense of wellbeing, feeling light or floating, and drowsiness (Alcohol and Drug Foundation, 2024). Others experience greater distress, with an increase in panic, anxiety, fear, paranoia, psychosis, and hallucinations (Government of Canada, 2024). Some effects, such as memory and decision-making challenges, paranoia, and intelligence quotient worsen over longer periods of time, while other effects occur after a short time (Government of Canada, 2024).

Synthetic drugs are highly addictive substances that are artificially created to copy the effects of other drugs (Royal Canadian Mounted Police [RCMP], 2013). As they can imitate a variety of other drugs, the effects of synthetic drugs can vary widely depending on the type of drug they are trying to mimic (Australian Government Department of Health and Aged Care, 2021; RCMP, 2013). Effects of synthetic drugs include but are not limited to: anxiety, paranoia,

hallucinations, dizziness, insomnia, alertness, appetite loss, euphoria, increased heart rate, heightened emotions, amplified sensory perceptions, lowered inhibition, appetite loss, confusion, incoordination, pain relief, and loss of speech or difficulty speaking (Australian Government Department of Health and Aged Care, 2021; RCMP, 2013). Unfortunately, there is limited research into the specific synthetic drugs used by survivors or traffickers. The present literature identifies synthetics as a drug used predominantly by traffickers to force compliance from survivors but does not provide further insight into the type of synthetic drugs used (Shelley, 2012).

Purpose of their Use

The present research and literature find that both traffickers and survivors utilize drugs for different purposes (Shelley, 2012).

Research has found that "drugs have a role in the recruitment, retention, and exploitation of human trafficking victims" (Shelley, 2012, p. 241). There are three reported usages of substances by traffickers: to recruit/lure survivors, to obtain coercive control, and to force survivor productivity. Traffickers and pimps utilize drugs in recruitment by preying on vulnerable individuals, building a perception of trust and care in the eyes of the survivor, then proceeding to gradually introduce them to drugs with the objective to get them addicted and dependent on the trafficker (Hammond & McGlone, 2014; Michaelis et al., 2022; Roberson, 2017; Stoklosa et al., 2017). Some frame drug use as a normal behaviour to the survivor, others use the trust and loyalty they have built with the survivor to convince them to use (Gerassi & Nichols, 2017; Michaelis et al., 2022). As discussed previously, particularly with finesse or boyfriend pimping recruitment strategies, the trafficker plays a role of a provider who will take care and love the survivor. Thus, when they request the survivor to use drugs or engage in other

acts, they will be compliant and loyal (Deshpande & Nour, 2013; Michaelis et al., 2022). Traffickers also target survivors who are already addicted to substances, luring them into trafficking with offers of drugs (Michaelis et al., 2022). Once they have become addicted or those with pre-existing addictions seek more substances, they enter a cycle where they are continuously paying back drug debts to their trafficker through their own exploitation, then proceeding to buy more drugs (Hammond & McGlone, 2014; Roberson, 2017). The survivor's exploitation generates profit for the trafficker and pays back the drug debt, leading them to continually profit from the survivor's addiction and exploitation (Roberson, 2017). This is one way that the trafficker establishes coercion and control over survivors. Traffickers also force survivors to use certain drugs to gain control and compliance over them, sometimes threatening them with violence or their loved ones if they do not obey (Contreras et al., 2017; Marburger & Pickover, 2020; Michaelis et al., 2022; Roberson, 2017). In one study, forced drug use was reported by 25% of victims (Lederer, 2014; as cited in Hopper, 2017). Studies of survivors have demonstrated much higher rates of addiction, including 80% (Hammond & McGlone, 2014; Michaelis et al., 2022). These survivors experienced violent, gang affiliated, or guerilla trafficking (Michaelis et al., 2022). Forced drug use and threats to harm are among common tactics of these traffickers, however, the present research does not tease out how many of the 80% were forced drugs or were possibly already addicted and targeted for it. Traffickers use certain drugs to render survivors submissive by lowering inhibitions, impairing judgement, 'brain washing' them, rendering them confused, and more (Michaelis et al., 2022). In this state they are extremely vulnerable to coercion and being overpowered by their trafficker. They may also force feed drugs to increase productivity and profits. This is done by feeding the survivor drugs to manage pain or to increase their energy so the trafficker can force more work and longer

encounters with buyers (Michaelis et al., 2022; Shelley, 2012). This might be done using opioids or stimulants, depending on the traffickers perceived need. They can be controlled by not only being forced drugs, but also through taking drugs away (Michaelis et al., 2022). As a survivor's dependency grows, so does their need for their next fix. The trafficker uses this need as an opportunity to control and coerce the survivor by withholding drugs if the survivor does not comply with the trafficker's demands (Michaelis et al., 2022). The presence and absence of drugs can be used as a punishment or reward depending on the context.

Research identifies three usages by survivors: pain management, escapism, and to avoid withdrawal. Survivors have reported using substances to numb physical pain (Hammond & McGlone, 2014; Marburger & Pickover, 2020; Roberson, 2017; Stoklosa et al., 2017). Given the numerous physical injuries and pain reported by survivors, it is logical that many have opted to use to cope with their current injuries and continuous harm and abuse by traffickers and those buying services. For youth survivors, alcohol may be the starting substance that later turns into hard drugs (Koegler et al., 2022). Survivors also identify using substances to cope with trauma by numbing emotional pain, trauma, and to try to regulate their nervous systems. Another use of substances by survivors to cope with emotional pain and trauma is to escape through dissociation (Stoklosa et al., 2017). Dissociation acts as a brief escape from what feels like a permanent, inescapable cycle of trauma and abuse (Deshpande & Nour, 2013; Hammond & McGlone, 2014; Marburger & Pickover, 2020; Michaelis et al., 2022; Roberson, 2017; Stoklosa et al., 2017). Opioids are reported as a substance of choice for survivors to cope with pain, which is sensible as opioids are among the most effective drugs to treat pain (Roberson, 2017; Stoklosa et al., 2017). Through substance use, survivors are distanced from physical and emotional suffering for a short time. While substance use is a tool used by survivors for the purpose of coping, there are

survivors who wish to stop using substances but who do not want to go through withdrawal. Numerous studies identify survivor fear of withdrawal as a barrier in stopping substance use (Gerassi et al., 2018; Government of Canada, 2024; Koegler et al., 2022; Roberson, 2017). Symptoms of withdrawal may include anxiety, fatigue, stomach pain, nausea, vomiting, diarrhea, increased pain, depression, sweating, chills, confusion, disorientation, hallucinations, agitation, and aggression (Government of Canada, 2024; World Health Organization [WHO], 2009). The severity of withdrawal symptoms can range from mild to severe, depending on the frequency and duration of drug use, as well as the dosage and type of drug used (Government of Canada, 2024; WHO, 2009). The literature found that survivors continue to use and remain with their trafficker to avoid symptoms, sickness, and the vulnerability of withdrawing on the street or in an unsafe place (Gerassi, 2018; Howarth, 2023; Koegler et al., 2022; Roberson, 2017). One piece of literature identifies traffickers using withdrawal fears to further coerce and control survivors, such as telling survivors that if they escaped, they would be arrested for their crimes and would have to withdraw alone in jail, inducing further fear and a belief that there are no options besides staying with the trafficker (Roberson, 2017). Those who choose to leave and successfully escape from their trafficker are often met with many barriers that impede access to withdrawal and detoxification support, addiction treatment, and other short and long-term needs.

Barriers to Survivors Accessing Support Services

Stigma

Stigma is "a process that attempts to disgrace a person or group based upon their circumstances or identity" (Cody, 2018, para. 1). The experience of stigma is commonplace for survivors of human sex trafficking. Stigma towards survivors is associated with greater violence, abuse, isolation, and reduced support (Cody, 2018; Preble, 2018). These factors as well as

discrimination are further aggravated for those who are marginalized because of their gender identity, sexual orientation, and race (Cody, 2018). On top of experiencing stigmatization for their involvement in sex work, it has been found that survivors also face stigma and discrimination for using substances (De Shalit, 2021; Hammond & McGlone, 2014; Preble, 2018). Stigma harbours harmful stereotypes, portrayals, misconceptions, and devaluation of survivors (Preble, 2018; Vijeyarasa, & Stein, 2010). There are various misconceptions and judgements about survivors that have spread through society. These include that they are not victims because they are paid or did not cross international borders, that trafficking is not illegal and they consented to it, that only women are victims of human sex trafficking, and that survivors are criminals (Fukushima et al., 2020; Judge et al., 2018; Omelas et al., 2023; Ren, 2014). The belief that survivors chose to be trafficked implicates the survivor as responsible for the consequences of trafficking and their current position. Two research studies found that blame is placed on survivors by members of society, with greater blame attributed by men (Menaker & Franklin, 2015; Omelas et al., 2023). Compared to survivors of other power-based crimes (such as sexual assaults and intimate partner violence), there is much greater blame attributed to survivors of human sex trafficking, even when aware of the role of force and coercion (Menaker & Franklin, 2015). In some cases, even survivors of other types of violence stigmatize those of human trafficking (Clawson & 2008). However, there are high levels of support for the implementation of survivor appropriate services. While further research is required to understand these attributions, the present research demonstrates how judgements of survivors can persist despite the awareness of refuting information. Such misconceptions overlook the roles of force, fraud, and coercion in the recruitment, entrapment, and exploitation of survivors (Ren, 2014). Despite these misconceptions of survivor responsibility and blame for their victimization, they

are commonly portrayed as helpless, weak, disempowered, infantilized, and in need of rescue (Omelas et al., 2023). The circulation of such stigmas sets the tone for judgement, and lack of support and safety.

The present literature finds that two types of stigma act as a barrier to survivors accessing support services: internalized stigma and shame, and stigma from the wider society, including service providers and systems. An examination of literature that considers experiences of internalized stigma and shame among survivors of human sex trafficking finds that such experiences are commonplace. Survivors across various studies report feeling shame for their addictions, illegal actions during their exploitation, health conditions due to their exploitation or drug use (such as HIV), feeling defective, and like a failure (Vijeyarasa & Stein, 2010; Hammond & McGlone, 2014; Lanctot et al., 2021; McAfee et al., 2020). One study in particular stands out as the felt shame and defectiveness was high in survivors despite controlling for past experiences of abuse/harm (Lanctot et al., 2021). This suggests that human trafficking is unique to other traumatic events, in the harm it causes to a person's self-worth, significant felt shame, and stigma. This demonstrates the need for further research to examine variables within human sex trafficking that contribute to the development of self-stigma and shame. Shame is experienced when one perceives themselves as bad and wrong (Fukushima, 2020). While shame can exist on its own, it has also been identified by product of stigma and coercion (Contreras et al., 2017). When stigmatizing messages are received and internalized, such as labelling sex workers and drug users as 'bad' and worthless, these labels become absorbed as a part of the view of self, seeing the self as bad and worthless and feeling ashamed of who they are (Contreras et al., 2017). Coercion from traffickers devaluing the survivor further solidifies survivor shame. Guilt is different from shame, as shame is feeling badly about the self and guilt is feeling badly

about one's actions, choices, or decisions (Britannica, 2024). The experience of shame and internalized stigma leads survivors to not disclose victimization, to disengage from potential supports, and to not seek supports and treatments for health conditions (Decker et al., 2009; Fukushima et al., 2020; Safdar & Khan, 2023). Disclosing victimization evokes high levels of shame itself (Contreras et al., 2017).

Both survivor perceptions and fears of stigma and judgement by service providers and others acted as a barrier to survivors in accessing and remaining in support services (Canadian Centre to End Human Trafficking, 2023; De Shalit et al., 2021; Gerassi & Nichols, 2017; Hopper, 2017; Price et al., 2021). Survivors report experiencing discrimination, racism, judgement, violence, and stigmatization from others while engaging in social services, with the magnitude amplified for those with intersecting identities including gender identity and race (Drydyk, 2023; Fukushima et al., 2020; Gerassi & Nichols, 2017; Marburger & Pickover, 2020; Price et al., 2021). It is common for survivors to have difficulty trusting others. Trauma itself impacts a survivor's ability to trust and changes how they relate with others (Judge et al., 2018). Past negative experiences with service providers, intense felt shame, and lack of support break down survivors trust for future providers to not further stigmatize or judge them (Contreras et al., 2017; Marburger & Pickover, 2020; Preble, 2018). These survivor concerns have validity. Studies that examined the perceptions of social service workers and provision of services found that survivors experience barriers in accessing programs and supports due to worker biases and stigma towards survivors (De Shalit et al., 2021; Langton et al., 2022). Perceptions of survivors as criminal, not obedient, addicts, and incompetent in decision making are among the judgements made by providers, as well as shaming them (Contreras et al., 2017, De Shalit et al., 2021; Duncan & DeHart, 2019; Fukushima et al., 2020). Stigma also lives in the policies of social

services, such as lack of service provision for non-female identifying survivors, those who use substances, and those who do not meet the socio-economic thresholds, such as not being impoverished enough (Fukushima et al., 2020). While some studies have acknowledged the impact of stigmas held by workers for the provision of services, acknowledgement of stigmas within policy are rarely acknowledged. Given the stigmatization survivors experience from others, service providers, and systems, it is no wonder they are reluctant to seek support.

Lack of Services in General and of Appropriate Human Trafficking Specific Services

In reviewing literature that examined services and needs for survivors, there is consensus that services designed for survivors of human sex trafficking are scarce (Clawson & Dutch, 2008; Cody, 2018; Hammond & McGlone, 2014; Judge et al., 2018; Roberson, 2017). Due to the lack of human sex trafficking specific services, survivors are directed to other services that are unable to meet their unique needs or are not appropriate for the context of human sex trafficking (Clawson & Dutch, 2008; Drydyk, 2023; Howarth, 2023; Judge et al., 2018). Common examples noted in the literature are programs for survivors of domestic violence, sexual assaults, and torture and transition houses (Clawson & Dutch, 2008; Duncan & DeHart, 2019; Howarth, 2023; Judge et al., 2018;). Transition houses are high barrier in that they have strict no substance use policies and often do not provide services to individuals experiencing significant mental health concerns (Duncan & DeHart, 2019; Langton et al., 2022; Preble et al., 2022). An additional barrier to transition houses is that the individual must be a survivor of domestic violence, meaning they are fleeing from an intimate partner or ex-partner. Despite power, control, and abuse dynamics within human trafficking and traffickers using romantic relationships to lure survivors, transition houses do not characterize these experiences as domestic violence and therefore decline survivors (Fukushima et al., 2020). Due to the high prevalence of addiction and

mental health difficulties amongst survivors of human sex trafficking and the extreme trauma associated with it, it is very likely that many survivors would not meet intake criteria for transition homes. In addition, transition homes' capacity is not large enough to serve domestic violence survivor populations let alone human trafficking survivors should they be considered, leading to long waitlists (Drydyk, 2023). Space in shelters is also not guaranteed, and numerous shelters are line up only and do not hold beds. Not all shelters have private space and are gender-based, and they can be extremely unstable, presenting further safety risks and re-traumatization (Doran et al., 2014; Du Mont et al., 2024). They cannot meet the needs of survivors (Drydyk, 2023).

Among the scarce services, there lacks culturally appropriate services, a lack of services in multiple languages, and lacked inclusivity for LGBTQIA2S+, men, and youth (Clawson & Dutch, 2008; Powell et al., 2018; Preble et. al., 2022). Acquisition of service providers with language skills and use of interpretation services when certain languages are not spoken by staff must be high priority to reach more survivors. There is a lack of appropriate shelters to support the safety needs of LGBTQIA2S+ survivors (Preble et. al., 2022). Survivors experience barriers in accessing supports due to language barriers, services unable to meet their unique needs, fears of marginalization, and they may be turned away due to their gender (Gerassi & Nichols, 2017; Gonzalez et al., 2019; Powell et all., 2018). Most services are limited to providing support to women, overlooking and turning away men, an action that is further stigmatizing (Doran et al., 2014). Men cannot seek support from some of the other common avenues like transition houses and sexual assault supports, as they are also geared towards women. In British Columbia (B.C.), only two organizations provide support to men who have experienced sexual violence: BC Male Survivors of Sexual Abuse and Men's Therapy Centre (n.d.). While these are useful resources

for some, they may not fit the needs of men who have survived human sex trafficking. Heteronormative, western, and gender exclusive services reflect bias within the structure of services.

Lack of funding is identified as a systemic barrier that restricts existing programs' capacity and the creation of additional survivor specific services (Drydyk, 2023; Doran et al., 2014; MacAfee et al., 2020; Powell et al., 2018). Survivors are placed on waitlists due to program space that cannot meet the high demands of the populations that they serve (Clawson & Dutch, 2008; Marburger & Pickover, 2020). For instance, there is one human trafficking specific service in B.C., despite B.C. having a population of approximately 5.6 million people (BC Stats, 2024). In addition to the lack of availability of survivor specific services, there are issues with survivors accessing other essential services to meet their needs due to lack of availability and high demand (Clawson & Dutch, 2008; Gerassi et al., 2019; Koegler, 2012; Marburger & Pickover, 2020). Immediate shelter, short and long-term housing, access to detoxification and addiction treatment services are identified as lacking availability (Clawson & Dutch, 2008; Doren et al., 2014; Duncan & DeHart, 2019; Gerassi et al., 2019; Koegler, 2012). In addition to lack of availability and waits for immediate/short/long-term housing and counselling, survivors with substance use addictions, severe mental health challenges, and criminal records face greater challenges to access stable housing (Clawson & Dutch, 2008; Langton et al., 2022; Judge et al., 2018). If a survivor is on a waitlist for a human trafficking support service, they cannot access safe housing until they have detoxed, but while they are on a waitlist for detoxification and addiction services, where are they to go and what are they to do?

Lack of Awareness and Understanding of Available Services

Most of the present literature exploring barriers to service access identifies lack of awareness and understanding of available services in the survivor's area as a barrier to service access (Fukushima et al., 2020; Gonzalez et al., 2019; Hammond & McGlone, 2014; Howarth, 2023; Price et al., 2021). This includes lack of awareness of human trafficking specific services and other general services, such as housing, social support services, medical supports, and substance abuse services (MacAfee et al., 2020). There is one report that opposes this view, as they found that most respondents (whom were survivors) identified having pre-existing knowledge of shelters, sexual health clinics, police stations, and hospitals and only did not know of services specific to human trafficking (Howarth, 2023). Survivors are most often connected to services through referrals by police, hospitals, and crisis lines (Duncan & DeHart, 2019; Marburger & Pickover, 2020). While this has worked for some survivors, some may not contact police or attend hospitals due to mistrust and fear, losing the opportunity to be made aware of and referred to resources (Howarth, 2023). The literature identifies that lack of written materials, such as brochures and posters in multiple languages in community settings is a barrier to survivors learning about alternatives (Nixon et al., 2002; as cited in Gonzales et al., 2019). Recommendations to raise awareness of available support options include putting up posters in frequented places, such as shelters, bus stops, libraries, and drop-in clinics; utilizing multiple languages on posters to support understanding; and dispatching more street outreach workers to connect with unhoused or transient survivors (Marburger & Pickover, 2020). Further research is required to better understand which services survivors are not aware of and further exploration of strategies to support survivor awareness.

Financial Limitations

A few studies identified financial limitations as a barrier to survivors accessing services. This is broken down into the inability to pay for out-of-pocket costs and the absence of health insurance (MacAfee et al., 2020; Powell et al., 2018; Clawson & Dutch, 2008). Limited funding makes some services costly (Doran et al., 2014; Du Mont et al., 2024; Howarth, 2023; Powell et al., 2018). Survivors may have incurred debts from trafficking (Litam, 2017; Roberson, 2017; Shelley, 2012). Financial support is among the immediate needs of survivors exiting trafficking (Howarth, 2023; Judge et al., 2018). Survivors seek job placements, employment, apprenticeships, and training opportunities to re-stabilize their lives and pay back loans/debt (Clawson & Dutch, 2008; Gerassi & Nichols, 2017; Gonzalez et al., 2019; Ren, 2014). It is understandable that they may struggle to afford services, such as counselling, private addiction treatments (to avoid waits), and housing are costly (Howarth, 2023). Increased funding to allow organizations/services to provide supports at low cost/no charge to survivors would have monumental impacts in the lives of survivors.

Transportation

The literature finds that lack of transportation is a barrier to survivors accessing services. Numerous studies found transportation to be an issue for survivors, making it difficult to attend appointments and services (MacAfee et al., 2020; Preble et al., 2022; Price et al., 2021; Powell et al., 2018). Given the limited number of services specific to human trafficking, survivors may not have a service in their area and would be required to travel greater distances to access services. Survivors living in an unfamiliar place and transit system may not know how to use the transit and may be afraid, and service providers do not have capacity to teach or travel with them (Clawson & Dutch, 2008). Services could be available in areas where transit is limited, or

survivors may live in areas with limited transit to reach services (Clawson & Dutch, 2008). Doing so without reliable transportation would be extremely difficult, if not impossible. Financial limitations further feed into this challenge, as survivors may not have the immediate funds to purchase a vehicle or pay for ride share.

Not Identifying as a Survivor of Human Sex Trafficking

A few sources found that survivors lack of identification with human sex trafficking acted as a barrier in seeking services. Survivors may not identify with trafficking due to the internalized shame when labelling their experience or they feel that labelling their experience as trafficking undermines their story (Contreras et al., 2017; Fukushima et al., 2020). Terms such as trafficking and prostitution come with connotations of criminality and delinquency, leading survivors to be mislabelled. Naturally, some survivors do not want to associate themselves with a label that indicates such stigmas. Some survivors felt that taking on the label of human trafficking survivor misidentified them, that it put them in a box amongst the stigmas and did not represent their unique lived experiences. For instance, in one study a survivor preferred identifying with being sexually exploited based on her specific experience. The ways that people enter trafficking can vary, and examples include exploitation from a partner, parents, forced marriages, or being trafficked overseas (UNODC, 2009). One person's perception of trafficking can vary from another's, and these examples can each be considered human trafficking even though they appear different from one another. There are survivors who do not believe they are being trafficked, which is attributed to lack of awareness and education.

There is a felt shame and vulnerability of speaking of the sexual abuse and assault components of trafficking. In one study, a survivor naming their experience as human trafficking took years of therapy and stated that this label brought up intense anger and shame (Contreras et

al., 2017). Shame can function to isolate or distance the self from memories of trauma and victimization, a measure of self-protection and preservation (Contreras et al., 2017; Fukushima et al., 2020). Further research is required to identify strategies to reduce barriers in seeking services due to not identifying as trafficked. Working through and changing narratives around stigma and the self in therapy is one important method, which will be discussed in chapter 3. A small but possibly impactful suggestion to reduce barriers is to change messaging and visuals in service brochures, posters and websites. Given that client's experiences and identities vary, messaging and visuals that are diverse and flexible and to include various experiences may better resonate with survivors (Gerassi & Nichols, 2017). It may resonate as if it is a message that shows that they are seen and are offered support and hope. Language changes could look like removal of the words trafficking, trafficked, slavery, and force. Messaging of support, empowerment and hope rather than messaging that focuses on the traumatic nature of human trafficking may draw in more survivors (Gerassi & Nichols, 2017). For example, messaging around help being available if one needs it, while avoiding use of images that are violent and potentially re-traumatizing (such as a survivor's wrists bound or hands on their neck), would be helpful (Gerassi & Nichols, 2017).

Current State & Prioritization of Needs

The literature found that for some survivors, their current psychological state acted as a barrier to accessing services. These included the lack of capacity to seek support due to being in crisis, for example, experiencing severe PTSD symptoms, a depressive low energy state, avoidant tendencies, dissociation, and other serious mental health problems (Gonzalez et al., 2019; MacAfee et al., 2020; Powell et al., 2018; Price et al., 2021). Survivors who are offered services while in this state may feel overwhelmed, struggle to comprehend their needs, and have

difficulty making decisions, which may lead them to decline services though later in time they would have decided differently (Gonzalez et al., 2019). Fulfilling the needs of their addiction, especially to manage pain and injury, can distract from seeking out and accessing services due to high barriers around substance use (Powell et al., 2018). Prioritizing in this way may stem from mistrust of health professionals and systems, leading to avoidance to seek medical care. Survivors may not be accessing services because it is not a priority need for them (Clawson & Dutch, 2008; MacAfee et al., 2020; Price et al., 2021).

Addiction as a Particular Barrier in Accessing Support Services

Barriers to accessing Substance Use Treatments in B.C.

In B.C., there are two types of treatment services: government funded and non-government (private) funded services. Both government funded and non-government funded services include inpatient, withdrawal management, and detoxification support (Canada Drug Rehab Directory, 2021). The main differences between accessing government and non-government funded services is in cost and wait times. Government funded services are only free to local, B.C. residents, and Canadian citizens depending on the service (Canada Drug Rehab Directory, 2021; Government of B.C., 2024). Individuals who do not have citizenship or permanent residency will face costs for treatment in Government funded addiction services. While survivors can experience numerous economic barriers to accessing services, survivors who have been forcibly moved from their home country and brought to B.C. experience additional economic barriers due to lack of health coverage.

Government funded inpatient support is when an individual stays at a hospital, speciality clinic or facility 24 hours a day to receive intensive treatment and care. Such treatment is a useful option versus out-patient support for those suffering from severe comorbid mental health issues

or physical health conditions, are unable to access outpatient services due to distance and lack of transportation, have unstable housing, or are living in a space that does not support their treatment goals, such as drugs accessible or others using (Health Link BC, 2023). Non-government funded inpatient services take place at private treatment centres. Like government funded services, they stay at the treatment centre 24 hours a day and receive monitored care, services and support. The duration of stay for individuals in inpatient care ranges from about 60-90 days depending on their needs. The main benefit to government funded inpatient treatment is that it is of no cost to B.C. residents, while private treatment services can cost upward of $60,000 depending on length of stay, the specific service, amenities and specialized care provided (Canada Drug Rehab Directory, 2021). It has been implied that government funded inpatient support is known to have less personalized support and hands-on care due to limited doctors and specialist availability, while a premium for private treatment is that there is better staffing to provide personalized care and greater hands-on support (Canada Drug Rehab Directory, 2021). Further research comparing patient experience and provision of services is necessary to speak to this claim. Government funded inpatient support has high demand as many cannot afford private treatments. Due to this high need, the wait time to access impatient support can average from 3-6 months (Canada Drug Rehab Directory, 2021). Meanwhile, private treatments have a much shorter wait time, on average of three to seven days.

Withdrawal management services provide support and monitoring of individuals going through withdrawal and the symptoms that come with it. Withdrawal management is a short service lasting 7 days (Government of B.C., 2024). Government funded withdrawal services can be provided as an inpatient, outpatient (in community), and at home with clinical team supervision (Government of B.C., 2024). Government funded withdrawal services have an

average wait time of about 2 weeks (as of July 2024) and are free. Information about the wait times and costs of private withdrawal services is not available. Only three to seven days is described for private treatments, but it does not specify where withdrawal management lies within this range (Canada Drug Rehab Directory, 2021).

Detoxification is the support of individuals experiencing withdrawal symptoms as toxins associated with the substance dependence clear from their body (Substance Abuse and Mental Health Services Administration, 2006). Depending on the severity of the addiction and substances used, inpatient detoxification is recommended to ensure safety (Adamec & Gwinnell, 2022). Prior to accessing government funded detoxification services, the individual must be assessed by a nurse at a mental health/addictions clinic or hospital. Government funded detoxification services are free to residents, however when researching current wait times there is no information available. I called the detoxification referral line through Vancouver Coastal Health. The worker advised that it is about 1 month wait to receive an assessment, then based on the assessment determination of need and availability of beds, the wait for detoxification may be brief or long. Private detoxification treatments can cost an average of $1,000 to $1,500 (for the entire stay) depending on specific needs (such a medications) and length of stay (Canada Drug Rehab Directory, 2021). Outpatient support services are another government funded support option. This can include accessing community substance use clinics for therapy groups, counselling, referrals to further supports, and education (Fraser Health Authority, 2024). Virtual supports are available in some health authorities. Outpatient services are cited as a good option for those with a stable living environment, have support, and can access treatment locations without issue (Health Link BC, 2023). Wait times for these services are not listed online, however according to the Island Health Authority, their virtual intensive Outpatient Addiction

Treatment Program has minimal to no wait time and includes individual and group therapy sessions (Island Health, n.d.). Further information about wait times for services would be greatly beneficial to allow individuals to assess their options and for counsellors and other service providers to have a greater sense of potential barriers individuals face due to waitlists.

Sobriety Requirements

The literature finds that sobriety requirements act as a significant barrier to survivors accessing immediate, short term, and long-term services. It was found that survivors faced the greatest barriers accessing human trafficking specific services and housing/shelters due to sobriety requirements (Gerassi, 2018; Judge et al., 2018; Langton et al., 2022; Preble et al., 2021 Powell et al., 2018). There are few housing/rental options for those addicted to substances and even fewer who provide specialized support to inhabitants with addictions, such as supportive recovery residences (Judge et al., 2018). Most human trafficking services, including those that provide shelter space, decline services to survivors who are experiencing mental health crises and active addiction (Langton et al., 2022; Powell et al., 2018). One literature piece discussed how some service providers utilize drug tests to ensure sobriety upon entry (Gerassi, 2018). A local example of sobriety requirements is Illuminate, a human trafficking support organization who requires survivors to be 3-7 days free of substances before they can access their services (Illuminate, 2023). Their commitment against addiction is so strong that they advise they will help survivors with arranging transportation to detoxification services. Despite human trafficking service providers identifying addiction treatment and detoxification as necessary for survivors and thus requiring sobriety to access services, the present research found that very few services offer detoxification and treatment services on site (Judge et al., 2018; Powell et al., 2018; Preble et al., 2022; Recknor et al., 2020). Like Illuminate, other services may help survivors find

addiction treatment services and refer to them, however even with a referral service provision is not expedited (Gerassi, 2018; Koegler et al., 2022). As discussed in the previous section, accessing detoxification comes with a wait, especially for government funded services. While offering transportation sounds great and could be useful to some survivors, in the meantime survivors are stuck in a gap between services, unsupported and at risk. Survivors report not being able to access detoxification and consequently human trafficking specific services that they need due to long waits and limited beds (Clawson & Dutch, 2008; Gerassi, 2018; Koegler et al., 2022). Out of desperate need for support, some survivors resort to detoxing in the street or managing to get apprehended for mental health to detoxification while in hospital (Gerassi, 2018). Some human trafficking services try to close this gap by providing conditional acceptance into programs with the requirement that the survivor engages in addiction treatments elsewhere (Koegler et al., 2022). Either way, the issue that remains that some survivors do not prioritize addiction treatment needs over other needs (such as food and housing), leading them to not seek treatment until these other needs are met, or they do not want currently to stop using substances. Survivors may continue to use substances or engage in other self-harm behaviours after escaping to cope the physical and emotional pain and trauma of their experience (Hopper, 2017; Preble, 2018). In reading the present studies and literature that shared the views of human trafficking service providers, it is apparent that service providers truly want to help survivors, that they believe they understand the needs of survivors, and believe that sobriety is an immediate need due to the role that addiction plays in exploitation and dependence on traffickers. While these workers and agencies appear to have good intentions, their perceptions of survivor needs (especially sobriety) are contributing to barriers in survivors meeting needs that they perceive as

immediate, including for shelter and the very human trafficking services that providers are barring them from.

Relapse Policies

Given that pre-existing addiction is a vulnerability capitalized on by traffickers to lure people into trafficking, survivors may have been addicted for a substantial amount of time. The stages of change model views relapse as an expected part of the change process and service providers have noted that relapse is common in survivors (Gerassi, 2018). However, many services with sobriety policies do not appear to see it the same way (Hopper, 2017). If a survivor relapses, they can experience termination from support until they are sober again, losing the service, support, and stabilization that they had gained. The survivor is on their own to find shelter and support, making them highly vulnerable to return to their trafficker or be exploited by another (Gerassi, 2018). The literature mentions how human sex trafficking has similarities with domestic violence in that survivors may fall back into the relationship approximately five times until they have left for good (Judge et al., 2018; Preble, 2018). More research into common patterns after leaving trafficking would be beneficial to understand how specific services can be flexible to support clients at various stages and to reduce risk/harm. Providing on-site safe detoxification for clients and support getting clients back on track after a relapse would be instrumental in reducing risk for re-trafficking and would significantly close gaps in service access.

Summary

The present chapter has demonstrated the profound effects of human sex trafficking exploitation on the physical, emotional, psychological, and behavioural wellbeing of survivors. It also clearly demonstrates the emmeshed relationship between addiction and exploitation. For

survivors, addiction is a risk factor for sexual exploitation and substances are used throughout victimization to cope with pain and trauma, and to avoid withdrawal. Traffickers take advantage of addiction and utilize substances in recruitment and the entire duration of a survivor's exploitation, using drugs as a part of force, fraud, and coercion. This chapter also provided an overview of the numerous substances utilized and their side effects. Despite this demonstration of enmeshment, survivors face barriers to access supports and resources after exiting due to their substance use. The chapter examined options that survivors have to access substance use treatments in BC if they wish, which are either private or government funded treatment services On top of sobriety requirements, they face a multitude of other barriers that interfere with service access. Chapter 3 will build on this chapter by recommending the utilization of trauma informed care, as well as harm reduction and strength-based approaches by counsellors and service providers to reduce barriers to service access. It also extends recommendations further to organizational and structural levels, pushing for the need to implement harm reduction in human trafficking support services to reduce barriers to service access. Funding and support of inhouse detoxification and addiction treatments would provide survivors with agency, reduce barriers, and close gaps in service provision. Counsellors, service providers, organizations, and systems need to consider their own biases and stigmas toward addiction and how they influence the language, views, behaviours and policies enacted toward survivors.

Chapter Three: Discussion and Applied Practices

Discussion

Chapter two addressed three purposes discussed in Chapter one. This section will discuss these findings, learnings, and appreciations, as well as limitations and outstanding system inequities.

The first purpose was to investigate the relationship between addiction and human sex trafficking. The present research established that addiction is interconnected with human sex trafficking. High rates of addiction and drug use were identified during exploitation: between 60-100% of those trafficked used substances and experienced addiction (Roberson, 2017; Shelley, 2012). Addiction is identified as a vulnerability risk factor for victimization, involved in the recruitment of survivors, and is a common factor in force, fraud, and coercion. It is embedded in all aspects of human sex trafficking. Substance use and addiction show up in recruitment of survivors in three ways. First, traffickers prey on individuals with pre-existing addiction and lure them in with drugs, exploiting them in the process (Michaelis et al., 2022). Second, traffickers coerce survivors to use drugs with the objective to develop an addiction, so the survivor becomes dependent on them and compliant (Gerassi & Nichols, 2017; Hammond & McGlone, 2014; Michaelis et al., 2022; Roberson, 2017; Stoklosa et al., 2017). This is achieved through normalization of drug use and taking advantage of the survivors' trust and loyalty to manipulate them into further using. This is a common practice in boyfriend/Romeo pimping (Deshpande & Nour, 2013; Michaelis et al., 2022). Third, some are immediately recruited into trafficking through violence, where they are essentially forced with threats or even abduction (Contreras et al., 2017; Hammond & McGlone, 2014; Marburger & Pickover, 2020; Michaelis et al., 2022). In this case, survivors are physically forced to ingest substances for the benefit of the trafficker (Contreras et al., 2017; Marburger & Pickover, 2020; Michaelis et al., 2022; Roberson, 2017).

As discussed previously in this capstone, drugs are used against the survivor's will to subdue them (Litam, 2017; Michaelis et al., 2022). Force can manifest through physical violence and intimidation (Contreras et al., 2017; Gonzalez et al., 2019; Litam, 2017). In coercion, drug use is influenced using threats to the survivors or their loved ones, and emotional manipulation as a part of boyfriend pimping (Contreras et al., 2017; Gonzalez et al., 2019; Litam, 2017). Drugs are also involved in coercion as a reward or punishment, ultimately coercing survivors to act in a certain way to either obtain the drugs or avoid their use (Michaelis et al., 2022). Drugs also make a survivor more vulnerable to being coerced, as they impair cognitive capabilities. In fraud, addiction is capitalized on by traffickers to keep survivors in debt. Survivors must pay back drug debts by exploitation to buyers or the trafficker, but due to their addiction they continue to need drugs and therefore become entrapped in a cycle of debt, addiction, and exploitation (Michaelis et al., 2022; Roberson, 2017; Shelley, 2012).

The research finds that substances are used both by traffickers and survivors. Traffickers use drugs to coerce, control and obtain survivor compliance (Contreras et al., 2017; Deshpande & Nour, 2013; Marburger & Pickover, 2020; McGlone, 2014; Michaelis et al., 2022; Roberson, 2017; Stoklosa et al., 2017). Survivors use substances to cope with trauma and pain and to avoid withdrawal symptoms (Deshpande & Nour, 2013; Gerassi et al., 2018; Government of Canada, 2024). Research identified opioids, alcohol, and marijuana as the most frequently used substances (Roberson, 2017; Stoklosa et al., 2017). Opioids are commonly used due to their high addictiveness and efficacy in pain management (Roberson, 2017; Stoklosa et al., 2017). The legality and accessibility to marijuana and alcohol contribute to its common usage (Hopper, 2017; Koegler et al., 2022). Stimulants and synthetic drug use was also reported (RCMP, 2013). The effects of each substance are discussed in depth, providing insight to what survivors may be

feeling or experiencing and how they or traffickers try to obtain these states for varying reasons. The research is clear that exploitation for the purpose of human sex trafficking has substantial, lasting negative impacts on the physical, behavioural, emotional, and psychological well-being of survivors. The list of effects is extensive. The most commonly cited effects across research include: PTSD (including complex PTSD), complex trauma, addiction, dental and jaw injuries, internal injuries and sexually transmitted infections/diseases, physical injuries (such as broken bones), malnutrition and dehydration, and interpersonal problems (Deshpande & Nour, 2013; Hammond & McGlone, 2014; Howarth, 2023; Judge et al., 2018). Such findings demonstrate the extensive needs experienced by survivors who escape their traffickers and therefore the importance of seeking to reduce barriers so survivors can meet such needs.

The second purpose was to examine barriers to survivors accessing support services. The research identified seven barriers that survivors face in accessing services: stigma, lack of appropriate human trafficking services and service availability, lack of awareness or understanding of available services, financial limitations, transportation issues, not identifying as a survivor of human sex trafficking exploitation, and current state and prioritization of needs. I did not initially realize there to be so many barriers. I anticipated that literal barriers of transportation, finances, lack of appropriate resources or lack of those in the survivors area would emerge. I did not anticipate inward experiences, states, and perspectives of individuals to also act as barriers. Stigma is an identified barrier that stood out. Within stigma, there is internalized stigma and social stigma from service providers, systems, and society. Survivors experience a double jeopardy where they are stigmatized for both their addiction and human trafficking victimization (De Shalit, 2021; Hammond & McGlone, 2014; Preble, 2018). Survivors report experiencing judgement, a lack of support, discrimination, and stigmatization from service

providers and police (Contreras et al., 2017; Duncan & DeHart, 2019; Gerassi & Nichols, 2017). Survivors also reported experiencing violence by others in the community (Cody, 2018; De Shalit et al., 2021; Drydyk, 2023; Fukushima et al., 2020). Experiences of stigma, discrimination, marginalization, abuse and violence by others is intensified for survivors who are people of colour, LGBTQIA2S+, and/or Indigenous (Cody, 2018; Gerassi & Nichols, 2017). Past experiences of stigma, discrimination and racism leads to reduced trust in service providers and police, and fear of experiencing stigma and the other factors associated acts as a barrier to client's seeking services. Experience of stigma can lead to the development of shame, a further barrier to accessing services and reaching out for help (Contreras et al., 2017; Decker at al, 2009; De Shalit, 2021; Fukushima et al., 2020; Lanctot et al., 2021). Limited studies feature service providers directly acknowledging that survivor perception of stigma impacts service access and admitting to partaking in or witnessing stigmatizing and judging behaviour. Particularly, victim blaming, seeking attention, and viewing survivors as criminal. As mentioned, I also did not consider how perception of self, current state and needs perception would act as barriers. Survivors not identifying with human sex trafficking may not relate to organization advertisement, brochures, or posters. I found this interesting as it demonstrated the nuances of human trafficking and each survivor's unique perspectives. Current state made sense given the impacts that trauma has, however, I initially did not consider it as a barrier along with the other more tangible ones.

The barriers impact access to human trafficking specific services, housing, specialized health and mental health care, and addiction treatments. Waitlists are identified as a frequent problem (under 'lack of appropriate human trafficking services and service availability') in accessing services. Waitlists occur due to a lack of service organizations to serve the population,

and lack of space within those services, such as limited beds (Clawson & Dutch, 2008; Gerassi et al., 2019; Koegler, 2012).

The third purpose statement was to examine addiction as a particular barrier in accessing support services. Since this section would assess the ways in which addiction can act as a barrier to treatment, I believe it to be important to research the available addiction treatment options in BC to understand the choices survivors have should they decide to stop using in order to access services with sobriety requirements. Withdrawal management, detoxification, and in-patient treatments are provided by privately funded and government funded treatment centres (Canada Drug Rehab Directory, 2021). Government funded treatments also provide outpatient care. The main difference between privately funded and government funded treatment centres are wait times, cost, and personalized care. Privately funded treatment centres had shorter wait times and were said to have more personalized care (meaning more treatment options and higher doctor-patient patio), however, they are costly compared to government funded treatments. Depending on the type of treatment, extra amenities and duration of stay, total treatment costs can range anywhere between $1,000-$60,000 (Canada Drug Rehab Directory, 2021). Government funded treatments are free to BC residents and have inpatient and outpatient treatment options: however, depending on the service being sought wait times can be lengthy and due to lower doctor to patient ratios there is little capacity for personalized treatments (Canada Drug Rehab Directory, 2021). Survivors can run into hardship trying to access free services due to long waits, but private treatment will likely not be an option as financial challenges and debt are common realities for those fleeing. Survivors who were trafficked from outside of BC and are not BC residents will face greater financial barriers, as government funded services are not free for them. I could not find detailed information as to how much government funded services would be for

someone not covered under MSP, and the only information I could find advised that the costs can be very high (WelcomeBC, 2024). The research found that sobriety requirements and relapse policies acted as a barrier to survivors accessing and remaining in support. Most human trafficking specific services have sobriety requirements, some even terminate survivor support if they relapse thus not upholding such requirements (Gerassi, 2018, Hopper, 2017; Judge et al., 2018; Langton et al., 2022; Preble et al., 2021). While they uphold this requirement, very few organizations had withdrawal management and detoxification supports on-site (Judge et al., 2018; Powell et al., 2018; Preble et al., 2022; Recknor et al., 2020). Some organizations offer conditional acceptance to survivors to help reduce the number that are turned away. They require that survivors access treatment to remain in their programs. While this can help close gaps in support, not all survivors are ready to seek help for their addictions or they are prioritizing the meeting of other needs before, such as housing or health care (Clawson & Dutch, 2008; MacAfee et al., 2020; Price et al., 2021). Given the long history of addiction for some survivors and their usage to manage pain, I do not believe it to be unreasonable that some survivors are not ready to immediately stop using. In addition to human trafficking specific services, substance use and active addiction was identified as a barrier in accessing housing and safe houses (Gerassi, 2018; Judge et al., 2018; Langton et al., 2022; Powell et al., 2018; Preble et al., 2021). Low barrier shelters are an option for a survivor, however, they are short-term, and bed availability is not guaranteed.

Limitations

I have identified six limitations or gaps in literature within the examined studies. Obtaining further information in response to these identified limitations would foster further

understanding about the nature of addiction within human sex trafficking, survivor service access, and experiences of survivors within Canada.

The first limitation is the gaps in research between types of substances used by survivors and traffickers and for what purposes. For example, it is known that alcohol and marijuana are among the most used substances by survivors and the effects of using these substances are well known. It is also known that survivors use substances to cope with pain, to self-regulate, and escape. However, the research does not identify how survivors utilize these substances to cope, self-regulate, or escape. For example, given marijuana and alcohol's effect on memory (impairment) and relaxation, it not unreasonable to theorize that survivors utilize these substances to try to forget traumatic experiences. However, there is no research, and the only connection made between use of a specific substance for a specific purpose are opioids to cope with pain. The research mentions that a purpose of substance use is for survivors to dissociate from the abuse and trauma they are experiencing, however, it does not specify or did not inquire which substances survivors utilize to achieve dissociation.

The second limitation is a lack of information about the frequency of drug use. The present research showed a large range, from 60-100% (Roberson, 2017; Shelley, 2012). It appears pre-existing type of recruitment experienced, presence or absence of pre-existing addiction, and participant age may relate to prevalence. However, this was not discussed in detail. How many times might a survivor use per day and what quantity of substances? More studies that seek to gather information about frequency of substance use and exploration of the factors influencing that number would be highly beneficial in gaining a clearer picture of the average of substance use frequency.

The third limitation is gaps in information about the frequency of forced drug use. Are drugs forced by traffickers at each interaction, are provided once a day, or is forced use dependent on other situational factors, such as primarily being used when traffickers anticipate an extended encounter? Despite forced drug use being cited as a common tactic by traffickers to subdue and control survivors, only two studies provided numbers around survivor reports of experiencing forced drug use. The two studies yielded different percentages: 15% of participants in one study and a little over 25% in another (Hopper, 2017; Roberson, 2017). As mentioned, one study found that 80% of survivors who experienced violent trafficking reported substance use (Hammond & McGlone, 2014; Michaelis et al., 2022). While forced use is reported as an especially common practice as part of violent trafficking, research differentiating between frequency of drug use, by choice or force (can include coercion), would build on present understandings of the nature of drug use within human sex trafficking exploitation.

The fourth limitation is gaps in research about addiction and drug use in youth survivors. Only one study examined youth drug use in human sex trafficking: 75% of youth survivors reported substance use (Roberson, 2017). Much like the previous limitations, further research is required to gain greater understanding of the frequency of substance use and the nature of addiction in youth survivors.

The fifth limitation is lack of information about survivor ability to access low-barrier shelters. They are one of the few, if not only, option for survivors with active addiction and mental health challenges needing a temporary place to stay. Experts in the field question the safety and suitability of such shelters given the lack of privacy, many being co-ed, an environment where there is drug use (particularly a problem for survivors trying to quit), lack of stability that could essentially be re-traumatizing, and not being specific to the needs of human

sex trafficking survivors (Doran et al., 2014; Du Mont et al., 2024). While it is not unreasonable to agree that shelters that primarily support unhoused individuals would not be able to meet the unique needs of survivors, as some experts have also echoed, there are no perspectives of survivors that speak to their ability access shelters (despite waitlists), their experiences, and if they were able to receive some resourcing or supports that were beneficial (Drydyk, 2023). If there were few individuals who could initially access shelters due to waitlists and more was known about negative or poor experiences with support, knowing such can be a further point in supporting the need for human trafficking organizations to reduce barriers.

Finally, most of the research studies were conducted in the United States of America. Greater research within Canada would provide more information about the experiences of survivors and service providers within the Canadian context and could provide more insight into specific barriers and structural issues within Canada.

Power and Systems Issues

Power and system issues contribute to the vulnerabilities that put individuals at greater risk of exploitation. Examples include economic inequality and poverty. Individuals can face such inequality from lack of opportunity due to gender identity, sexual orientation, status, race, and ability, as well as intersections between these various planes (Brooks & Heaslip, 2019; Gerassi & Nichols, 2017). Lack of opportunity can push individuals to a place where they are vulnerable, desperately seeking any opportunity to survive. Underneath inequality is racism, prejudice, and stigma. As discussed, stigma toward addiction, substance use, and involvement in what is viewed as sex work. Stigma, racism, and prejudice impact the quality of treatment and care provided by health clinicians and service workers to survivors (De Shalit et al., 2021;

Langton et al., 2022). Poor care, perceptions of stigma and judgement deter survivors from seeking support, further contributing to their vulnerability.

There is a lack of human trafficking specific services for men and LGBTQIA2S+ survivors. The research also reflects a lack of culturally diverse services (Clawson & Dutch, 2008; Powell et al., 2018; Preble et. al., 2022). This demonstrates that the needs of these populations are not prioritized or are seemingly forgotten. People of colour and LGBTQIA2S+ individuals are disproportionately represented in sex work and exploitation, though many statistics (including Canadian statistics) do not include race, immigration status, LGBTQIA2S+, or Indigenous background to reflect this (Gerassi & Nichols, 2017). Data upholds gender binary, which I believe is reflective of systems issues toward LGBTQIA2S+ individuals and cisgender normativity.

A significant system issue is negative views and stigma toward addiction. Such are deeply imbedded in the policies and practices of organizations, as well as in some service providers. Most human trafficking organizations maintaining sobriety requirements is a clear demonstration of this. These biases may sit unconsciously with some organization leaders or workers providing services. Given addiction being a vulnerability for trafficking, I can see providers wishing to stop addictions with the intention to reduce vulnerability and likelihood of returning to traffickers (if there is no addiction then returning to fund addiction will not occur). I have seen organization websites advising that they are inclusive and believe in individual freedoms, however this does not seem to include individuals with active addictions. Rigid barriers truthfully demonstrate deeply rooted stigmas toward addiction. Organizations want to help survivors in the way that they believe they should be helped. This may come at the expense of the survivor, who may fall into the cracks and keep them vulnerable to being exploited again.

Application

This section addresses the fourth purpose of this capstone by making recommendations for counsellors, service providers, and organizations to reduce barriers in service access through the implementation of trauma-informed care, harm reduction approaches, and specific held attitudes. It will also call for change by organizations and systems to implement and fund harm reduction approaches.

Recommendations for Counsellors, Service Providers, and Organizations

Trauma-Informed Care. Trauma-informed care is guided by an understanding of the social, emotional, physical, behavioural and psychological impacts of trauma on individuals (Gerassi & Nichols, 2017; Judge et al., 2018). This includes the impacts of multiple and complex trauma that has occurred within human sex trafficking exploitation as well as cumulatively throughout the survivor's life. Experience of trauma and mental health disorder was found to be prevalent. Knowing the emotional, behavioural and social impacts of trauma, counsellors and service providers should understand how trauma makes it difficult for them to approach counselling and support services.

Trauma-informed care is the best practice for working with individuals who have experienced trauma (Gerassi & Nichols, 2017). Given the prevalence of trauma and trauma disorders amongst human sex trafficking survivors, I believe that it is ethical and in the best interest of survivors for counsellors and service providers to provide trauma-informed care to survivors. In a study where trauma-informed care was provided by service providers, survivors reported it to be among the most helpful supports received, along with housing, financial support, and access to detoxification/addiction treatments (Department of Justice Canada, 2023). On the opposite end, in a study where survivors provided feedback about the needs of survivors exiting

trafficking, they report trauma-informed care from counsellors, service providers, and medical professionals as a high-ranking need (Howarth, 2023; Powell et al., 2018). Core components of trauma-informed care are the promotion of safety, avoiding re-traumatization, and empowerment with a focus on individual strengths (Gerassi & Nichols, 2017; Marburger & Pickover, 2020).

Safety. Safety is an essential subset of trauma-informed care. Safety includes psychological, emotional, and physical safety. Felt safety is an important component in building trust (Marburger & Pickover, 2020). A counsellor who fosters trust and felt safety with a survivor can be instrumental in reducing barriers to service access as well as increasing physical safety. It is important for counsellors to recognize that building safety and trust with survivor can be a long process (Chambers et al., 2024). It is important to take time and to not rush or push for trust. Given the effects of trauma, counsellors must understand how beginning therapy can be overwhelming and triggering for a person, experiences that might dissuade a person from beginning (Judge et al., 2018). Focusing on stabilizing the client prior to trauma work is essential to build safety and to prevent harms from launching into difficult topics if the client will not be able to cope with the aftermath of such and to ensure they are in a state where deep work can be properly processed (Judge et al., 2018). This is known as a stabilization phase, that focuses on client physical safety, self-regulation, and reduction of symptoms (Judge et al., 2018). Safety can also involve planning for safety around suicide and possibly assisting clients with resources to find shelter. Stabilization and support of self-regulation can help prevent client's from fleeing from supports and engage in their environments and others in an adaptive way. It helps to offset mistrust commonly experienced with service providers and felt shame that act as barriers to accessing services. It models a trusting relationship, fostering the client's ability to trust others and therefore with time mistrust becomes a lesser barrier to accessing services. Recommended

practices for counsellors and service providers to foster survivor safety are creating a calm and comfortable counselling environment (consider noise, lighting, furnishings, and room temperature), being in a consistent space, and to use the language of the survivor. Notice the words used by the survivor to describe their experience, as they may not use 'exploited' or 'trafficked' in relation to their experience and may not refer to themselves as 'traumatized'. It is recommended that counsellors use their language, as it orients to their reality and is not pathologizing or labelling. It is possible that the client's classification of their experience and trauma may shift with time, and counsellors should follow with the client and gently examine these shifts and insights together. Being transparent with survivors about confidentiality and informed consent, ensuring understanding and inviting questions, are essential (Gerassi & Nichols, 2017; Hemmings et al., 2016; Marburger & Pickover, 2020). Demonstrating such practices are essential for both counsellors and service providers, as creating safety and building trust supports client retention in services and overall wellbeing. A final phase of trauma-informed care stabilization is supporting the client in reintegrating with community, social relationships, and addressing additional long-term needs (Judge et al., 2018). This brings to attention the need for the counsellor to assess and re-assess client short- and long-term needs. Resourcing with the client can be greatly beneficial to support their receipt of holistic and wrap-around care (Powell et al., 2018). This might require the counsellor to do some research, assist with phone calls, and making referrals. The counsellor helps to reduce gaps in survivor needs being met, as the counsellor naturally cannot meet the survivor's needs alone.

Avoiding Re-Traumatization. Avoiding re-traumatization is a component of trauma-informed care that helps promote safety. After focusing primarily on stabilizing clients, counselling should begin to involve processing trauma while preventing re-traumatization (Judge

et al., 2018). This includes the safe space discussed previously to prevent triggers, only asking necessary questions, and not pushing the client to go into detail or discuss certain elements unless they are ready/would like to discuss them (Hemmings et al., 2016). Giving back agency and control to the survivor helps to avoid further re-traumatization and foster safety (Gerassi & Nichols, 2017; Marburger & Pickover, 2020; Preble, 2018). Counsellors can support client agency by engaging in collaboration that is driven by the client's values and vision of change. This can look like collaborating to support the client in setting achievable goals that are meaningful to them and allowing the clients choice (Gerassi & Nichols, 2017; Hopper, 2017). This component is necessary because forcing change and specific methods to reach this change that is not desired by the client is not effective long-term and can be re-traumatizing, as it brings them back to a time where they had no control over their situations or the ability to meet their needs (Drydyk, 2023). Involving clients in goal setting and centering support around their goals and needs promotes their voice and gives them back control of their life. Supporting the client's agency also shows care and genuine desire to support them, rather than only supporting if they will align with a prescribed regimen or lens (such as sobriety).

Empowerment and Strengths Focus. Showing encouragement and empowering survivors instead of demonizing or judging them also helps to lift felt shame that weighs on their well-being and accessing of supports (Preble, 2018). Components of strengths-based approaches can arise as a part of empowering and encouraging clients by acknowledging their strengths, learned wisdom, and resilience (Gerassi & Nichols, 2017). Strengths should always be integrated into client work, but is especially useful in problem solving, planning goals, and at points of difficulty where clients are feeling stuck (Gerassi & Nichols, 2017; Preble, 2018). Both counsellors and service providers should focus on their strengths reminding them of their

strengths and abilities and encouraging them as they lean into making their own decisions. Doing such helps the survivor to become unstuck and to continue to grow.

Harm Reduction. Harm reduction is a care strategy that focuses on safety and reducing risks of harm from engaging in activities that place a client at risk (Chambers et al., 2024; Gerassi & Nichols, 2017; Preble, 2018). This can include reducing risks due to behaviours such as substance use or engagement with traffickers and pimps, and environmental risks, such as an unsafe environment (Preble, 2018). Methods to support client safety and reduce risk of harm is to provide opportunity for STI testing, clean needles or support accessing programs that provide them, creating a safety plan, provision of condoms, and goal setting to reduce risk taking behaviours (Gerassi & Nichols, 2017; Preble, 2018). A harm reduction approach assumes the client to have the strengths to overcome challenges and believe in the importance for client's to be active agents in making decisions. They both believe in client freewill and freedom (Howarth, 2023; Preble, 2018). They recognize the need for client choice, even if it involves substance use and other risk-taking behaviours. Harm reduction is in direct opposition to abstinence-based models, which are rigid in requiring sobriety as a condition to receive support. Harm reduction is flexible to the unique needs of each survivor. I argue four reasons to implement harm reduction to support survivors and reduce barriers.

First, it is effective in building trust, which can reduce a barrier to access due to stigma and related mistrust in service providers. Studies show that sex workers who received harm reduction-based supports were more engaged in services, with 95% returning for follow-up support and 75% participating in clean needle exchange (Open Society Institute, 2015; cited in Preble, 2018). Organizations that newly implemented harm reduction approaches experienced a 25% increase in service engagement (Open Society Institute, 2015; cited in Preble, 2018). Unlike

abstinence-based services, harm reduction demonstrates acceptance of survivors as they are. Survivors can become isolated due to stigma and addiction, experiencing a lack of acceptance by other organizations, service providers, society, and even family (Cody, 2018; Preble, 2018). It is kind, compassionate, empathetic, and patient (Chambers et al., 2024). The building of trust and focus on client agency helps to offset the consequences of stigma and therefore barriers to service access.

Second, harm reduction is successful in treating client addiction and reducing risk taking behaviours. Research found more successful outcomes in addiction treatment when they are flexible, collaborative, and holds client as the active agent in change (Preble, 2018). They also found reductions in risky sexual behaviours, experiences of violence, and time in sex work (Preble, 2018).

Third, it keeps access open to survivors by barriers to service caused by sobriety requirements and relapse policies. It is not realistic to believe that every survivor, after possibly years of addiction prior to being exploited, continued voluntary use to cope with trauma or forced drug use by traffickers, can suddenly become sober the moment they escape from trafficking or that becoming sober is their immediate priority. Harm reduction recognizes the need to make gradual changes at the pace best suited to the client's current state and needs. As mentioned previously, psychological theory acknowledges relapse as a common part of the process of healing from addiction (Hopper, 2017). Keeping the door open reduces shame due to relapses or returns and maintains a connection for clients to return as they are, not disconnecting them from services and termination support until they are sober (Hopper, 2017; Preble, 2018). This prevents survivors from falling into the gaps between services by providing a safe base to return to whether they are sober or not. Abstinence-based models are inflexible, restrictive, and

non-collaborative (Preble, 2018). It imposes their perceptions of what is best for the client and forces their desired outcome and treatment rather than incorporating survivor voices (Preble, 2018).

Fourth, it fosters survivor free will and agency previously compromised in exploitation. Abstinence-based approaches take away the free will of survivors. They are to comply to the vision of recovery or healing from addiction and trafficking exploitation decided by the service provider and their organization's policy. As mentioned, in addition to controlling substance use, services may also control survivor's actions through curfews and chore schedules (Drydyk, 2023). Ironically, the voice and control of a survivor is again taken away, much like during exploitation, which can be re-triggering (Preble, 2017). Harm reduction approaches are collaborative and foster survivor to ultimately make their own decisions, express their needs, and to live their life freely.

Therapist Attitudes. There are numerous attitudes, thought processes, and approaches that can help to support survivors well-being and reduce barriers to service access.

Foundational therapeutic skills, including unconditional positive regard, non-judgement, genuine care, and concern for the client fosters trust and safety. It shows the client that regardless of their struggle, relapses, or experiences, they are safe, valued, and accepted. This is monumental for both counsellors and service providers, showing clients that they are safe, accepted and do not need to run away. Taking a non-judgemental stance helps reduce survivor felt shame when sharing their experiences and expressing their needs (and learning how to do so) (Gerassi & Nichols, 2017; Hopper, 2017). Being sensitive to the tone of voice used (such as a soft tone), maintaining eye contact to show engagement, and using non-stigmatizing or shaming language (Stoklosa et al., 2017).

Reflecting on held biases toward sex work, human sex trafficking, and addiction is important. Not having awareness of views towards these populations can lead to the enactment of social stigmas in the space that is supposed to be safe, thus harming the relationship, maintaining distrust, and further building internal stigmas and shame that lead survivors to refrain from engaging in services. An example is victim blaming. Service provider reflection on biases is also important as research has shown that their actions, whether intentional or not, have led survivors to feel stigmatized and judged. Service providers and organizations must reflect on their role in maintaining barriers. For instance, why is an abstinence-based model utilized? Is it shown to be highly effective in treating survivors with addiction, is it the easier route, does it require fewer resources, or are there negative views toward drug users? Preble (2018) suggests organizations to inquire about the stigmatizing narratives that occur within their organization. Anonymous surveys are one potential approach to obtain worker feedback on such stigmatizing narratives. Engaging in a human sex trafficking awareness course would be beneficial to both counsellors and service providers as it fosters understanding of the process of human sex trafficking, especially the coercion, force, and fraud involved, to better understand the experiences of survivors (Drydyk, 2023). I recommend that organizations provide proper training in harm reduction practices and trauma-informed approaches to service providers to ensure the provision of excellent and ethical care. This recommendation applies to service providers who do not work in human trafficking organizations, but shelters and domestic violence shelters. This can help equip workers to recognize human sex trafficking, provide appropriate support, resourcing, and aid individuals who have just experienced victimization. This would help counsellors, service providers and organizations to collectively support the closing of gaps in care.

Recommendations for Systems

To support organizations to provide harm reduction-based care and reduce barriers to support services access, there needs to be change at a systems level. There is a need for increased funding for service provision and expansion of current services to increase support capacities. This includes increased funding for more beds in human trafficking shelters and programs as well as reserved space in general shelters for survivors (Drydyk, 2023). As the executive director of the Canadian Centre to End Human Trafficking, Drydyk advises that housing and shelters are the most requested needs by callers to the Canadian Human Trafficking hotline, however, she acknowledges difficulty meeting these needs due to limited space and high barriers, leading survivors to experience gaps in support that call takers may not be able to remedy due to their limitations. Research supports that shelter and housing are among the greatest needs of survivors, even being identified as an area for improvement in availability (Du Mont et al., 2024; Heidinger, 2023; Marburger & Pickover, 2020; Preble et al., 2022). I echo the call to action for greater funding for more specialized space at shelters, transition houses, and organizations and the creation of low barrier housing (or even low barrier housing set aside) for survivors of human sex trafficking. Such action would reduce waitlists, a prevalent barrier experienced by survivors, allow more individuals to access much needed support and safety upon exiting, and reduce the numbers of survivors falling into the cracks and at risk for further exploitation. A component of funding that needs to be considered is funding for detoxification and on-site addiction treatment services. In addition to having properly trained service providers, allocating funding for health professionals at human trafficking organizations would allow for proper detoxification and addiction services to be provided. Having in-house supports would reduce the need to refer survivors out for services, leading to gaps in service provision due to waitlists, lack of available

services in the area depending on the survivor's location, and transportation issues. Having detoxification and addiction services on-site would greatly benefit organizations utilizing harm reduction and abstinence-based approaches, as they would no longer need to turn away survivors in immediate crisis for positive drug tests. In addition to reducing barriers to access the services themselves, it would support organizations that utilize a harm reduction model by offering more choices for survivors and supporting their agency (Powell et al., 2018). For abstinence-based organizations, it would support organizations to accept clients who have yet to abstain from drugs rather than creating service gaps and vulnerability to further exploitation by requiring them to find detoxification and shelter elsewhere. Thus, with more options, more survivors can be served and supported in a timely manner.

Systems must consider support for survivors of human sex trafficking as important, regardless of addiction. The national strategy to combat human trafficking discusses strategy from the years 2019-2024 to protect people from human trafficking exploitation (Public Safety Canada, 2019). Amongst the numerous strategies, providing increased funding for community organizations service provision is one of them. There is not much detail as to how these components will be executed, and if the services receiving more funding are low barrier and accept individuals in active addiction. In researching to determine if increases in the funding of BC services have occurred, I found that $150,000 in funding will be provided to the counter-exploitation unit of Family Services of Greater Vancouver (FSGV) (BC Gov News, 2024). They are community-based support workers that provide support and resources to people who have experienced human trafficking, sexual assaults, gender-based violence, and domestic violence (FSGV, 2022). They work both in community and within units of police organizations, including the Domestic Violence Unit at New Westminster Police /Vancouver Police Departments and the

Counter Exploitation Unit of the Vancouver Police Department. This is a fantastic step as there would be greater capacity to connect to survivors, provide resources, and support. Surely such an increase will help reduce some barriers as workers can assist in bringing services to awareness. However, Family Services does not provide in-house shelter, human trafficking specific programs, or substance use treatment. There is still an issue of enough funding to expand on preexisting programs that support immediate and short-term needs. I could not find information about the expansion of beds at shelter/organizations and housing for survivors from 2019-2024. Julia Drydyk (2023), the executive director of the Canadian Centre to End Human Trafficking and its hotline, previously received $14.51 million in funding from the federal government in 2018, and $2.89 million ongoing. Her call to action expresses the need for expansion of shelter beds for survivors, more beds at human trafficking organizations, more funding for housing and specific spaces for survivor populations in affordable housing projects. I believe this suggests that such needs remain unfulfilled and that funding for those services are inadequate. I also want to acknowledge that the Covid-19 global pandemic occurred within this time frame, which may have interfered with the completion of 2019-2024 strategy goals. There is a three-year action plan for the provincial government of BC to implement more programming and supports for survivors of gender-based violence and a strengthened response to the missing and murdered Indigenous women and girls crisis (Ending Violence Association of BC, 2023). The plan includes new services for sexual assault survivors, increased funding to transition houses, and free counselling to survivors of sexual assault and intimate partner violence (Ending Violence Association of BC, 2023). These are a few of the aims of the plan, however, they are more specific to survivors of domestic violence and sexual assaults. My hope is that with the expansion of transition house funding, there will be space for survivors and that sexual assault-

based programs will expand to provide supports specific to the experiences and needs of sex trafficking survivors.

I invite systems to reflect on stigma and bias towards exploitation and drug use. How do stigmatizing views of survivors impact the prioritization of services for them and what services are being provided? Despite addiction being closely emmeshed with human sex trafficking, there is no conversation around addiction regarding survivor support and prevention of human sex trafficking. Is this due to biased views around drug use and harm reduction perspectives that compete with abstinence-based supports? Can systems see it as acceptable for a person to receive support and still use substances? Do systems value harm reduction, or do they view substance use as a major flaw or as criminal? If they have stigmas and biases toward substance users, consider how their views can further barricade survivors from services through restricting support to services which are low barrier. Within Provincial and Federal action plans, I do not see information about providing funding for organizations to utilize harm reduction approaches or to create service organizations to do so. They do mention the desire for care grounding in trauma- informed practices, as well as being culturally inclusive for Indigenous survivors. I am glad to see this and am hopeful to see such supports become available in the coming years. I did not see mention of care made available to men or individuals who are LGBTQIA2S, however, I am hopeful that such populations are not forgotten in planning and that funded organizations will create safe spaces for these individuals.

Conclusions

This capstone has provided information about human sex trafficking. It demonstrated the deeply intertwined relationship between exploitation and addiction. My hope is that this brings awareness to the prevalence of addiction and substance use within human sex trafficking

victimization. This capstone also brought attention to the numerous, often intersecting barriers and addiction specific barriers that make it difficult for survivors to receive care and for their unique needs. Survivors seeking human trafficking support likely are turned away due to their substance use, as many places are sobriety based, and they are advised to seek treatment. In the case of the organization that my colleague dealt with, they advised if a detoxification is arranged, they can assist with transportation. I learned the detox wait times are about 1 month for an initial assessment followed by the booking of detoxification depending on factors such as severity of addiction and withdrawal symptom risk. Private options are quicker but can be costly. I have learned that financial barriers and debts would make it difficult for the average survivor to be able to pay out of pocket expenses for detox and other private treatments. While waiting for detoxification, or if the survivor is not ready to stop using, they may look for shelter as an immediate need. They are turned away from transitional houses due to substance use and the trafficker-survivor dynamics may not be considered as a domestic violence threshold. They may seek short- term housing but are met with long waits or barriers due to their substance use. If they do access detox, it is not guaranteed that they will not have to wait for the human trafficking service due to lack of beds. This is all assuming there is an organization that is within their area and that they have the capacity to seek support in the moment, not even considering the potential fears of violence, discrimination, and stigma.

Demonstration of the prevalence of addiction and barriers in survivors accessing services demonstrate the need to shift social service supports to be based from a trauma-informed, harm reduction and strengths-based approach. Changes need to occur at individual, organizational, and systems levels. Counsellors must utilize these practices to disentangle stigma and shame and to help survivors to rebuild their ability to trust, support survivor safety, assist survivors in

stabilizing amidst the trauma and harms due to their exploitation, build on strengths, and support clients to reclaim their power and agency that was previously lost. Such actions will reduce some barriers in service access for survivors. Counsellors cannot control all barriers and limitations, and this is where advocacy is essential. The counsellor must use their platform to advocate for organization and systems change. Service providers must act similarly, especially providing specific harm reduction strategies to enhance survivor safety, building of trust, provide support without judgement, focus on strengths, collaboration, and resourcing. Organizations must consider how their present approaches pose barriers, seek change, and provide adequate training to service providers. Such training would provide a thorough understanding of human sex trafficking, trauma-informed practice, and harm reduction. Systems must allocate timely funding to allow for in-house addiction supports at human trafficking organizations, such as detoxification, treatment, and the trained medical professionals who do so. Doing so will allow for more survivors to have their needs met, and demonstrates a narrative of acceptance, care, and inclusion rather than stigma, shame, and exclusion. Greater funding to expand on bed space for survivors and training for other community services, such as at shelters and transition houses, would further aid survivors to meet emergency needs while in crisis. Funding is essential for supports inclusive of gender and cultural identities. I invite all readers, counsellors, service providers, organizations, and systems to reflect on their own views and potential biases toward human sex trafficking survivors, sex workers, and addiction. The essential question is: how can I contribute to making British Columbia more understanding, caring, less stigmatizing, and an inclusive place for survivors to exist and rebuild their lives?

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