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Identifying and Assisting Human Trafficking Survivors: A Post-Training Analysis of First Responders

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Cover Page Footnote

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First responders and the agencies for which they work face numerous challenges in identifying and assisting human trafficking survivors. This article aims to outline the ways in which first responders in a Midwestern state identify and provide services to human trafficking survivors. Six months after attending a two-day training aimed at recognizing and assisting human trafficking survivors, first responders were invited to participate in a follow-up survey regarding the training that they received. Responses were collected from 270 participants who work at various government, medical, or social service agencies

in both rural and urban service areas across the state. Results focus on perceived prevalence of human trafficking, type of trafficking survivor populations served, barriers to service provision, and confidence in identifying indicators of human trafficking.

Keywords: Human trafficking, first responders, provision, community services, victim identification

Human trafficking (HT) is recognized globally as a violation of basic human rights with significant implications for victims' health and wellbeing (Baye & Heumann, 2014; Greenbaum et al., 2015). Prevalence figures for HT are notoriously suspect; nonetheless, the International Labour Organization (2017)—with the assistance of the Walk Free Foundation—recently revealed a new "global estimate" of 24.9 million trafficking victims worldwide at any given point. Victims are often vulnerable individuals who have struggled with poverty, have limited access to education, have a history of child abuse or neglect, have experienced homelessness, or may have been transported to another country in which they are unfamiliar with its laws, language, and culture (Clawson et al., 2009; Victims of Trafficking and Violence Protection Act of 2000).

It is now well understood that trafficking in persons does not just occur in low- and middle-income countries, but within the borders of the United States as well (Bales & Lize, 2005; Brennan, 2014; Goździak, 2016). Within the U.S., as elsewhere, victim identification is difficult—largely due to the clandestine nature of the trafficking industry—thereby limiting critical services to survivors that might improve quality of life and wellbeing. First responders (FR) are poised to come into contact with HT survivors via their work in medical settings, social service agencies, and law enforcement. The ability of FRs to correctly identify HT victims is paramount to their ability to provide appropriate services and assistance. Despite the potential value to including FRs in anti-trafficking research, to date, such studies are relatively uncommon. To this end, we sought to ascertain information from FRs that could be used, we believe, in future trainings for those most likely to encounter HT survivors. Four

goals guided this study. First, we sought to assess FRs' beliefs regarding the commonality and prevalence of HT. Second, this investigation was intended to identify common demographics of HT survivors receiving services. The third goal was to delineate barriers to service provision as well as to survivors' seeking services. Finally, we sought to identify FRs' perceptions of training and preparedness in identifying and responding to the needs of HT survivors. Below, we provide context from the literature regarding HT in Nebraska, as well as FRs' experience with HT.

Literature Review

Human Trafficking in Nebraska

In the United States, as elsewhere, there are two commonly recognized categories of HT: sex trafficking and labor trafficking. Victims trafficked into the commercial sex industry may be forced into activities such as prostitution, pornography, and exotic dancing (Richards, 2004; U.S. Department of Justice, 2017). Labor trafficking victims are often forced to work in dangerous or extreme conditions in factories, farming, restaurants, or in household domestic servitude (U.S. Department of Justice, 2017). Due to the multifaceted nature of victim identification for researchers, service providers, and victims themselves, accurate estimates of the rates of HT prove difficult to obtain (Clawson et al., 2009). Within the U.S. specifically, official prevalence rates are elusive; however, between 2016 and 2017 the Polaris Project (2018) identified a 13% increase in rates of *identified victims*, through the use of their HT hotline.

Domestically, HT is most frequently associated with large cities and urban centers, and typically coastal states and other major international points of entry (Schwarz et al., 2018). As a land-locked, rural state that lacks a thriving tourism industry, Nebraska does not fit the profile. However, two unique features of the state make Nebraska potentially attractive for HT perpetrators. First, Interstate 80 (I-80), a prominent intercoastal highway, cuts across a 455-mile corridor from east to west through the center of the state. I-80 is a major thoroughfare for the transportation of goods; as such, it is populated with numerous commercial truck stops and rest areas. Since the commercial trucking industry is implicated as a significant player

in the trafficking of girls and women for purposes of sexual exploitation (Polaris Project, 2012; Shared Hope International, 2018), these truck stops and rest areas have the capacity for playing a role in the trafficking process. Second, agriculture is Nebraska's leading industry, which contributed $25 billion to the state's economy in 2014 (Nebraska Department of Agriculture, 2016). In 2016, 92% of Nebraska land was utilized by farms and ranches (Nebraska Department of Agriculture, 2016). Agricultural workers are often migrants and thus are vulnerable to labor exploitation owing to undocumented immigration status, rural isolation, and limited knowledge of their individual rights. Despite these two prominent factors contributing to HT within the state, rates of victimization are unknown.

First Responders and Anti-Trafficking Training

FRs are those who are likely to encounter, or be a first point of contact for, HT survivors, because of their employment (e.g., law enforcement, medical professions, victims' services, and community-based organizations). FRs face numerous challenges in identifying and reporting HT offenses. Generally, this group lacks training regarding elements of HT, including victim identification and the provision of services (Farrell et al., 2010). Limited training likely influences FRs' depth of knowledge about HT, signs indicative of HT victim status, and services victims may require. As FRs have specific access to HT survivors, they are in a distinctive position to provide a variety of resources, including assistance in exiting their situation if the victim is prepared to do so. With such access, it is crucial to know how FRs can best be prepared to identify and provide services to victims of HT.

Health care providers and law enforcement are two examples of FRs that often encounter HT survivors during their exploitation. Health care providers are among those *most likely* to encounter HT survivors and are therefore in a unique position to provide assistance (Dovydaitis, 2010; Grace et al., 2014; Stoklosa et al., 2017). However, a national study of 180 health care providers indicated that only five percent of participants had received training on identifying and responding to HT victims (Chisolm-Straker et al., 2012). In regards to identifying labor trafficking victims, Recknor et al. (2018) reported that health

care providers simply did not know the correct questions to ask, and that providers were uncertain about identifying patients as victims of HT in part because of an inability to distinguish between prostitution and sex trafficking or poor working conditions and labor trafficking. Although many health care providers indicate that training on HT would increase their ability to recognize victims, justifying resources for training is challenging when there is a lack of previously reported victims being treated (Recknor et al., 2018). Therefore, a cycle is formed where health care providers do not receive adequate training to identify or provide services to HT victims, followed by low funding allocations for further training, as only a meager number of cases are reported.

Similarly, law enforcement's ability to identify HT victims is particularly important in that they are a likely source to encounter victims through their work (Wilson et al., 2006). Although they are likely to encounter victims, a lack of knowledge regarding HT can lead to underestimating the magnitude of the problem. In a national study of 210 law enforcement personnel, it was found that participants who had more knowledge about HT had an increased likelihood of viewing the issue as a serious matter (Clawson et al., 2006). Gaps in knowledge and protocol also can impact the outcomes and services available to victims when law enforcement personnel address potential HT cases. Wilson and Dalton (2008) identified differences in how law enforcement addresses minors participating in the commercial sex industry. Looking at two cities within the state of Ohio, one city's law enforcement personnel interviewed and debriefed these individuals as potential HT victims; in another city, minors were treated as offenders, and the possibility of their status as a victim of HT was not addressed (Wilson & Dalton, 2008).

Barriers in Accessing and Providing Services

Since many victims of HT come from vulnerable populations, traffickers are purposeful in exploiting these vulnerabilities to their own benefit. The U.S. Department of Justice (2017) reports that traffickers often use false promises of safety, stability, love, or a better life to manipulate their victims into servitude. Considering the level of control that traffickers hold

over their victims, HT survivors are in need of wide-ranging services, including but not limited to safety, housing, medical care, mental health, legal assistance, food, clothing, advocacy, substance abuse treatment, job training and employment, education, crisis intervention, counseling, legal guardianship, child care, transportation, and service coordination (Clawson & Dutch, 2008; Lederer & Wetzel, 2014). Although the needs of survivors are widespread, community service agencies face barriers in identifying, implementing, and providing these services to the individuals who would benefit from them.

Barriers that FRs face in providing assistance to HT victims include lack of knowledge and training regarding HT; availability and understanding of culturally appropriate services; language barriers; difficulty in identifying victims; ineffective coordination of services; safety concerns; and lack of resources and funding (Clawson & Dutch, 2008; Clawson et al., 2009; Davy, 2015; Powell, Asbill, Louis, et al., 2018). Without proper training, service providers that interface with HT survivors may not recognize that the individual is a victim, rendering the provision of services impossible. However, after receiving training regarding HT, service providers have been shown to more frequently recognize indicators of trafficking. Grace et al. (2014) found that for health care providers who underwent HT training, the proportion of providers who suspected their patient was a victim of HT increased from 17% to 38%. When trainings occur, it is imperative that evaluation and feedback are incorporated to gain an understanding of participants' acquired knowledge and potential future directions to improve the training. Rollins et al. (2017) stated, "As training programs and the public health lens become more widely adopted, building practice-policy-feedback loops will help ensure that evidence-based standards of care are developed and applied effectively to all populations at risk for human trafficking" (p. 64).

While service providers face numerous difficulties in offering services, HT victims also face barriers in accessing them. Fear of the trafficker can limit a victim's willingness or ability to vocalize their victimization to service providers (Recknor et al., 2018; Rollins et al., 2017). Further, traffickers often will not leave their victims alone with service providers, impeding the ability of the service provider and the victim to communicate openly and safely (Lederer & Wetzel, 2014). When offering services to

individuals that appear to be potential HT victims, it is best to attempt to speak to them alone, separating them from potential traffickers and allowing for safe communication (Powell, Asbill, Brew, et al., 2018). Minors and parents face additional barriers in accessing services due to concerns of being reported to Child Protective Services (CPS) (Gibbs et al., 2015). Many FRs are mandated reporters, and thus must report any instances of suspected child abuse and/or neglect to CPS (Powell, Asbill, Louis, et al., 2018).

Physically accessing available services is another barrier to survivors of HT in receiving assistance that is available to them. Recknor et al. (2018) reported that health service providers indicate that a lack of coordinated community resources for HT services prevents referrals from being made, which impacts victims' hopefulness of receiving help—therefore they do not attempt to disclose their status as a trafficking victim. Another recent study supported this report, finding that the best way to reduce barriers for HT victims in accessing much-needed services is to collocate services, providing numerous resources in the same location (Gibbs et al., 2015). Waitlists and cost of service also provide challenges to victims' abilities to access services (Clawson & Dutch, 2008).

The stigma associated with work performed during their victimizations is an additional barrier to HT victims pursuing services (Clawson & Dutch, 2008; Zimmerman et al., 2008). Often, victims are embarrassed or feel ashamed of the assumptions that will be made about them if they disclose their experiences. As many HT victims are involved in illegal activity as a part of their bondage, the fear of deportation or arrest also presents an obstacle to accessing available services (Farrell et al., 2010; Powell, Asbill, Brew, et al., 2018). Additionally, as the legal landscape regarding HT is developing, penalties for traffickers and solicitors are also changing; for example, in Nebraska, Legislative Bill 289 allows for the penalty of life in prison for traffickers and up to 50 years in prison for those paying for services from victims of sex or labor trafficking (Duggan, 2017). Victims may be unaware of legislative changes such as these when deciding whether or not to pursue services or report their victim status.

Context

In 2015, the U.S. Bureau of Justice Assistance and the Office of Victims of Crime partnered to fund comprehensive, multidisciplinary, state-wide task forces with the explicit goal of enhancing collaboration between law enforcement and victim service partners in local communities. The Nebraska Human Trafficking Task Force (NHTTF) was commissioned in October 2015. Specialized FR training was a significant part of the grant and was supervised by the Nebraska Attorney General's Office. The Salvation Army was the administrator of the survivors' needs and services coordination component of the grant. The Salvation Army Fight to End Trafficking (SAFE-T) was thus established and included a services director and three regional coordinators. The NHTTF conducted trainings for FRs in six regions across the state of Nebraska over a three month period of time. The training lasted two days and covered topics such as policies and definitions of HT, survivor advocacy, identifying trafficking survivors, investigating sex trafficking, and immigration. All FRs who completed the training were targeted for inclusion in this investigation.

Methods

Procedures

Across the six regional locations, 698 FRs attended the training. Six months after trainings were complete, all 698 attendees were invited to participate in the post training survey via email listserv. Survey questions were developed in conjunction with the NHTTF trainers. A Qualtrics survey link was active for participants to access for a period of eight months. Upon completion of the survey, participants could elect to enter a drawing for a chance to win one of six $50 gift cards. In total, 297 responses were recorded. However, entries having a majority of incomplete data were removed and the final sample consists of 270 responses.

Survey Instrument

The survey instrument consisted of 32 questions. In addition to demographics, participants responded to questions to assess HT knowledge (prevalence, victim identification), service provision, and barriers to providing services. Response choices included Likert scale (e.g., "Based on your agency's experience, how often would you say human trafficking occurs, not just in your jurisdiction, but throughout Nebraska?"); dichotomous (e.g., "Does your agency provide services to human trafficking survivors?"); multiple choice (e.g., "In your opinion, what barriers exist for your agency in providing services to human trafficking victims?"); and long answer (e.g., "To what extent was the Nebraska Human Trafficking Task Force Training useful for you professionally?").

Participants

Survey participants included 270 FRs representing all six behavioral health regions of the state of Nebraska (see Table 1 for demographic data). Participants were grouped into three categories based on the type of agencies in which they were

Table 1. Participants' Agency Type, Gender, and Location

Participant Demographics	Sample *(n = 270)*	Percentage
Agency Type		
Medical and Mental Health Care	36	13.33%
Justice System and Government	123	45.56%
Social Services	111	41.11%
Gender		
Male	84	31.11%
Female	184	68.15%
Undisclosed	2	0.74%
Location		
Rural	138	51.11%
Urban	132	48.89%

Note: The two participants who did not share their gender were not included in data analysis by gender.

employed: (a) government and justice system, (b) medical and mental health care, and (c) social services. Government and justice system positions included law enforcement, probation, prosecution, legal defense, and government agency roles. Social services included positions with education, domestic violence and sexual assault prevention, youth services, foster care, and general nonprofit agencies. Medical and mental health positions included forensic nurses, emergency clinic medical staff, and other health care professionals who might encounter HT victims. Participants were also grouped by gender and the locations of the agencies at which they were employed, with a near-even divide between participants in rural and urban settings.

Data Analysis

Data were analyzed using SPSS Version 25 software. Bivariate correlations were conducted to explore associations between location (urban, rural), gender, and agency (medical and mental health care, justice system and government, social services) in relation to survey results. Independent *t* tests were used to determine mean differences regarding location and gender, and analysis of variance (ANOVA) tests were conducted to examine mean differences between agency types. Chi-square tests of independence were used to examine the relationship between location, gender, and agency with multiple survey factors. Finally, short answer responses were summarized and presented using thematic analysis.

Results

Perception of Human Trafficking Prevalence

Survey participants were asked to gauge the prevalence of HT within their own communities and across the state as a whole. To gain an understanding of their responses, we reviewed the following questions from the survey: (1) "Based on your agency's experience, how often would you say human trafficking occurs in your jurisdiction?" and (2) "Based on your agency's experience, how often would you say human trafficking occurs throughout Nebraska?" Table 2 indicates participants'

Table 2. Perceptions of Human Trafficking Prevalence by Location

Prevalence	Jurisdiction *n* (%)	State of Nebraska *n* (%)
Extremely Rarely	12 (4.4)	1 (0.4)
Rarely	35 (13.0)	4 (1.5)
Happens Sometimes	108 (40.0)	23 (8.5)
Often	88 (32.6)	147 (54.4)
Extremely Often	27 (10.0)	95 (35.2)

n = 270

perceived prevalence of HT within their own communities and across the entire state of Nebraska.

Bivariate correlations revealed a significant positive association between location (rural/urban) and perception of the prevalence of HT within a given jurisdiction, $r(270) = .25$, $p < .001$. A significant positive association was also found between gender and how often HT is perceived to occur within a given jurisdiction ($r(268) = .19$, $p = .002$), as well how often HT is perceived to occur statewide ($r(268) = .21$, $p < .001$). Results indicate a positive association between female participants and viewing prevalence of HT as occurring more frequently both locally and across the state.

Independent samples *t* tests allowed for comparison of responses by gender (male/female) and location type (rural/urban). There was a significant difference between rural ($M = 3.07$, $SD = .92$) and urban ($M = 3.55$, $SD = .97$) participant responses regarding perception of HT in their jurisdiction, $t(268) = -4.19$, $p < .001$. Not surprisingly, rural participants believe HT occurs less often in their jurisdiction than urban participants. No significant difference was found between rural ($M = 4.23$, $SD = .67$) and urban ($M = 4.22$, $SD = .72$) participant responses regarding the perceived frequency of statewide HT, $t(268) = .144$, $p = .89$.

A significant difference was found between male ($M = 3.05$, $SD = .97$) and female ($M = 3.43$, $SD = .95$) responses regarding perceived rates of HT in their jurisdiction, $t(266) = -3.08$, $p =$

.002. Specifically, male participants believe HT occurs in their jurisdictions less often than do their female counterparts. In addition, there was a significant difference between male (M = 4.02, SD = .78) and female (M = 4.33, SD = .61) participants regarding statewide frequency of HT, $t(266) = -3.50$, $p = .001$. These results suggest male participants believe HT occurs less often statewide than female participants.

A one-way between subjects ANOVA was conducted to compare how frequently participants working in the justice/government, medical/mental health, and social services fields reported that, based on their agencies' experiences, HT occurs in their jurisdiction. No significant differences were found between agencies' reporting on the perceived frequency of HT in their jurisdictions, $F(2, 267) = 0.38$, $p = .69$. In addition, no significant differences were found between agencies regarding the perceived frequency of statewide HT $F(2, 267) = 2.87$, $p = .06$.

Service Provision

To determine the rates at which agencies provided services to HT survivors, participants were asked, "Does your agency provide services to human trafficking survivors?" The majority (62.6%) of participants reported that their agency did provide services to HT survivors. Of the remaining participants, 11.9% indicated that although their agencies were not currently providing services to HT survivors, they planned to in the future. Chi-square tests of independence revealed that there was a significant difference between genders in the way participants responded to this question, $X^2(2, 268) = 7.69$, $p = .02$, $V = 0.17$. Females were more likely than males to indicate that their agencies provided services to HT survivors (67.9% and 51.2%, respectively). There were no significant relationships found between agency or location type regarding service provision.

In seeking to understand the populations to which FRs were providing services, participants were asked if their agencies had provided services to sex trafficked minors, sex trafficked adults, or individuals involved in labor trafficking. Results are presented in Table 3. Chi-square tests of independence revealed no significant relationships between gender, location, or agency type and responses to this question. Although results do not show a significant relationship, these results are indicative of

Table 3. Types of Trafficking Encountered by Participants

	Overall Sample n (%)	Male *n* (%)	Female *n* (%)	Rural *n* (%)	Urban *n* (%)	Justice / Gov *n* (%)	Medical *n* (%)	Social Services *n* (%)
Sex Trafficking Survivors-Minors	97 (37.6)	27 (33.8)	69 (39.2)	51 (38.9)	46 (36.2)	42 (36.2)	12 (35.3)	43 (39.8)
Sex Trafficking Survivors - Adults	105 (40.7)	32 (40.0)	72 (40.9)	49 (37.4)	56 (44.1)	53 (45.7)	12 (35.3)	40 (37.0)
Labor Trafficking Survivors	66 (25.6)	20 (25.0)	46 (26.1)	35 (26.7)	31 (24.4)	33 (28.4)	8 (23.5)	25 (23.1)

n = 258

the differences in rates of service provision for sex and labor trafficking, with only 25.6% of participants indicating that their agency had provided services to labor trafficking survivors, whereas 37.6% of participants indicated providing services to sex trafficking survivors who were minors and 40.7% to adults.

To better understand the demographics of the HT survivors to whom participants were providing services, we asked, "Based on experiences with your agency, which demographic group of trafficking survivors do you see most/least often?" Participants were able to select one of five options: (a) *Minor U.S. Citizens*, (b) *Minor Non U.S. Citizens*, (c) *Adult U.S. Citizens*, (d) *Adult Non U.S. Citizens*, or (e) *We don't see any trafficking survivors*. Results are presented in Tables 4 and 5, respectively. Observed in Table 4, bivariate correlations revealed a significant positive association between the survivor group that participants see *most* often and location ($r(270) = .20$, $p = .001$), gender ($r(268) = .16$, $p = .009$), and agency type ($r(270) = .12$, $p = .045$). These results show that (1) within rural settings, the majority of participants (34.1%) most often saw adult U.S. citizens, and in urban settings, the majority of participants (42.4%) most often saw minor U.S. citizens; (2) the majority (38.6%) of female participants most often saw minor U.S. citizens, whereas the majority of males (38.1%) most often saw adult U.S. citizens; and (3) participants working within the justice/government sector were evenly divided between most often seeing minor U.S. citizens (31.7%) and adult U.S.

Table 4. Human Trafficking Survivors Seen Most Often

	Overall Sample n (%)	Male *n* (%)	Female *n* (%)	Rural *n* (%)	Urban *n* (%)	Justice / Gov *n* (%)	Medical *n* (%)	Social Services *n* (%)
Minor US citizens	92 (34.1)	21 (25.0)	71 (38.6)	36 (26.1)	56 (42.4)	39 (31.7)	10 (27.8)	43 (38.7)
Minor non US citizens	13 (4.8)	1 (1.2)	12 (6.5)	7 (5.1)	6 (4.5)	3 (2.4)	2 (5.6)	8 (7.2)
Adult US citizens	92 (34.1)	32 (38.1)	58 (31.5)	47 (34.1)	45 (34.1)	39 (31.7)	17 (47.2)	36 (32.4)
Adult non US citizens	11 (4.1)	6 (7.1)	5 (2.7)	8 (5.8)	3 (2.3)	7 (5.7)	2 (5.6)	2 (1.8)
We do not see HT survivors	62 (23.0)	24 (28.6)	38 (20.7)	40 (29.0)	22 (16.7)	35 (28.5)	5 (13.9)	22 (19.8)

n = 270

Table 5. Human Trafficking Survivors Seen Least Often

	Overall Sample n (%)	Male *n* (%)	Female *n* (%)	Rural *n* (%)	Urban *n* (%)	Justice / Gov *n* (%)	Medical *n* (%)	Social Services *n* (%)
Minor US Citizens	28 (10.4)	12 (14.3)	16 (8.7)	19 (13.8)	9 (6.8)	15 (12.2)	3 (8.3)	10 (9.0)
Minor non US citizens	69 (25.6)	20 (23.8)	47 (25.5)	31 (22.5)	38 (28.8)	25 (20.3)	10 (27.8)	34 (30.6)
Adult US Citizens	55 (20.4)	9 (10.7)	46 (25.0)	22 (15.9)	33 (25.0)	19 (15.4)	11 (30.6)	25 (22.5)
Adult non US citizens	55 (20.4)	17 (20.2)	38 (20.7)	26 (18.8)	29 (22.0)	26 (21.1)	7 (19.4)	22 (19.8)
We do not see HT survivors	63 (23.3)	26 (31.0)	37 (20.1)	40 (29.0)	23 (17.4)	38 (30.9)	5 (13.9)	20 (18.0)

n = 270

citizens (31.7%), the majority (47.2%) of those working within the medical field most often saw adult U.S. citizens, and finally, the majority (38.7%) of participants working within social services most often saw minor U.S. citizens.

Chi-square tests for independence indicated three significant relationships regarding populations seen most or least often (see Tables 4 and 5). When examining responses for which populations were seen *most* often (see Table 4), a significant

difference was revealed between location types ($X^2(4, 270) = 11.84$, $p = .02$, $V = 0.21$) and gender ($X^2(4, 268) = 11.54$, $p = .02$, $V = 0.21$). Finally, seen within Table 5, a significant difference was found between which population was seen *least* often and gender, $X^2(4, 268) = 10.42$, $p = .03$, $V = 0.20$. This finding reflects data which indicated that the majority (31.0%) of male participants reported not seeing HT survivors within work conducted in their agency, and the majority (25.5%) of female participants selected minor non U.S. citizens as the population that they saw least often.

Service Provision Barriers

Participants were asked to identify the barriers that they believed existed for their agency in providing services to HT survivors. To respond to the question, participants were provided with numerous options to select (e.g., language barriers, lack of support/coordination with other service providers) and were able to choose as many options as they felt applied. Tables 6-8 illustrate barriers to providing services to HT survivors; results are divided by gender, location, and agency type. Of note, the majority of all participants (57.6%) selected *lack of funding/resources* as a barrier to the provision of services to HT survivors.

Next, participants were asked to identify the barriers that they felt existed for HT survivors seeking services, and were again provided with multiple options to select (e.g., language, held in captivity, shame/embarrassment). See Tables 6-8 for the frequency at which participants selected each barrier for HT survivors to access services. Overall, participants identified numerous barriers that they believed to deter HT survivors from accessing services; the most frequently selected option (87.8%) was *lack of trust in service providers/the system*.

In examining the differences between responses by gender (see Table 6), chi-square tests of independence revealed three significant relationships. First, chi-square analysis revealed a significant difference between survivor access barrier *being held in captivity* and gender, $X^2 (1, 260) = 7.59$, $p = .006$, $V = 0.17$. Men, more often than women, reported *being held in captivity* was a barrier to service access for HT survivors (75.0% and 60.6%, respectively). Second, a significant difference between *issues of safety* as a barrier to service provision and gender was found, $X^2 (1, 260) = 4.38$, $p = .04$, $V = 0.13$. Women, more often than men,

Table 6. Comparisons by Gender of Barriers for Agencies to Provide Services and Barriers for HT Survivors to Access Services

Barriers for agencies to provide services	Overall sample *n* (%)	Male *n* (%)	Female *n* (%)	Chi-square tests of independence
Lack of support/coordination with federal agencies	55 (21.0)	13(15.9)	41(23.0)	$X^2(1)=1.76$ ns
Lack of support/coordination with other service providers	61 (23.3)	13(15.9)	46(25.8)	$X^2(1)=3.19$ ns
Lack of funding / resources	151 (57.6)	52(63.4)	98(55.1)	$X^2(1)=1.61$ ns
Lack of knowledge about services needed by trafficking survivors	99 (37.8)	35(41.7)	63(35.4)	$X^2(1)=1.27$ ns
Lack of training / information about HT	78 (29.8)	24(29.3)	54(30.3)	$X^2(1)=0.03$ ns
Lack of organizational policy or procedures for addressing the needs of trafficking survivors	101 (38.5)	31(37.8)	69(38.8)	$X^2(1)=0.02$ ns
Inadequate staffing	95(36.3)	41(50.0)	53(29.8)	$X^2(1)=9.95$** $V=0.20$ a
Issues of safety	45(17.2)	8(9.8)	36(20.2)	$X^2(1)=4.38$* $V=0.13$ a
Language barriers	61 (23.3)	20(24.4)	40(22.5)	$X^2(1)=0.12$ ns
Barriers for HT survivors to access services				
Fear of deportation	200 (76.30)	60(75.0)	138(76.7)	$X^2(1)=0.08$ns
Fear of violence against self or family	211 (80.5)	68(85.0)	141(78.3)	$X^2(1)=1.56$ ns
Isolation/no support	215 (82.1)	71(88.8)	142(78.9)	$X^2(1)=3.64$ ns
Shame/embarrassment	218 (83.2)	67(83.8)	149(82.8)	$X^2(1)=0.04$ ns
Lack of trust in service providers/the system	230 (87.8)	72(90.0)	156(86.7)	$X^2(1)=0.57$ ns
No knowledge of available services	218 (83.2)	69(86.3)	147(81.7)	$X^2(1)=0.83$ ns
Doesn't recognize self as HT survivor	224 (85.5)	69(86.3)	153(85.0)	$X^2(1)=0.07$ ns
Lack of transportation/ geographical isolation	174 (66.4)	55(68.8)	117(65.0)	$X^2(1)=0.35$ ns
Language barriers	177 (67.6)	54(67.5)	121(67.2)	$X^2(1)=.002$ ns
Lack of community awareness about HT	184 (70.2)	59(73.8)	123(68.3)	$X^2(1)=0.77$ ns
Held in captivity	171 (65.3)	60(75.0)	109(60.6)	$X^2(1)=5.08$** $V=0.14$ a
Lack of culturally appropriate services	155 (59.2)	49(61.3)	104(57.8)	$X^2(1)=0.28$ ns

n=258; ***$p\leq0.001$,**$p\leq0.01$, *$p<.05$, ns, $p>0.05$; *V* =effect size (phi coefficient or Cramer's *V*), [a]a significant difference with an effect size ≥Cohen's (1998) definition of "small"

Table 7. Comparisons by Location of Barriers for Agencies to Provide Services and Barriers for HT Survivors to Access Services

Barriers for agencies to provide services	Overall sample *n* (%)	Rural *n* (%)	Urban *n* (%)	Chi-square tests of independence
Lack of support/coordination with federal agencies	55 (21.0)	23(16.7)	32(24.2)	$X^2(1)=2.84$ ns
Lack of support/coordination with other service providers	61 (23.3)	26(19.1)	35(26.5)	$X^2(1)=2.75$ ns
Lack of funding/resources	151 (57.6)	85(62.5)	66(52.4)	$X^2(1)=2.74$ ns
Lack of knowledge about services needed by trafficking survivors	99 (37.8)	46(33.3)	53(40.2)	$X^2(1)=1.89$ ns
Lack of training/information about HT	78 (29.8)	44(32.4)	34(27.0)	$X^2(1)=0.90$ ns
Lack of organizational policy or procedures for addressing the needs of trafficking survivors	101 (38.5)	48(77.4)	53(75.2)	$X^2(1)=1.26$ ns
Inadequate staffing	95(36.3)	50(36.8)	45(35.7)	$X^2(1)=0.03$ ns
Issues of safety	45(17.2)	24(17.6)	21(16.7)	$X^2(1)=0.04$ ns
Language barriers	61 (23.3)	35(25.7)	26(20.6)	$X^2(2)=0.95$ ns
Barriers for HT survivors to access services				
Fear of deportation	200 (76.30)	103(77.4)	97(75.2)	$X^2(1)=0.18$ ns
Fear of violence against self or family	211 (80.5)	104(75.4)	107(81.1)	$X^2(1)=0.94$ ns
Isolation/no support	215 (82.1)	108(81.2)	107(82.9)	$X^2(1)=0.13$ ns
Shame/embarrassment	218 (83.2)	110(82.7)	108(83.7)	$X^2(1)=0.05$ ns
Lack of trust in service providers/the system	230 (87.8)	116(87.2)	114(88.4)	$X^2(1)=0.08$ ns
No knowledge of available services	218 (83.2)	119(89.5)	99(6.7)	$X^2(1)=7.59$ ** $V=0.17$ a
Doesn't recognize self as HT survivor	224 (85.5)	116(87.2)	108(83.7)	$X^2(1)=0.65$ ns
Lack of transportation/ geographical isolation	174 (66.4)	92(69.2)	82(63.6)	$X^2(1)=0.92$ ns
Language barriers	177 (67.6)	90(67.7)	87(67.4)	$X^2(1)=0.00$ ns
Lack of community awareness about HT	184 (70.2)	98(73.7)	86(66.7)	$X^2(1)=1.54$ ns
Held in captivity	171 (65.3)	88(66.2)	83(64.3)	$X^2(1)=0.10$ ns
Lack of culturally appropriate services	155 (59.2)	77(57.9)	78(60.5)	$X^2(1)=0.18$ ns

n=260; ***$p\leq0.001$,**$p\leq0.01$, *$p<.05$, ns, $p>0.05$; V =effect size (phi coefficient or Cramer's V), [a]a significant difference with an effect size ≥Cohen's (1998) definition of "small".

Table 8. Comparisons by Agency Type of Barriers for Agencies to Provide Services and Barriers for HT Survivors to Access Services

Barriers for agencies to provide services	Overall sample *n* (%)	Justice/Gov *n* (%)	Medical *n* (%)	Social Services *n* (%)	Chi-square tests of independence
Lack of support/coordination with federal agencies	55 (21.0)	18(14.6)	8(22.9)	29(26.9)	$X^2(2)=4.48$ ns
Lack of support/coordination with other service providers	61 (23.3)	16(13.4)	8(22.9)	37(34.3)	$X^2(2)=13.74$*** $V=0.23$ a
Lack of funding/resources	151 (57.6)	68(57.1)	19(54.3)	64(59.3)	$X^2(2)=0.29$ ns
Lack of knowledge about services needed by trafficking survivors	99 (37.8)	42(35.3)	13(37.1)	44(40.7)	$X^2(2)=0.72$ ns
Lack of training/information about HT	78 (29.8)	34(28.6)	11(31.4)	33(30.6)	$X^2(2)=0.16$ ns
Lack of organizational policy/procedures for addressing the needs of trafficking survivors	101 (38.5)	46(38.7)	11(31.4)	44(39.6)	$X^2(2)=0.97$ ns $V=0.21$ a
Inadequate staffing	95(36.3)	63(47.1)	24(31.4)	80(25.9)	$X^2(2)=11.35$**
Issues of safety	45(17.2)	12(10.1)	7(20.0)	26(24.1)	$X^2(2)=8.02$** $V=0.17$ a
Language barriers	61 (23.3)	31(26.1)	6(17.1)	24(22.2)	$X^2(2)=1.32$ ns
Barriers for survivors to access services					
Fear of deportation	200 (76.30)	90(76.3)	25(71.4)	85(78.0)	$X^2(2)=0.63$ ns
Fear of violence against self or family	211 (80.5)	101(85.6)	27(77.1)	83(76.1)	$X^2(2)=3.52$ ns
Isolation/no support	215 (82.1)	103(87.3)	28(80.0)	84(77.1)	$X^2(2)=4.14$ ns
Shame/embarrassment	218 (83.2)	98(83.1)	29(82.9)	91(83.5)	$X^2(2)=0.11$ ns
Lack of trust in service providers/ the system	230 (87.8)	106(89.8)	29(82.9)	95(87.2)	$X^2(2)=1.29$ ns
No knowledge of available services	218 (83.2)	96(81.4)	28(80.0)	94(86.2)	$X^2(2)=1.26$ ns
Doesn't recognize self as human trafficking survivor	224 (85.5)	104(88.1)	26(74.3)	94(86.2)	$X^2(2)=4.26$ ns
Lack of transportation/ geographical isolation	174 (66.4)	83(70.3)	20(57.1)	71(65.1)	$X^2(2)=2.24$ ns
Language barriers	177 (67.6)	81(68.6)	25(71.4)	71(65.1)	$X^2(2)=0.59$ ns
Lack of community awareness about HT	184 (70.2)	85(72.0)	24(66.7)	75(68.8)	$X^2(2)=0.33$ ns
Held in captivity	171 (65.3)	81(68.6)	24(68.6)	66(60.6)	$X^2(2)=1.83$ ns
Lack of culturally appropriate services	155 (59.2)	70(59.3)	21(60.0)	64(58.7)	$X^2(2)=0.02$ ns

n=260; ***$p\leq0.001$,**$p\leq0.01$, *$p<.05$, ns, $p>0.05$; V =effect size (phi coefficient or Cramer's V), [a]a significant difference with an effect size ≥Cohen's (1998) definition of "small".

reported *issues of safety* as a barrier for agencies to provide services to HT survivors (20.2% and 9.8%, respectively). Third, a significant difference was found between gender and *lack of staffing* as a barrier to the provision of services, X^2 (1, 260) =9.95, p = .002, V=0.20. Men, more often than women, reported *lack of staffing* as a barrier (50.0% and 29.8%, respectively). No other significant differences between barriers and gender were found.

As shown in Table 7, chi-square tests of independence were conducted to examine the relationship between the location of participants (i.e., rural or urban) and the barriers for agencies to provide services and HT survivors to access services. First, the relationship between *no knowledge of available services* and location was significant, X^2(1, 262) =7.59, p = .006, V=0.17.

Rural, more than urban respondents, believed that no knowledge of available services to HT survivors is a barrier to service access (89.5% and 76.7% respectively). No other significant differences between barriers and location type were observed.

Differences between agency type (i.e., justice/government, medical, social services) and each barrier were examined using chi-square tests of independence (see Table 8). Significant relationships among three barriers for agencies to provide services to survivors were found. First, participants from different agency types had significant differences in identifying *lack of support/coordination with other service providers*, X^2 (2, 262) =13.74, p = .001, V=0.23. Participants working in the social services field, more often than those in justice/government or the medical field, reported *lack of support/coordination with other service providers* as a barrier to provision of services to HT survivors (34.3%, 13.4%, and 22.9%, respectively).

Second, *issues of safety* revealed a statistically significant difference between agency types, X^2 (2, 262) =8.02, p = .02, V=0.17. Participants working in the social services field, more often than those in the medical field or justice/government, reported *issues of safety* as a barrier to provision of services to HT survivors (24.1%, 20.0%, and 10.1%, respectively). Third, chi-square revealed a significant difference between agency types in identifying *inadequate staffing* as a barrier to providing services, X^2 (2, 262) =11.35, p = .003, V=0.21. Participants working in the justice/government field, more often than those in social services or medical field, reported *inadequate staffing* as a barrier to provision of services to HT survivors (47.1%, 31.4%, and 25.9%,

respectively). No other significant differences between barriers and agency type were found.

First Responder Preparedness

The final goal of this research was to uncover FRs' abilities to identify and provide services to HT survivors, as well as the abilities of the agencies which employ them. Results from the survey questions addressing this goal are outlined below.

Ability to Identify Human Trafficking Cases

To ascertain participants' views on their own ability to recognize HT, we asked them to use a 5-point scale to indicate the level at which they agreed or disagreed with the statement "Since attending the NHTTF training, I feel confident in my ability to recognize indicators of human trafficking." Overwhelmingly, participants felt positively about their abilities, with nearly 90% of participants (n = 255) slightly agreeing (40.4%) or agreeing (47.5%) with the statement. Using the same scale, participants were then asked to indicate the level at which they agreed or disagreed with the statement, "My department/agency/office is adequately trained to recognize indicators of human trafficking." This time, far fewer participants indicated confidence. Of all participants (n = 255), 38.4% slightly agreed and 19.2% agreed, signaling that participants had a much higher confidence level in their personal abilities than those of the agencies they worked for as a whole. In addressing sex and labor trafficking separately, 55.7% of participants (n = 255) indicated a level of confidence in their agency, with 40.8% slightly agreeing and 14.9% agreeing that their department was adequately trained to handle cases involving sex trafficking. For labor trafficking cases, only 38.0% of participants (n = 255) indicated a level of confidence in their agency, with 29.4% slightly agreeing and 8.6% agreeing. Taken together, these results show that just over half of participants felt that their agencies were equipped to handle sex trafficking cases, but far fewer participants felt the same regarding cases involving labor trafficking. No significant differences were found between agency type, gender, or location regarding these questions.

As an evaluative question for participant knowledge regarding who would constitute a victim of HT, participants were asked, "To what extent do you agree or disagree with the statement 'Minors should not be charged with the crime of prostitution'?" Participants responded using a 6-point scale with a range in agreement (i.e., strongly [dis]agree, [dis]agree, slightly [dis]agree). Among all participants (n =270), 17.4% disagreed in some manner with the statement, indicating a lack of connection between definitions of trafficking and application to practice.

In separating male and female responses, bivariate correlations revealed a significant positive association in the responses from this question and gender ($r(270) = .25$, $p < .001$), indicating that female participants were correlated with more strongly agreeing that minors should not be charged with the crime of prostitution. Additionally, independent samples t tests revealed a significant difference between male ($M = 4.39$, $SD = 1.63$) and female ($M = 5.20$, $SD = 1.34$) participants, $t(266) = -3.98$, $p = < .001$. These results indicate that being a male has an effect on punitive views regarding prostituted minors.

In analysis by agency type, bivariate correlations indicated a significant positive association between this question and agency type, $r(270) = .28$, $p < .001$. An ANOVA test revealed further information, as a significant difference was found between agency types in participant views regarding whether or not minors should be charged with the crime of prostitution, $F(2, 267) = 11.46$, $p = < .001$. A post hoc Tukey test indicated that a significant difference existed between mean scores for social services agencies ($M = 5.42$, $SD = 1.19$) and both justice/government ($M = 4.54$, $SD = 1.58$, $p < .001$) and medical/mental health ($M = 4.72$, $SD = 1.67$, $p = .032$) agencies. No significant differences were found between justice/government and medical/mental health agencies. Taken together, these results suggest that agency type has an effect on punitive views regarding prostituted minors, specifically suggesting that FRs at social services agencies are less likely to indicate that minors should be charged with prostitution.

No significant differences were found between participants in rural or urban settings regarding their views on whether or not minors should be charged with the crime of prostitution.

Training Usefulness

Of the participants who provided a short answer response regarding the impact of the training as a whole (n = 241), a significant portion emphasized the value of increased awareness of and ability to identify HT in their professional roles. A program director working within child advocacy summarized this sentiment, stating, "(The training) helped me learn what signs to recognize and how prevalent this problem really is." Other participants indicated the far-reaching impact that the training had on their perspectives as service providers. One participant working for the state government stated,

> I had a sense of hopelessness when I heard about Human Trafficking before the training. The training was so well done that it provided real life scenarios for how to help, what to say and how to understand and recognize (human trafficking). The survivors provided hope and ways to be the change that they needed. The truths and myths presented were extremely helpful and I left feeling empowered that there is hope to help the most vulnerable.

Additionally, the value placed on increased awareness was shared by participants across agency types. One participant employed in the justice system explained,

> Working in probation we come into contact with victims of trafficking for reasons other than them being trafficked. Being able to recognize signs of possible trafficking has helped me to explore that possibility with them further and refer to services that might be helpful for them.

Similar responses were shared by participants from the social services and medical professions.

Many participants indicated feeling a sense of connectedness with other service providers following the training, allowing for more opportunities for collaboration when addressing HT locally. A participant working within youth services stated, "I appreciate the task force for keeping me up to date on where and how people are being trafficked in our area. We now feel like we have a network and support to deal with these issues."

Participants also indicated that the training helped promote a shift towards working across sectors to address challenges related to HT. One participant, who worked for a domestic violence program, stated that, "Since the training we have been working closely with law enforcement and other community agencies to be on the lookout for other victims." Although not a direct goal of the NHTTF training, by bringing together FRs across sectors, it facilitated increased communication and collaboration in communities.

Participants also highlighted that they gained a greater understanding of local resources available for trafficking survivors from the training. Many indicated that the training provided them with additional support services to supply to the clients that they serve. A participant working within the foster care system was able to immediately put this knowledge into practice; she stated, "At the time of training, I was working with a teen who was part of sex trafficking and it was nice to get useful information for her to use when looking at support services." While most participants reported a significant appreciation of the additional information about resources and services that were gained at the training, some participants discussed gaps in understanding how to put this knowledge into action. One participant stated, "It seemed to me, in our small group activities, that most all of the individuals didn't know what steps to take if they suspected sex trafficking in their community or how to approach the situation." Statements such as this signal that FRs in all fields may not be able to quickly apply trainings in a practical way.

Most participants recognized the strengths of the training, but some also noted a need for increased access and information. Addressing this, a high school counselor stated, "The training was good but it needs to be done more often and get more in depth." Providing more detail, a crime victim advocate highlighted some of the benefits of making trainings such as this more accessible:

> This training needs to be made more available so others in law enforcement become aware of the signs and what options are available for victims. Being somewhat of a new topic to the profession, as more officers become trained, the overall

> profession will become better equipped to recognize, handle, and direct victims towards assistance, as well as to prosecute those responsible.

Although this comment is specific to law enforcement, participants across all agency types discussed a desire for further trainings.

Discussion

Our overarching goal for this research was to outline ways in which FRs identify and provide services to survivors of HT. To reach this goal, we first examined FRs' beliefs regarding the prevalence of HT. As a whole, participants viewed HT as occurring more frequently statewide than in their own jurisdictions. However, female participants and those that work in urban locations were significantly more likely to indicate that HT was occurring more frequently in their own jurisdictions. Female participants were also more likely to view the prevalence of HT as occurring more frequently across the state than their male counterparts.

These findings tie into prior research. Specifically, Renzetti et al. (2015) examined pre and post HT training surveys, collected from 325 police officers in Kentucky. Results indicated that personal beliefs regarding the prevalence of HT within the police officer's jurisdiction may influence the chances that HT cases will be identified and investigated. Considering that female participants and those living in urban locations were more likely to view HT as occurring more frequently in their jurisdictions, these populations may also have a higher likelihood of identifying and investigating cases of HT.

Next, we aimed to identify the populations of HT survivors to which FRs provide services. Participants provided services to sex trafficking survivors at higher rates than individuals who were trafficked for the provision of labor. These results are consistent with those found by Schwarz et al. (2018), who assessed 667 frontline responders across two Midwestern states. In looking more deeply at the demographic characteristics of HT survivors, participants in our study identified minor U.S. citizens and adult U.S. citizens as being seen the most often by participants (34.1% each). However, in examining the data further, it was found that female and male participants differed on this,

with more females indicating that they interact most frequently with minor U.S. citizens, and male participants indicating that they interact most frequently with adult U.S. citizens. Further, participants working in urban locations were much more likely to indicate that they most often interacted with minor U.S. citizens, and rural participants with adult U.S. citizens. Finally, it is of note that minor non U.S. citizens were identified as the group seen least often by participants.

Additionally, we sought to identify the perceived barriers for HT survivors to receive services. A body of literature reports on the barriers that exist in providing services to HT survivors (see Clawson & Dutch, 2008; Clawson et al., 2009; Davy, 2015; Powell, Asbill, Louis, et al., 2018); for example, in a recent study of 15 mental health service providers, many respondents reported that the complex nature of the mental health care system provided a barrier to HT survivors in receiving appropriate benefits (Powell, Asbill, Louis, et al., 2018). These complexities often resulted in multiple medication prescriptions, having multiple providers, and premature diagnoses, highlighting how barriers in receiving and accessing services can add to the vulnerability and risks associated with HT victimization (Powell, Asbill, Louis, et al., 2018). Our work adds to the discussion of vulnerabilities associated with HT through analysis of identified barriers by gender, location, and agency type.

When examining the barriers that participants faced in providing services to survivors of HT, the most frequently cited barrier was a *lack of funding/resources*. In fact, over half (57.6%) of the participants indicated that funding was a barrier to providing services. This, too, is consistent with results reported by Schwarz et al. (2018). In the present study, lack of resources was followed by *lack of organizational policy or procedures addressing the needs of trafficking survivors*, *lack of knowledge about services needed by trafficking survivors*, and *inadequate staffing*. Regarding the perceived barriers for HT survivors to access services, participants most frequently selected *lack of trust in service providers/the system*. This was followed by *doesn't recognize self as human trafficking survivor, no knowledge of available services*, and *shame/embarrassment*. Participants working in rural areas identified *no knowledge of available services* more often than participants working in urban areas, suggesting that service providers in rural

areas may be in need of increased advertisement or outreach. It was also found that participants working in the social services were more likely to indicate that *lack of support/coordination* and *issues of safety* were significant barriers than those working in the medical field or justice/government roles. These results suggest that social service agencies, more so than other fields, may want to increase their efforts regarding supporting staff, coordinating with other agencies, and providing measures of safety. Additionally, we found that participants working in a justice/government role identified *inadequate staffing* as a barrier to service provision more frequently than participants from other agency types.

Finally, our research aimed to evaluate FRs' confidence regarding their ability to identify and provide services to HT survivors. Participants were far more likely to indicate having confidence in their own ability to recognize indicators of HT, as compared to their feelings of confidence in their agency's ability to do the same. When differentiating between sex and labor trafficking, participants had less confidence in their agency's ability to identify recognize signs of labor trafficking. This finding was foreseeable, as participants have been exposed to more sex trafficking cases through their work than labor trafficking cases; the increased exposure likely increased FRs' confidence in their agencies' abilities to identify trafficking cases. This finding is supported by available literature that discusses the gaps in focus between the two types of trafficking. For example, Sanford et al. (2016) found that in a study of 128 newspaper articles, 64% referred to sex trafficking, whereas only 11% referenced labor trafficking, and 13% discussed both. The tendency for the media to address sex trafficking more than labor trafficking can shift public perception of the problem (Sanford et al., 2016).

In aiming to understand participants' application of information learned during the HT training, our research provides insight into how FRs are addressing HT survivors' needs. Results suggest a difference in values and focus between the justice/government and medical sectors and those employed at social services agencies. Although the minority, nearly 20% of the participants in some way disagreed with the statement, "Minors should not be charged with the crime of prostitution." Female participants and those working at social service agencies were

significantly more likely to agree with the statement. The Victims of Trafficking and Violence Protection Act of 2000 defines HT as, "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age" (p. 8). Thus, the 17.4% of participants who indicated that they disagreed in some manner with the statement that minors should not be charged with the crime of prostitution were not appropriately applying the act and legal definitions.

Other research has identified similar distinctions within the law enforcement field. Farrell et al. (2010) state,

> [L]aw enforcement is familiar with and is likely to have established routines for investigating prostitution. As a result, the police automatically might view a woman engaged in prostitution as a perpetrator of a crime rather than a potential crime victim. (p. 206)

Adding to the complexity, Farrell and Pfeffer (2014) found that within their sample of law enforcement and prosecutors, participants were uncertain regarding definitions within HT laws. Specifically, there was confusion in determining whether victim consent was given freely or was given through forceful actions, as well as differentiating between exploitive labor practices and HT. Kotrla (2010) noted this tendency toward punitive action for minors, stating, "Because youths who have been involved in illegal activities, including those in commercial sex industries, have traditionally been viewed as offenders or delinquents, there are still some who fail to see these individuals as victims" (p. 184).

Overwhelmingly, participants indicated that the training increased awareness regarding the problem of HT, indicators that it is occurring, and resources available for survivors. Additionally, participants noted that the exposure to other FRs from various agency types allowed for opportunities for collaboration and support across sectors. Participants also described weaknesses in the training, suggesting that future trainings should focus on action items such as what specific steps to take after identifying signs of HT in a potential survivor. Furthermore, many participants discussed the need for trainings to occur more frequently and to include more in-depth information. As such, resources

such as the U.S. Department of Health and Human Services' (2019) Stop, Observe, Ask, Respond (SOAR) Training, from the Office of Trafficking in Persons, may be beneficial.

Limitations

A pre-training survey was not conducted, eliminating the possibility of comparison of pre and post training knowledge and responses. Additionally, the survey was available for participants to complete for an extended period of time after attending training; therefore, recollections could have been skewed. The survey was available for an extended period of time to increase potential participation rates; however, participation rates remained below 40% (38.68%), highlighting a limitation of the study. Although participants from across the state of Nebraska were surveyed, from both rural and urban locations, the geographical scope limits the transferability of results. Although limitations exist, results from this study offer valuable insight into the views of FRs after undergoing HT training.

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