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Adapting Peer Support Models for Survivors at the Intersection of Trafficking and Substance Use

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TABLE OF CONTENTS

INTRODUCTION

Trafficking survivors seeking help for substance use issues need access to recovery programs that acknowledge and address their co-occurring needs using a trauma-informed[1] and survivor-informed[2] approach. Research on the experiences of survivors of trafficking frequently demonstrates a link between substance use and trafficking (Cole, Sprang, Lee, & Cohen, 2016; Cook, Barnet, Ilaji-Maghsoodi, Ports, & Bath, 2018; Hopper, 2017a; Hopper, 2017c; Reid, Baglivio, Piquero, Greenwald, & Epps, 2017; Varma, Gillespie, McCracken, & Greenbaum, 2015). Based on a sample of 215 help-seeking youth in the National Child Traumatic Stress Network Core Data Set, Cole et al. (2016) found that commercial sexual exploitation (CSE) youth had significantly higher rates of substance use (66 percent) compared to the sample of youth who experienced sexual abuse/assault (32 percent). Hopper's (2017c) study on the experiences of 32 youth survivors of sex trafficking highlighted the role of substance use before, during, and after the exploitation, including that substance use was an issue for one-third of the participants. This growing body of literature on the relationship between trafficking and substance use highlights the need for substance use services that include a safe, judgment-free environment (see also, Cole & Sprang, 2014; Gerassi, 2015; Hopper, 2017b; Macy & Johns, 2011; Stoklosa, MacGibbon, & Stoklosa, 2017; Vatne Bintliff, Stark, Brown, & Alonso, 2018).

Trafficking Definition

There are two types of trafficking—**sex trafficking** and **labor trafficking**. The Trafficking Victims Protection Act of 2000 (TVPA) provides comprehensive definitions of each type:
(1) **sex trafficking** is defined as "the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the 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" (and)
(2) **labor trafficking** is defined as "the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery" (22 U.S.C. § 7102).

Research on the experiences and needs of trafficking survivors highlights the call by survivors for group intervention models, peer support, and community building with other survivors (see Hopper, Azar, Bhattacharyya, Malebranche, & Brennan, 2018; Rajaram & Tidball, 2016). A combination of the peer support group framework and trauma-informed practices warrants further exploration to identify how an integrated model may help support trafficking survivors with co-occurring substance use issues. Peer-led recovery support groups provide a framework for bringing people with shared lived experience together to recover and heal in a nonjudgmental environment. Peer support groups are a popular type of group therapy that gained prominence through Alcoholics Anonymous (AA). Since its inception in the 1930s, AA involves peer-led meetings that utilize the Twelve-Step Treatment Model to guide participants through the recovery process. AA is a voluntary, community-based recovery program for

[1] Substance Abuse and Mental Health Services Administration (2014) provides the following definition of a trauma-informed approach: "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization" (p. 9).

[2] Fellows from the 2017 Human Trafficking Leadership Academy (HTLA) developed the following definition: "a survivor-informed practice includes meaningful input from a diverse community of survivors at all stages of a program or project, including development, implementation, and evaluation" (Human Trafficking Leadership Academy, 2017, p. 1).

anyone seeking help with an addiction to alcohol, and it is known for its emphasis on shared experiences of the peer leaders. AA's framework and Twelve-Step program has been replicated to address a variety of recovery needs (e.g., narcotics, gambling, and overeating). To develop a peer support recovery program model that meets the needs of trafficking survivors, additional research is needed to understand how a program could infuse a trauma-informed approach in all aspects of programming and implementation.

Methodology

A search for academic literature was conducted on Academic Search Complete and Google Scholar for peer-reviewed journal articles published within the last 10 years. The key words included *peer support, twelve step program, Alcoholics Anonymous, substance use, Al-Anon/Alateen, sex trafficking, human trafficking,* and *commercial sexual exploitation of children*. Furthermore, web content was reviewed from a variety of sources, including federal and state agencies and nongovernmental organizations. These resources were used to answer the following research questions:

1. What are the potential impacts of substance use before, during, and after trafficking exploitation in relation to the needs of survivors?
2. What are the core components of peer support models?
3. What is the foundation for the Alcoholics Anonymous program?
4. What aspects of the Alcoholics Anonymous model are empirically supported?
5. What aspects of the peer support group framework need to be modified to fill the gap in the types of services available for trafficking survivors with concurrent substance use treatment/recovery needs?

Trafficking Survivors and Substance Use Recovery Needs

The interplay between trafficking and substance use is complex. Substance use and exposure are a risk factor for trafficking, and it is used as a coercion and control mechanism during exploitation (Cole & Sprang, 2014; Hopper, 2017a; Macy & Johns, 2011; Polaris, 2018). In addition, some survivors continue to struggle with drug and alcohol use as a coping mechanism during and after their exploitation. For example, Cole & Sprang (2014) explored the awareness and knowledge of trafficking professionals working with youth trafficking survivors across various geographic communities. When asked about risk factors and how traffickers maintain control, substance use was commonly mentioned in both scenarios. Hopper (2017a) highlights how labor trafficking survivors may use substances to cope with trauma-related memories especially in situations where the exploitation was tied to drug trafficking rings or the exploitation lead to chronic health conditions. Regardless of the source of their substance use, trafficking survivors dealing with substance use need comprehensive services that adequately address their needs as a survivor and for co-occurring substance use.

Substance Use, CSE, and the Child Welfare System
In a study of 87 youth in a treatment program for CSE survivors in the child welfare system, Landers, McGrath, Johnson, Armstrong, & Dollard (2017) found that almost half (47 percent) of the sample experienced substance use that interfered with life functioning, and 17 percent exhibited symptoms of addiction (p. 702).

There is a lack of research that speaks to substance use among adult and/or labor trafficking survivors. More research is needed to understand the full breadth of trafficking survivors' experiences, but available research on the experiences of survivors of trafficking has identified a link between substance use and trafficking (Cole et al., 2016; Cook et al., 2018; Franchino-Olsen, 2019; Hopper, 2017a; Hopper, 2017c; Reid et al., 2017; Sprang & Cole, 2018; Varma et al., 2015). Furthermore, substance use is frequently identified as a risk factor for trafficking (Hopper, 2017c; Hopper et al., 2018; Reid et al., 2017). Cole et al. (2016) examined the experiences of a sample of youth CSE survivors compared to a matched sample of youth who had experienced sexual use/assault but not CSE. The CSE group reported significantly higher rates of several at-risk behaviors, including substance use[3] and alcohol use and significantly higher rates of substance use (66 percent) as an issue after the exploitation (Cole et al., 2016). Overall, the authors found that the CSE group experienced higher rates of juvenile justice and child welfare system involvement, more risk behaviors and clinical problems, and greater levels of trauma symptoms. Varma et al. (2015) also examined the characteristics of CSE youth compared to a matched sample of youth who experienced child sexual abuse, but the goal of the study was to develop an effective screening tool to identify CSE youth when they are seeking medical care. Consistent with Cole et al.'s (2016) findings, the CSE sample experienced significantly higher rates of a history of substance use (i.e., drug or alcohol use) (70 percent), and 50 percent had a history of multiple drug use (Varma et al., 2015).

Looking at the interaction of substance use and mental health, Cook et al. (2018) examined the mental health and substance use needs of youth trafficking survivors participating in a specialty trafficking court program. The study aims to fill a gap by examining the unique experiences of CSE youth involved in the juvenile justice system, and its findings highlight high rates of mental health problems and substance use (i.e., use of any illegal substance) among the youth in their sample (76 percent and 88 percent, respectively). In addition, significantly higher rates of substance use were found in the group of youth who reported a mental health problem and a history of use (Cook et al., 2018). These findings illustrate the complex needs of trafficking survivors and highlight the importance of understanding the multifaceted needs of survivors, which can include trauma, mental health challenges, and substance use.

The overlaps in risk factors for trafficking and types of adverse childhood experiences (ACEs)—specifically substance use and familial substance use—offer a framework for understanding how substance use impacts the lives of trafficking survivors (Hopper, 2017c; Hopper et al., 2018; Sprang & Cole, 2018). Looking specifically at familial sex trafficking of minors, Sprang & Cole (2018) found that parents were using illicit drugs to profit from the exploitation of their children. Nearly 82 percent of the youth sex trafficking cases involved parents using illicit drugs to profit from the trafficking of their children, and 29 percent of cases involved a youth's drug addiction as a means of control (Sprang & Cole, 2018). Although the sample was small (31 child welfare-involved youth), the study examines the characteristics of familial sex trafficking, and their sample, which included nearly 42 percent males, was notable. The findings highlight the role of parental substance use as a driving factor and sustaining force for sex trafficking by family members.

[3] The specific types of substances included in "substance use" were not defined.

Looking more broadly, Hopper (2017c) explores poly-victimization experienced by youth survivors of sex trafficking to examine the impact of trauma before, during, and after their exploitation. The study is situated in the understanding that many trafficking survivors have a prior history of risk factors associated with child maltreatment, childhood adversity, and early trauma exposure. The study analyzed the charts of 32 participants of a program that provides direct services to trafficking survivors. The findings related to risk factors prior to trafficking indicated that a vast majority of the sample experienced a history of victimization or emotional neglect and attachment disturbance. The youth in the sample reported substance use or dependence by their caregivers and the use of drugs or alcohol during the initiation process (39 percent and 47 percent, respectively) (Hopper, 2017c). In addition, one-third of the sample experienced substance use issues. These findings highlight how substance use can influence a trafficking situation in many ways: as a risk factor, coercion or control technique during the exploitation, and a coping mechanism after exploitation, and all three reasons require attention when seeking services. As outlined in Figure 1, Hopper (2017c) offers recommendations to inform the practices of agencies and organization working with trafficking survivors. These recommendations note the importance of addressing trauma and substance use concurrently and providing opportunities for connection and empowerment, which offers a framework for exploring if a peer support group model may align with the broader trafficking movement that emphasizes the role of shared experiences.

Figure 1: Service Provision Recommendations for Trafficking Survivors

- Trauma-informed systems for trafficking youth
- Safety planning
- Structured, consistent comprehensive services for trafficked children
- Continuity of care for young adult sex trafficking survivors
- Additional support for victim witnesses
- Culturally and linguistically appropriate services
- Pacing and regulation in trauma-focused treatment
- Trauma and substance use addressed concurrently
- Parenting support
- Opportunities for connection, empowerment, and leadership
- Identification of strengths and assistance with future planning

(Hopper, 2017c, pp. 170–171)

PEER SUPPORT GROUPS

One potential avenue for addressing the concurrent needs of trafficking survivors is through group therapy or peer support group modalities. Hopper et al. (2018) note that group modalities have been highlighted as a promising approach for trafficking survivors, but more research is needed to develop therapeutic options specifically for trafficking survivors. To further understand the group therapy framework and its potential application for trafficking survivors, a broad overview of group therapy with an emphasis on peer support models and their effectiveness is provided. Next, we examine the characteristics of AA—one of the most widely used forms of peer support groups for substance use—and provide a brief overview of the state of the literature on its effectiveness. AA's program model has been replicated to meet the needs of individuals seeking help for a variety of addictions (e.g., narcotics, gambling, overeating) and adapted to meet the needs of family and friends who are affected by substance use (i.e., Al-Anon). Due to the relationship between familial substance use and trafficking, the Al-Anon program and its effectiveness are examined.

Peer support is a type of group therapy that includes a variety of programmatic aspects, leadership types, and guidelines. There is not one set program model for peer support; instead, it is an overarching framework that is adaptable to a variety of settings, including substance use recovery and mental health. The core components of peer support include (1) participants who are peers with similar lived experience, (2) a trainer or volunteer facilitator who may or may not have lived experience, and (3)

voluntary participation (Community Tool Box, 2019). Peer support is widely used in recovery programs and accepted as part of a continuum of recovery services (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Blanch, Filson, Penney, & Cave, 2012; Reif et al., 2014; Substance Abuse and Mental Health Services Administration, 2017). In a nationally representative sample of the U.S. population, Kelly, Bergman, Hoeppner, Vilsaint, & White (2017) found that the most commonly used recovery support service was mutual help groups at 45 percent (e.g., AA, Narcotics Anonymous, SMART Recovery), followed by professional treatment support services at 28 percent. Within the context of recovery programs, researchers have explored various definitions and frameworks for peer support groups. Using the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of peer recovery support as a guide, Reif et al. (2014) state that some of the key components of peer recovery support programs include putting recovery first, focusing on strengths and resiliencies, and being inclusive of peers in all aspects of the program. These characteristics are expanded in Tracy & Wallace's (2016) literature review on peer support groups. The characteristics of peer support included giving and receiving, nonprofessional and nonclinical individuals with similar experiences, and the goal of achieving long-term recovery from psychiatric and substance use issues (Tracy & Wallace, 2016).

There are many different types of peer support activities, including peer mentoring or coaching, formal support groups, one-on-one peer support, and peer-led support in twelve-step groups (Bassuk et al., 2016; Blanch et al., 2012; Center for Substance Abuse Treatment, 2009; Reif et al., 2014). Bassuk et al. (2016) explain that the most well-known type of peer support programs are mutual aid modalities and are distinct from other forms of peer support in that they are informal, facilitation does not require training, and they are rooted in bidirectional mutual support. AA is one example of this type of peer support group. Furthermore, mutual aid modalities are distinct from other peer-based recovery programs that include more formal structures, peer recovery coaches, and multiple forms of service delivery (e.g., one-on-one services, recovery housing, program in academic setting).

Figure 2: Principles of Peer Support

- Voluntary
- Nonjudgmental
- Empathetic
- Respectful
- Honest and direct communication
- Mutual responsibility
- Sharing power
- Reciprocal

(Blanch et al., 2012, p. 14–15.)

Regardless of the specific type or location of a peer support, there are overarching themes that are foundational to peer support models. Blanch et al.'s (2012) guidebook for engaging women in trauma-informed peer support services explains that the foundational aspects of peer support include shared experiences, the diverse background of participants, focusing on strength, and supporting one another to grow and heal. The principles outlined in Figure 2 provide a comprehensive overview of the foundational components of peer support and what makes it unique from other forms of group therapy and recovery services.

Peer support recovery programs are rooted in the theoretical framework of social support (Reif et al., 2014); more specifically, peer-led support groups are formed through a shared identity or experience and provide emotional support through an empathetic, caring relationship (Center for Substance Abuse Treatment, 2009). Peer-led support groups are unique in their understanding and position of peers in their programs. The term for peers has a more nuanced definition for peer support groups than in traditional social support literature because peers are equal and have their own lived experience with substance use and recovery (Blanch et al., 2012; Reif et al., 2014). This relationship is the foundation for the asymmetrical relationship in peer support groups, and the shared experience makes peer-led support groups distinct.

Effectiveness of Peer Recovery Support Programs

The broad framework for peer support, variability in the program terminology and implementation, and differences in methodological rigor have hampered the ability for the field to determine effectiveness (Tracy & Wallace, 2016). However, the empirical research suggests peer recovery support programs are correlated with positive outcomes, including abstinence from substance use (Bassuk et al., 2016; Reif et al., 2014; Tracy & Wallace, 2016). In a literature review of 10 studies on peer support services for the treatment of addiction, Tracy & Wallace (2016) noted promising positive effects of the peer support model for addiction recovery.[4] In addition to benefits associated with substance use, the studies included in their review highlighted benefits related to treatment engagement, HIV/HCV risk behaviors, and secondary substance-related behaviors. Through a literature search, Reif et al. (2014) examined the effectiveness of 10 peer recovery support studies by examining their methodological quality and effectiveness of the service in each study,[5] and the authors concluded that that there is some empirical support for peer recovery support services. Three studies demonstrated positive outcomes, including improved relationships with providers, reduced relapse rates, increased satisfaction with treatment, and increased treatment retention.

Bassuk et al. (2016) also found beneficial effects of peer-delivered recovery support services in their review of nine empirical studies examining the effectiveness of peer support interventions for addiction.[6] A majority of the studies included a measure of abstinence as the substance use outcome and a variety of other recovery-related outcomes (e.g., housing stability, medical care, and criminal justice charges). The systematic review indicated that most of the studies reported statistically significant findings related to the peer-delivered program and improvements to substance use. Even with promising findings on the effectiveness of peer support groups, research has identified the need for more rigorous research because the variations in service models, populations, and reported outcomes are limitations of a holistic understanding of the impact of peer support groups (Bassuk et al., 2016; Reif et al., 2014; Tracy & Wallace, 2016).

Researchers have measured success for peer recovery support groups, using a range of measures or indicators to align with the complex experiences of various populations. For example, Marlow et al. (2015) evaluated the effectiveness of a peer-based intervention program for 20 formerly incarcerated adults. They measured the effectiveness of the program by examining self-esteem, abstinence self-efficacy (i.e., a 20-item questionnaire that assesses a person's confidence with abstaining in a variety of situations), social support, effective coping, and participation in twelve-step meetings. The quantitative findings demonstrated that participants felt more confident about their ability to abstain from substance use based on the significant difference for two of the self-efficacy subscales (i.e., negative affect and habitual craving).The qualitative findings highlighted the positive impact of role modeling on reinforcing the belief that change is possible. Although the small sample size is a limitation of the study, the findings illustrate the benefits of a peer-based intervention model.

Although the peer support group program framework is widely utilized within the realm of substance use recovery, the framework is adaptable, and it has been successfully applied to address the needs of individuals seeking services for a variety of concerns (i.e., homelessness, depression, and childhood trauma). Bean, Shafer, & Glennon (2013) evaluated the effectiveness of a peer support model that provides housing for medically vulnerable individuals, which includes mental health, physical health, and substance use problems. The program includes peer support specialists who have shared

[4] Literature search included articles published between 1999 and 2015.
[5] Literature search included articles published between 1995 and 2012.
[6] Literature search included articles published between 1998 and 2014.

experiences with those seeking services. Using interview and arrest data, the authors found significant increases in participants' quality of life (as measured by the World Health Organization's Quality of Life Scale) and reductions in substance use when comparing the participants' experiences at the beginning of the program and after 6 months. The Quality of Life scale examines a variety of aspects of a person's life, including physical and psychological well-being, environment, and medical care. Although it is an exploratory study with a small sample size, Bean et al. (2013) highlight the potential benefits of a peer support program. Pfeiffer, Heisler, Piette, Rogers, & Valenstein (2011) assessed the effectiveness of peer support for people with depression. The meta-analysis reviewed studies that compared the effects of peer support interventions to usual care or psychotherapy and peer support to group cognitive behavioral therapy.[7] The findings indicated an improvement of depression symptoms for peer support interventions when compared to usual care and comparable effects to cognitive behavioral therapy.

McCormack & Katalinic (2016) examined the dynamics of a residential peer support program for survivors of childhood trauma through interviews with the facilitators who were also previous residents of the program. Through interpretative phenomenological analysis, one overarching theme, *altruistic growth*, summarized the participants' reflections on the program. Altruistic growth was defined by the participants with two subordinate themes. The first subordinate theme, *modeling through respect*, emphasized how the program offered a safe, nonjudgmental healing space where hope, empowerment, and respect for self and others were central to the program's success. The second subordinate theme, *reciprocal model of care*, highlighted that participation as a facilitator in this program promotes healing opportunities and ongoing professional and personal growth through practiced reflection. For example, the facilitators reflected on the challenge of facing the mirror, which included their own past trauma as they led participants through the healing process, and how learning and facilitating resulted in an interdependency between promoting growth and triggering their own prior experiences with trauma (McCormack & Katalinic, 2016). In their unique position as survivors and facilitators, they needed to manage their own reactions as they guided others through the recovery process. The study offers insight into the importance of a nonjudgmental, empowering, and survivor-led program for individuals seeking recovery related to trauma. The findings on altruistic growth illustrate how the peer facilitators' personal healing, in turn, can support participants' recovery. These preliminary findings have contributed to a growing acceptance for integrating peer support models into the mental health context; however, additional research is needed to explore long-term outcomes of this peer support program, particularly delineating if the *reciprocal model of care* is experienced across other facilitators and, if so, how it might enhance or impede program outcomes.

[7] Literature search included articles published between 1993 and 2010.

Cultural differences are an important factor for peer support groups, and the adaptability of peer support groups allows for modifications to address the needs of varying cultural and ethnic groups. For example, Kelley, Snell, & Bingham (2015) utilized a case study approach to examine a community-based peer recovery support (PRS) program in a Native community and gathered information from a variety of sources (e.g., program staff, tribal leaders, individuals in recovery). PRS services involve peer-based mentoring and education to help individuals in recovery from substance use and mental health disorders, and some of the distinct elements of applying the approach to Native communities include the importance of cultural practices, elders and family, and history. Overall, the study emphasized the importance of (1) recognizing cultural traditions and community context, (2) gaining buy-in from community members and tribal leaders, (3) maintaining program flexibility to meet diverse needs, and (4) focusing on building capacity and strengthening the communities. Kelley and colleagues (2015) highlight the adaptability of PRS and provide a foundation for understanding the role of culture when implementing peer recovery support services in Native communities.

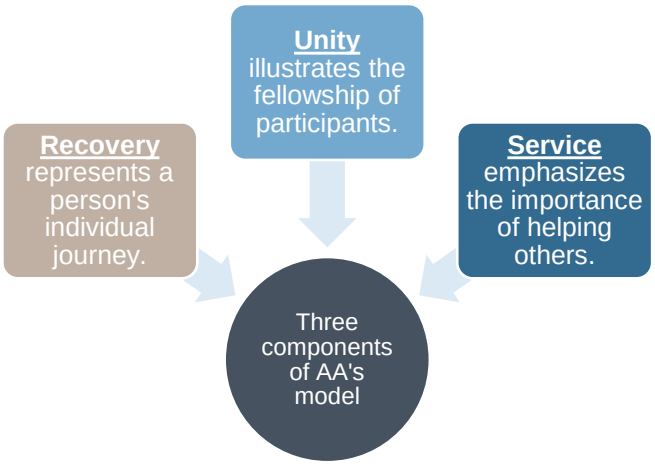
Challenges With Cultural Competency in Peer Support Groups

Jonikas et. al (2010) highlight the importance of developing cultural competency in behavioral health care systems, which involves promoting a foundation of knowledge, attitudes, and skills to assist individuals from diverse backgrounds achieve recovery. The study identified barriers and challenges with meeting the multicultural needs of participants in mental health peer-run support groups. Compared to white respondents, multicultural respondents were more likely to note the following challenges:

- Peer staff not recognizing the need for cultural competency training
- Program lacking information on members' cultures
- Peer staff not willing to learn about different cultures

ALCOHOLICS ANONYMOUS AND THE TWELVE-STEP PROGRAM

Alcoholics Anonymous Recovery Model[8]



One of the most well-known peer support programs for substance use recovery is Alcoholics Anonymous (AA), which uses a peer-led support framework with its Twelve-Step program as the guide for participants. AA is a community-based approach to peer support rooted in a mutual-help framework, which is also referred to as a mutual-aid modality because it includes bidirectional support, does not require training for facilitators, and is in an informal setting. It is a fellowship open to anyone seeking help with an addiction to alcohol, and it is a voluntary, nonprofessional program known for the anonymity of its members and sponsorship by peers with shared experiences with alcohol addiction. Participants follow the Twelve Steps, a program that

[8] Summarized from Borkman (2008).

encompasses a set of principles that are spiritual[9] in nature to guide them on their journey through recovery. Kelly, Stout, Magill, Tonigan, & Pagano (2011) explain how AA (and related Twelve Step programs) are spiritual in that they encourage the participant to rely on a personally defined God or "Higher Power." The program encourages the use of prayer and meditation, and recovery is labeled as a spiritual awakening or spiritual experience. Greenfield & Tonigan (2013) explain that step-work, the process of systematically working each of the Twelve Steps, is a cornerstone of AA and encouraged during participation (AA's Twelve Steps are outlined in Table 1). In sum, the foundational aspects of AA are peer-led support, the Twelve-Step program, and opportunities for sponsorship. According to 2017 estimates, there are nearly 1.3 million active members and nearly 62,000 groups across the United States (Alcoholics Anonymous, 2018). A 2014 study of membership characteristics conducted by Alcoholics Anonymous found that nearly one-third of members are men, a majority of members are white (89 percent), members attend an average of two-and-a-half meetings per week, and the top four ways they were introduced to AA were through an AA member, treatment facility, self-motivated, and family (Alcoholics Anonymous, 2014a). In a discussion of the popularity and effectiveness of AA for special populations (e.g., women, older people, racial and ethnic groups), Timko (2008) noted that there is a dearth of research on outcomes of AA for many racial and ethnic minority groups, and available research highlights that AA may be less attractive to people of color because AA is rooted in Euro-American and Western cultural values. More research is needed to understand the popularity and effectiveness of AA for people of color and individuals from various ethnic and cultural backgrounds.

Table 1: Alcoholics Anonymous Twelve Steps
1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.
(Source: Alcoholics Anonymous, 2016)

Prior research discussing AA's effectiveness notes mixed findings on various measures of effectiveness and highlights challenges with methodological quality such as self-selection bias and other biases, lack of a representative sample, variability in how success is measured, and lack of rigorous experimental studies, including controlled studies (Gossop, Stewart, & Marsden, 2008; Humphreys, Blodgett, & Wagner, 2014; Kaskutas, 2009; Kelly, 2017; Magura, McKean, Kosten, & Tonigan, 2013; Ye & Kaskutas, 2009). Research using a wide range of data collection and analysis techniques (e.g., interviews, surveys, propensity scores) has examined AA's effect on abstinence. Overall, findings indicate support for AA's effectiveness; however, it is important to note that a variety of factors may

[9] In *Many Paths to Spirituality,* Alcoholics Anonymous (2014b) explains that the AA program does not conform to specific religious or spiritual concepts. The terminology they use (i.e., "a Power greater than themselves" and "God, *as we understood Him*") leaves the interpretation open to each participant and is their way of promoting inclusivity (p. 6).

influence how and to what degree AA participation results in abstinence, and more rigorous research is needed to fully understand the effectiveness on abstinence.

Examining the role of spirituality within AA's program from the viewpoint of AA participants, Sifers & Peltz (2013) conducted a survey of 187 AA members to gather their beliefs and attitudes about AA principles, the organization, and the Twelve Steps. Some key takeaways from the findings include the following:

- Although a majority of members identify as Christian, the religious and spiritual beliefs of members are diverse and align with AA's tenet of inclusivity. Some AA members considered the program spiritual rather than religious.
- Respondents highlighted the importance of working the steps, spirituality, developing coping strategies, and using the available tools (such as a sponsor or AA literature) to stay sober.
- As a result of criticisms of some phrases used in AA, some respondents noted incorporating personal interpretations of the steps to meet their needs. For example, Step Three involves creating a trusting relationship with a Higher Power, and many respondents interpreted this step as taking spiritual actions and coming to terms with the things in their life they cannot change.

Although the implications for the study are meant to inform practitioners' knowledge of AA, the study provides insights into the impact of AA from the experiences of AA members. Another core component of AA's peer support group model is sponsorship. Tonigan & Rice (2010) describe AA sponsorship at the intersection of a supportive social network and working the Twelve Steps, both with the goal of achieving abstinence. With the goal of understanding the effects of having an AA sponsor on substance use, the authors analyzed data from questionnaires, interviews, and toxicology screens over the course of a year with a sample 182 individuals who participated in a community-based AA program. Examining the effect of sponsorship, the results indicated that having a sponsor early in a person's tenure with AA (i.e., within the first 3 months of participation) had a significant effect on abstinence from alcohol. Although more research is needed to understand the impact of AA sponsorship, an AA sponsor plays an important role in the underpinnings of AA's peer support model and potential success with recovery.

To address concerns with the quality of evidence related to the effectiveness of AA, Kaskutas (2009) conducted a literature review on AA effectiveness and organized the review using six criteria related to causation: magnitude of effect, dose response effect, consistent effect, temporally accurate effects, specific effects, and plausibility. The review takes a critical look at the strength of the relationship between exposure to AA and abstinence, levels of involvement in AA, consistency in findings related to meeting attendance, timing of baseline AA exposure and abstinence, influence of confounding variables, and consistency with theoretical perspectives on behavioral change (Kaskutas, 2009). Looking at higher rates of abstinence as the outcome variable, the study concluded that there was strong support for all the criteria except the criterion related to the experimental evidence establishing the specificity of the effect (i.e., experimental evidence), which has mixed findings in the studies. Kelly's (2017) literature review examines the effectiveness of AA through an analysis of its mechanisms of behavior change.[10] In sum, the body of literature highlights that AA is an effective intervention model as measured by sustained abstinence and remission. Kelly (2017) explains that social, cognitive, and affective mechanisms affect the benefits that AA members gain from participation, and only a small portion of AA participants are influenced by spirituality as a mechanism of change. The findings highlight that the impact of peer relationships on recovery support are important when looking to adapt the peer recovery support group framework to different settings or to assist individuals with shared, unique experiences.

[10] Literature included articles published between 1990 and 2015.

Due to the voluntary nature of AA, self-selection bias is a notable concern in observational studies of AA effectiveness, and researchers are using innovative statistical techniques to address this concern. Ye & Kaskutas (2009) aim to overcome methodological challenges related to selection bias in studies examining the effectiveness of AA by using the propensity score method. Looking at AA attendance over a 12-month period and using abstinence during the final 30 days of the followup period as the outcome variable for effectiveness, the study included a cohort of more than 500 individuals who participated in substance use treatment. The propensity scores—the predicted probabilities of attending AA—were calculated using potential confounding variables separated into six categories (i.e., self-motivation, external coercion, alcohol problem severity, help-seeking, social influence, and demographics) (Ye & Kaskutas, 2009). The most pertinent finding indicated that AA was most helpful for individuals who had a lower propensity to attend AA compared to individuals with a high propensity. This suggests that AA might be most effective for those individuals whose substance use was less serious, had less exposure to AA and other treatments in their past history, and had less motivation to change. While these finding seems counterintuitive, it suggests that AA is most helpful for those that, without AA, would not have any treatment (Ye & Kaskutas, 2009). More research is needed to confirm these findings. Using secondary data analysis of six datasets from randomized trials of AA-facilitated interventions, Humphreys et al. (2014) used instrumental variable models to examine the relationship between AA attendance and abstinence from alcohol. In all except one dataset, an increase in AA attendance resulted in an increase in days of abstinence at two time points (i.e., 3-month followup and 15-month followup). Humphreys et al. (2014) suspect that high rates of preexisting AA attendance in the remaining dataset may explain why there was no significant increase in abstinence. Even though researchers have continued to apply propensity score techniques to test the effectiveness of AA (see Magura et al. 2013), more research is needed to understand the effectiveness of AA using statistical methods that address selection biases in observational studies.

Adaptations of Peer Support and Twelve-Step Programs

Example Peer Support Groups

- Narcotics Anonymous
- Gamblers Anonymous
- Overeaters Anonymous
- Food Addicts Anonymous
- Codependents Anonymous
- Sex and Love Addicts Anonymous

Outside the realm of recovery from alcohol addiction, peer support programs have adopted the same framework as AA (e.g., peer support, Twelve-Step program) and aim to help with recovery for various other addictions, compulsions, and issues. As AA grew in popularity, other peer support groups were created using the AA framework and Twelve-Step program to help individuals struggling with a variety of recovery needs, including narcotics, gambling, overeating or food addiction, codependency, and sex or love addiction. These programs adapted AA's Twelve-Step Program to address specific needs of the group and adopted the overall guidelines and tenets of AA. For example, Narcotics Anonymous provides a peer support network and recovery services for individuals seeking help with a drug addiction.

SEX WORKERS ANONYMOUS

Founded in the late 1980s, Sex Workers Anonymous is a Twelve-Step program for anyone who is seeking support to leave the commercial sex industry, including trafficking survivors. It is a support group and offers a 24/7 hotline, which is answered by someone who has shared experience with recovery from the sex industry, and the program is outlined in its Recovery Guide. Due to a shortage of program reviews and access to program materials, not much is known about the program, its approach, or its effectiveness for participants.

Peer support expanded its framework to include support for friends and family members of individuals with substance use. The impact of substance use on friends and family members is well documented (e.g., Lander, Howsare, & Byrne, 2013; Timko et al., 2013) and led to the creation of support groups for friends and family members of individuals with substance use issues. These support groups utilize a similar peer-led, shared experience model with the integration of a Twelve-Step program to help individuals deal with the impact of someone else's substance use problem on them. Al-Anon Family Groups is a peer support program for individuals seeking help to manage the negative impacts of someone's drinking problem. The participants all share a common experience of being impacted by someone's drinking problem, whether they are in recovery or not. The mutual support program offers a space for people with common experiences to share stories, support one another, and identify mechanisms for dealing with someone else's drinking problem. The program emphasizes anonymity and uses a Twelve-Step program to help participants. Al-Anon also offers a specific fellowship for teenagers called Alateen, which provides a supportive environment for young people between the ages of 13 and 18 who are impacted by someone's drinking problem. This unique fellowship for teenagers was created because teenagers have different emotional and spiritual needs compared to adults (Orchid Recovery Center, 2019).

Studies examining the aspects and outcomes related to support groups for concerned others such as Al-Anon and Alateen are lacking, but a growing body of research is examining various aspects of Al-Anon to understand the program's benefits (Timko et al., 2013; Timko, Halvorson, Kong, & Moos, 2015; Timko, Laudet, & Moos, 2016). Timko et al. (2015) identified bonding, goal direction, and access to role models and rewarding activities as mechanisms that are beneficial to Al-Anon participants. In a study examining the influence of continued attendance at Al-Anon meetings, Timko et al. (2016) found that individuals with sustained attendance experienced many benefits, including learning how to handle problems due to the drinker, better quality of life, and having better relationships with family and friends. These findings provide a snapshot of how Al-Anon may positively impact the lives and well-being of participants.

Individuals with multifaceted needs that fall outside the realm of substance use have created and sought out alternative peer support groups for their unique needs. Using the twelve-step peer support group model, peer support models can be applied and modified as needed to address co-occurring mental and health conditions. Individuals with a dual diagnosis of substance use and mental illness may experience alienation at traditional twelve-step substance use programs due to their experience with mental illness, and Dual Diagnosis Anonymous[11] (DDA) was developed as a peer support program for this population. Monica, Nikkel, & Drake (2010) explain that DDA programs resemble traditional peer support/twelve-step programs like AA and NA but added five steps that include acknowledging both illnesses, accepting help for both conditions, understanding the importance of a variety of interventions, combining illness self-management with peer supports and spirituality, and working the program by helping others. A notable variation in DDA is that cross-talk is encouraged so that participants have an

Figure 3: Five Rules of Respect of DDA

1. First, and most importantly, who you see here and what is said here, let it stay here! (Here! Here!) Confidentiality and anonymity are the spiritual foundations that keep our recovery possible.
2. Questions and answers are welcome and positive feedback is given, when asked for.
3. Keep it real.
4. Try not to disrupt the group.
5. It is OK to pass, if you do not wish to share.

(Dual Diagnosis Anonymous of Oregon, 2019)

[11] Dual Diagnosis Anonymous (DDA), Dual Recovery Anonymous (DRA), and Double Trouble in Recovery (DTR) are three recovery programs for individuals with co-occurring mental health and substance use issues.

opportunity to provide feedback, ask questions, and respond as others are sharing. In DDA, the Five Rules of Respect (see Figure 3) provides a framework for mutual respect and acceptance and supports a safe, positive environment for participants. Similarly, Dual Recovery Anonymous programs acknowledge the variability in the experiences of their members and encourage participants to accept each other's differences and unique experiences with dual disorders as a way to bond instead of separating them (Dual Recovery Anonymous, 2019a).

Matusow et al. (2013) conducted focus groups with participants of a mutual help program called Double Trouble in Recovery for individuals dually diagnosed with substance use and a mental illness. The findings indicated that the participants benefited from a safe, supportive environment and the opportunity to share and gather knowledge about mental health, medications, and their relationship with substance use. These benefits are reinforced by Roush, Monica, Carpenter-Song, & Drake (2015) in a qualitative study of a DDA program. Roush et al. (2015) noted that four themes emerged that emphasized the usefulness of a twelve-step peer support program for individuals seeking support for co-occurring conditions. The four themes were the acceptance by others, mutual understanding of the interaction between substance use and mental illness, openness to give and receive feedback, and mutual support for hope and recovery. This study and DDA provide insight into how the twelve-step program has been adapted to address the needs of individuals with co-occurring needs and modifications such as integrating feedback are potentially useful if monitored and mutually accepted by all members. Overall, the successful application of peer recovery support programs to various settings and populations offers insight into how these programs' successes and lessons learned can be leveraged for trafficking survivors seeking help with substance use. In sum, the table below provides an overview of the Twelve-Step Programs discussed above, including three programs (DDA, DRA, and DTR) that offer recovery support for individuals with a dual diagnosis. Although these three programs primarily serve the same population, there are nuances to each program that illustrate how Twelve-Step Programs can be adapted to meet the recovery needs of individuals with multifaceted needs.

Overview of Select Twelve-Step Programs Previously Discussed
Alcoholics Anonymous: Developed in the 1930s, it was the **first peer-led support group** for individuals seeking help with an **addiction to alcohol.** The creators **developed the Twelve Step program** to help guide participants through the recovery process.
Al-Anon & Alateen: Peer support groups for individuals—such as friends, family members, and teenagers—seeking **help to manage the negative impacts of someone's drinking problem.** The groups use a modified Twelve-Step program.
Dual Diagnosis Anonymous: DDA is a peer-led support group for individuals with **co-occurring substance use and mental health issues.** In addition to the adapted Twelve Steps, DDA added **five steps** for participants. A notable modification is that **cross-talk** between participants is encouraged.
Dual Recovery Anonymous: DRA is a peer-led support group for **individuals with a dual disorder** (i.e., substance use and an emotional or psychiatric illness). The program encourages participants to work through the Twelve Steps, which were adapted from AA. A notable component of their program is an emphasis on **accepting participants' differences** in experiences with dual diagnosis.
Double Trouble in Recovery: DTR was **adapted from AA's Twelve-Step program** to address the needs of individuals who are **dually diagnosed** with substance use and a mental illness.

Applying the Peer Support Model to Prevent and Assist Trafficking Survivors With Substance Use Issues

Substance use and familial substance use are risk factors for trafficking victimization. Substance use is used as not only a coercion or control tactic during trafficking exploitation, but also as a coping

mechanism for survivors. Although more research is needed to understand the experiences of trafficking survivors with more diverse backgrounds and exploitation experiences, substance use is frequently noted as a concern of survivors and substance use recovery services are needed. AA, a peer-led support group, is one of the most widely used substance use recovery programs and, although mixed, empirical literature on the effectiveness of peer-led support groups illustrates promising aspects that result in abstinence. Peer support groups are adaptable, and programs have made notable modifications to the peer support group framework to address the needs of a variety of populations and concerns (e.g., dual diagnosis, Native communities, childhood trauma).

Guiding Principles for Creating a Survivor-Informed Organization

1. Empowerment-based engagement
2. Trauma-informed engagement
3. Culturally relevant, sensitive, and inclusive engagement
4. Ethical engagement

(National Human Trafficking Training and Technical Assistance Center, 2018)

Practitioners and survivors have emphasized the need for trauma-informed, survivor-informed substance use treatment options for survivors with co-occurring substance use issues (Vatne Bintliff et al., 2018; Human Trafficking Leadership Academy, 2018). For example, the Department of Health and Human Services Office on Trafficking in Persons (OTIP) brought together a diverse group of trafficking survivors and allied professionals to collaborate and develop leadership skills through the Human Trafficking Leadership Academy (HTLA) with the goal of making recommendations to enhance service provision for survivors. The group provided a potential model for supporting survivors struggling with co-occurring disorders through the implementation of a survivors peer support group. The survivors peer support group would provide not only a safe, nurturing environment to work through recovery, but also empowerment to survivors through leadership and shared learning. The recommended model adapts the twelve-step model from AA and applies the Guiding Principles for Human Trafficking Survivor[12]. Because survivors are diverse, the program could tailor group structure and positions to the needs of the community; and overall, the model would help connect members of the network of survivors across the country. The HTLA fellows recognized that some aspects of the structure of a traditional peer support group would need to be modified to account for the unique situations of survivors. The model outlines potential risks or liabilities that noted the importance of having clear rules and guidelines on confidentiality and referrals from service providers to aid in participant readiness and ongoing support. Also, it would be important to have a community referral hotline for members who could no longer participate and have an open door policy to support survivors at every stage of their recovery.

The HTLA fellows conducted a survey of 41 trafficking survivors to understand their needs after exiting trafficking. A vast majority (83 percent) responded that they used drugs or alcohol while involved in trafficking, but only about a third (32 percent) of survivors went through any type of rehabilitation. To gauge interest in the idea of a peer support group, the survey asked if a survivor-led, peer support group for survivors that addressed substance use issues and other issues that survivors may face would be more effective, and 83 percent agreed (Human Trafficking Leadership Academy, 2018). Although it was a small sample, the results reinforce prior research on the substance use recovery needs of trafficking survivors and highlight the need for a survivor-informed approach to meeting survivors' needs.

[12] The Guiding Principles for Human Trafficking Survivors is a resource developed by the Catholic Charities of Louisville's Bakhita Empowerment Initiative in conjunction with multiple state and local organizations as a part of the ACF Region 4 human trafficking task force. It provides a best practices framework for agencies providing services to victims of human trafficking. For more information, see https://cclou.org/wp-content/uploads/2018/11/Guiding-Principles-for-Agencies-16-FINAL.pdf

To gather the perspectives of survivors on the proposed peer support group model, one of the HTLA fellows met with a group of 10 trafficking survivors in the form of a "fireside chat" on three separate occasions in Cincinnati, OH. All of the adult survivors are currently community leaders, are out of their trafficking situation, and experienced 10–22 years in substance use recovery. The group mentioned many of the previous components of peer support such as feeling hopeful, being nonjudgmental, and feeling welcome as vital aspects of a program. Table 2 provides an overview of HTLA's recommendations for a survivors peer support group.

Table 2: Recommendations for Developing a Peer Support Group for Trafficking Survivors

1.	Pilot a peer support group for survivors through a federally funded grant.
2.	Research the benefits and drawbacks of a survivor-only peer recovery support group.
3.	Develop a toolkit and workbook in collaboration with survivor leaders.
4.	Based on lessons learned from the pilot program and review of literature, launch peer support groups for survivors in short- and long-term federally funded treatment facilities and explore feasibility for offering programs to survivors through community programs.
5.	Offer training to agency staff on trauma-informed practices.

(Source: Human Trafficking Leadership Academy, 2018)

More research is needed to explore the prevalence of substance use among trafficking survivors, reasons for reported underutilization of substance use recovery services, and best practices for addressing the substance use recovery needs of survivors, such as peer support models and trauma-informed programs (see Cook et al., 2018; Gerassi, 2018; Hopper, 2017a; Hopper, 2017c; Macy & Johns, 2011; Twigg, 2017). For example, Hopper (2017a) explains that human trafficking reports note that substance use issues are a concern for trafficking survivors but there is a lack of research on the prevalence of substance use. The available research underscores the importance of offering substance use recovery services for survivors who may need services throughout their recovery. Macy & Johns (2011) explored the needs of international survivors of sex trafficking and noted that substance use recovery services are an important step for survivors to establish stability in their lives. Twigg (2017) focused on the service needs for domestic minor of sex trafficking survivors and concluded that substance use services were an immediate need. Whether it is an immediate or long-term need of trafficking survivors, having the services available to survivors if needed is crucial (Twigg, 2017). Prior research emphasizes the need for substance use treatment for trafficking survivors that includes a trauma-informed framework because most substance use recovery services do not address trauma in their program (Hopper, 2017a; Macy & Johns, 2011).

Substance use recovery services may be underutilized by trafficking survivors for a variety of reasons, including reluctance due to fear of discrimination and feelings of shame, lack of trauma-informed programs, and barriers related to requirements of facilities (Clawson & Dutch, 2008; Gerassi, 2018; Hopper, 2017a; Macy & Johns, 2011). Looking specifically at barriers for accessing detox facilities, substance use treatment, and residential services among a sample of female survivors of CSE, Gerassi (2018) noted that strict sobriety requirements enforced by many residential facilities were a deterrent. More research is

Potential Barriers to Survivors Accessing Substance Use Recovery Services

According to Clawson & Dutch (2008), service providers reported that survivors may be reluctant to disclose their substance use issues due to the following reasons:

- Fear of stigma
- Feelings of shame about their trafficking experiences
- Feelings of shame about their substance use problems
- Denial that their substance use is an issue

needed to understand barriers to trafficking survivors accessing substance use recovery services such as access to care and cost of care.

One potential avenue for exploration is developing and testing a model for a peer recovery support program rooted in the best practices of peer support groups and infuses trauma-informed, survivor-informed principles. As previously discussed, many of the core components of the peer support group model (e.g., respectful, nonjudgmental, empathetic, honest, and direct communication) align with the recovery needs of survivors, but aspects of peer support models are problematic, including some of the steps in the Twelve-Step program. Prior research on the positive impacts of peer support groups for individuals with co-occurring substance use and mental health issues (e.g, Dual Diagnosis Anonymous, Double Trouble in Recovery) illustrates the adaptability of peer support groups that utilize a Twelve Step program (see Matusow et al., 2013; Monica et al., 2010; Roush et al., 2015). As summarized in Aase, Jason, & Robinson's (2008) literature review of Twelve Step programs for dually diagnosed individuals, specialized programs offer individuals support and mutual understanding in a more comprehensive way to address their co-occurring needs. Dual Diagnosis Anonymous modified the AA framework to meet the unique needs and varied experiences of individuals with co-occurring needs. This modification provides a foundation for potentially developing a peer support recovery group for trafficking survivors. Additional exploration is needed to understand how the peer support model can be customized to address the complex needs of trafficking survivors to integrate trauma-informed, survivor-informed, and culturally competent services.

SAMHSA's Six Key Principles of a Trauma-Informed Approach

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

(Substance Abuse and Mental Health Services Administration, 2014)

Based on the information gathered, our recommendation is to further explore the possibility of a peer recovery support model for trafficking survivors to address their co-occurring needs. The following questions will help guide the development of a program that will effectively meet the needs of survivors.

1. What guidelines or principles are needed in a peer-led support group for trafficking survivors?

Additional considerations for trafficking victims would need to be established in a peer support program. Although not an exhaustive list, some potential concerns that warrant additional attention related to establishing guidelines and principles include safety concerns, location of meetings (e.g., public spaces, online, precautions for security of participants), and inclusivity or exclusivity of meetings on the basis of gender, type of trafficking, or other factors. Domestic violence literature may be one avenue for understanding mechanisms that ensure a safe space for survivors, but overall, guidelines and principles for establishing and maintaining a peer support group for survivors involves thoughtful consideration of the special needs of trafficking survivors with diverse needs and experiences.

2. What components are important in residential versus community-based settings?

Survivors may need substance use recovery services throughout various times in their recovery process. Having a framework that can be applied to residential and community-based settings will increase accessibility for survivors, but some aspects are important when developing a model: safety, availability, and fidelity of implementation.

3. How can a trauma-informed focus enhance the supportive environment of peer support groups?

In peer support groups, a supportive environment is beneficial to participants. For trafficking survivors, a supportive environment needs to incorporate another layer of support by incorporating trauma-informed practices. For example, many aspects of AA's Twelve Steps are problematic for trafficking survivors, and some require modification or elimination. Some peer support groups have modified their Twelve Step program to encourage a supportive, respectful environment such as DDA's addition of Five Steps.

Dual Diagnosis Anonymous' Five Additional Steps

1. Acceptance is the beginning of the recovery journey
2. Willingness to accept help
3. Recognizes the importance of therapy, medications, and remaining clean and sober; members are encouraged to keep an open mind regarding treatments; each individual's right to choose is respected
4. Reminds members they are not alone
5. Emphasizes ongoing recovery and service to others

(Monica et al., 2010, p. 739)

These Five Steps focus on acceptance, meeting people where they are, accepting an individual's choice throughout recovery, and mutual support. Table 3 outlines some of AA's Twelve Steps, the corresponding adaptation of each step from Dual Recovery Anonymous, and brief descriptions of the steps that are not trauma-informed using SAMHSA's key principles for a trauma-informed approach as a guide.

Table 3: Alcoholics Anonymous Twelve Steps[13]	Dual Recovery Anonymous Twelve Steps[14]	Applying TIC Principles to Illustrate Potentially Problematic Aspects of the Twelve Steps
1. We admitted we were powerless over alcohol—that our lives had become unmanageable.	1. We admitted we were powerless over our dual illness of chemical dependency and emotional or psychiatric illness—that our lives had become unmanageable.	TIC principles: empowerment, voice and choice (lack of while in a trafficking situation and working to take that back) Recognize that traffickers take away a survivor's agency and ability to choose. It is important to empower survivors and allow them to have a voice and choice in their recovery journey.
2. Came to believe that a Power greater than ourselves could restore us to sanity.	2. Came to believe that a Higher Power of our understanding could restore us to sanity.	TIC principles: empowerment, voice and choice (lack of while in a trafficking situation and working to take that back) It is important to understand the inception of the substance use issue, which may be more complex for trafficking survivors, especially when it is compounded with the trauma associated with their exploitation.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.	3. Made a decision to turn our will and our lives over to the care of our Higher Power, *to help us to rebuild our lives in a positive and caring way.*	TIC principles: empowerment, voice and choice (lack of while in a trafficking situation and working to take that back) and collaboration and mutuality (which is the higher power) Traffickers take away a survivor's agency, which may lead to an individual having a difficult time regaining their own agency. It is important to empower survivors to help them regain those skills that were taken away and not turn over their agency/voice to another immediately.
4. Made a searching and fearless moral inventory of ourselves.	4. Made a searching and fearless personal inventory of ourselves.	
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.	5. Admitted to our Higher Power, to ourselves, and to another human being the exact nature of our *liabilities and our assets.*	TIC principles: empowerment, voice and choice (lack of while in a trafficking situation) and trustworthiness and transparency Recognize the fear and danger experienced while in trafficking situation, which may have led to wrongdoings as a result of surviving.
6. Were entirely ready to have God remove all these defects of character.	6. Were entirely ready to have our Higher Power *remove all our liabilities.*	TIC principles: trustworthiness and transparency What may be seen as "defects of character" are often trauma manifestations.
7. Humbly asked Him to remove our shortcomings.	7. Humbly asked our Higher Power to remove these liabilities and *to help us to strengthen our assets for recovery.*	
8. Made a list of all persons we had harmed and became willing to make amends to them all.	8. Made a list of all persons we had harmed and became willing to make amends to them all.	TIC principles: empowerment, voice and choice (lack of while in a trafficking situation) and safety Often, harm done to another had to do with survival and ensuring one's own safety. Survivor was forced, coerced, or defrauded into their situation. Therefore, it was the trafficker who harmed them.

[13] Alcoholics Anonymous (2016).

[14] Dual Recovery Anonymous (2019b) (emphasis added).

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.	9. Made direct amends to such people wherever possible, except when to do so would injure them or others.	TIC principles: empowerment, voice and choice (lack of while in a trafficking situation) and safety Often, harm done to another had to do with survival and ensuring one's own safety. Survivor was forced, coerced, or defrauded into their situation. Therefore, it was the trafficker who harmed them.
10. Continued to take personal inventory and when we were wrong promptly admitted it.	10. Continued to take personal inventory and when wrong promptly admitted it, *while continuing to recognize our progress in dual recovery.*	
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.	11. Sought through prayer and meditation to improve our conscious contact with our Higher Power, praying only for knowledge of our Higher Power's will for us and the power to carry that out.	
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.	12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to others who experience dual disorders and to practice these principles in all our affairs.	

4. **What aspects of sponsorship and peer faciliatators are most important to integrate into a program?**

Sponsorship is a core component of peer-led recovery programs like AA, and the benefits and challenges related to sponsorship and peer facilitators are important factors to peer-led programs, especially when trauma is a potential component of healing. Due to the influence of trauma in the lives of survivors, additional attention to preparation and implementation of sponsorship and peer facilitation program aspects are warranted (such as self-care plans and providing clinical support for sponsors as needed), and applying SAMHSA's key principles for a trauma-informed approach is a useful starting point.

5. **How will groups develop and implement strategies for infusing cultural compentency into programming?**

Survivors have diverse backgrounds and a multitude of different experiences related to their exploitation. Cultural competency plays a vital role in acknowledging the role of a person's ethnicity, culture, and beliefs and how this influences their healing process. The inclusion of cultural competency is important, but strategies for incorporating cultural competency may vary depending on several factors, including the type of peer support model, level of training of the facilitator including trauma training and integration of self-care techniques, identities of participants (e.g. ethnic, LGBTQI, gender, age, location) and experiences of the participants (e.g., labor versus sex trafficking, domestic versus international trafficking).

6. **What role could service providers play in the creation and overall success of a program?**

Survivors may need a wide range of services, and service providers are well positioned to assist survivors, including offering links to programs and ongoing support for participants. Service providers could provide assistance with trauma-informed care, safety concerns, and culturally competent programming due to their experience and training. Through collaboration with potential peer support groups, service providers could address concerns about safety and readiness among potential participants and develop connections to have services available if a participant is triggered and needs additional support. In a similar way that substance use treatment providers are knowledgeable of and recommend AA programs, service providers could play a critical role in successful program implementation.

7. **What services are programs providing to trafficking survivors with concurrent substance use recovery needs?**

Many programs that offer services to trafficking survivors integrate various aspects of the peer support model and/or substance use treatment into their service provision. To understand the most effective ways to meet the needs of survivors, additional research is needed to better understand programs that offer substance use and peer support services to trafficking survivors to explore effectiveness in meeting the program's goals and positive outcomes for participants. The programs listed below are human trafficking programs in the United States that offer substance use recovery services and/or nationally based trafficking peer support services for trafficking survivors. The list is not exhaustive, but it provides examples of services.

Programs		
Name	**Location**	**Description**
Off the Streets program at Cincinnati	Cincinnati, OH	The program provides a **nonjudgmental environment that focuses on empowerment** and offers housing, referrals to community services, and comprehensive case management

Union Bethel (CUB)		services to survivors of trafficking and exploitation. The staff have had **lived experiences,** and Off the Streets offers **evidence-based programs** to **address co-occurring needs with substance use and mental illness.** After a review of its program data, CUB identified a large number of clients who experienced substance use throughout their exploitation and noted a gap in their programming to assist in recovery. CUB then became **certified substance use and mental health counselors.**[15]
Girls Educational & Mentoring Services (GEMS)	New York, NY	The program offers **survivor-led and survivor-engaged** programming for girls and young women who have experienced CSE and domestic trafficking. GEMS includes a wide range of services including educational and youth development, housing, a Survivor Leadership Program, and court advocacy. Their "Victim, Survivor, Leader" program is a best practice that emphasizes increasing **social support,** becoming self-sufficient, and **empowerment through promoting advocacy for themselves and their peers.**[16]
Community Against Sexual Harm	Sacramento, CA	The program was formed through a collaborative approach to assist survivors of trafficking or commercial sexual exploitation. The foundation of the program is **peer-based, harm reduction mentoring,** and the peer mentors have similar lived experiences and provide **outreach** and **nonjudgmental support services.** They provide a variety of services, including education, access to medical care, access to necessities, and mental health services.[17]
Refuge for Women	Lexington, KY	The program offers **evidence-based, trauma-informed programming** for survivors of trafficking or sexual exploitation. Refuge for Women is a faith-based organization that provides long-term care, including safe housing and **services to overcome addiction,** heal from trauma, and building life skills. Trained staff provide **individual and group counseling therapy** and use a phased approach to help survivors reach their goals.[18]
My Life My Choice	Boston, MA	The program offers **survivor empowerment,** prevention and education opportunities, and professional training and advocacy to work to end CSE of youth. Core aspects of survivor empowerment include **one-on-one mentoring,** leadership initiatives, case management, and community building.[19]
Thistle Farms	Nashville, TN	The Magdalene program offers a **2-year residential community** for female survivors of trafficking, prostitution, and addiction. Thistle Farms is a therapeutic community that provides **housing, health care, counseling,** and **employment** through social

[15] https://www.cubcincy.org/how-we-help/off-the-streets/
[16] https://www.gems-girls.org/
[17] https://www.cashsac.org/
[18] http://www.refugeforwomen.org/
[19] http://www.fightingexploitation.org/

		enterprises. Residents focus on **recovery** in the first part of the program and individual and **group therapy** are also offered.[20]
Rebecca Bender Initiative[21]	National	The program includes two components: Elevate and Equip. Equip involves **training** to first responders to **identify and respond to trafficking** victims. Elevate emphasizes **survivor empowerment** and offers **online courses**, video lessons, and workbook activities for survivors to help them heal and reach their goals.
National Survivor Network[22]	National	The program is a **survivor-led program** whose goal is to foster connections among trafficking survivors. The National Survivor Network supports survivors through survivor-led advocacy, **peer-to-peer mentorship,** and empowerment.

CONCLUSION

Substance use is a prevalent issue for trafficking survivors, and services that concurrently address survivors' needs with substance use and healing from exploitation are needed. Understanding the role of substance use in the lives of survivors offers opportunities for prevention, intervention, and service provision for survivors. Practitioners, survivors, and researchers have identified the need for more comprehensive support services for trafficking survivors, including the potential for developing peer-led recovery support programs for survivors. Trauma-informed care is an important component of providing services for survivors, and additional research on how to infuse trauma-informed, survivor-informed practices into peer-led support programs is needed to ensure that the program adequately meets the needs of survivors with diverse backgrounds and experiences. Recommendations on possible avenues of exploration are provided.

[20] https://thistlefarms.org/
[21] https://rebeccabender.org/
[22] https://nationalsurvivornetwork.org/

REFERENCES

Aase, D.M., Jason, L.A., & Robinson, W.L. (2008). 12-step participation among dually-diagnosed individuals: A review of individual and contextual factors. *Clinical Psychology Review*, *28*(7), 1235–1248.

Alcoholics Anonymous. (2014a). *2014 membership survey*. [Pamphlet]. Alcoholics Anonymous World Services, Inc. https://www.aa.org/assets/en_US/p-48_membershipsurvey.pdf

Alcoholics Anonymous. (2014b). *Many paths to spirituality.* [Pamphlet]. Alcoholics Anonymous World Services, Inc. https://www.aa.org/assets/en_US/p-84_manypathstospirituality.pdf

Alcoholics Anonymous. (2016). *The twelve steps of Alcoholics Anonymous*. [Service material]. Alcoholics Anonymous World Services, Inc. https://www.aa.org/assets/en_US/smf-121_en.pdf

Alcoholics Anonymous. (2018). *Estimates of A.A. groups and members as of January 1, 2018*. [Service material]. https://www.aa.org/assets/en_US/smf-53_en.pdf

Bassuk, E.L., Hanson, J., Greene, R.N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, *63*, 1–9.

Bean, K.F., Shafer, M.S., & Glennon, M. (2013). The impact of housing first and peer support on people who are medically vulnerable and homeless. *Psychiatric Rehabilitation Journal*, *36*(1), 48.

Blanch, A., Filson, B., Penney, D., & Cave, C. (2012). *Engaging women in trauma-informed peer support: A guidebook*. Alexandria, VA: National Center for Trauma-Informed Care.

Borkman, T. (2008). The twelve-step recovery model of AA: A voluntary mutual help association. In *Recent developments in alcoholism* (pp. 9–35). New York, NY: Springer

Center for Substance Abuse Treatment. (2009). *What are peer recovery support services?* [HHS Publication No. (SMA) 09-4454]. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Clawson, H.J., & Dutch, N. (2008). *Addressing the needs of victims of human trafficking: Challenges, barriers, and promising practices*. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/system/files/pdf/75471/ib.pdf

Cole, J., Sprang, G., Lee, R., & Cohen, J. (2016). The trauma of commercial sexual exploitation of youth: A comparison of CSE victims to sexual abuse victims in a clinical sample. *Journal of Interpersonal Violence*, *31*(1), 122–146.

Cole, J., & Sprang, G. (2014). Sex trafficking of minors in metropolitan, micropolitan, and rural communities. *Child Abuse & Neglect*, *40*, 113–123.

Community Tool Box. (2019). *Section 2. Creating and facilitating peer support groups*. https://ctb.ku.edu/en/table-of-contents/implement/enhancing-support/peer-support-groups/main

Cook, M.C., Barnert, E., Ijadi-Maghsoodi, R., Ports, K., & Bath, E. (2018). Exploring mental health and substance use treatment needs of commercially sexually exploited youth participating in a specialty juvenile court. *Behavioral Medicine*, *44*(3), 242–249.

Dual Diagnosis Anonymous of Oregon. (2019). *The five rules of respect of dual diagnosis anonymous.* http://ddaoforegon.com/readings.htm#5%20steps

Dual Recovery Anonymous. (2019a). *Accepting differences*. http://www.draonline.org/accept_diffs.html

Dual Recovery Anonymous. (2019b). *The twelve steps of dual recovery anonymous*. http://www.draonline.org/dra_steps.html

Franchino-Olsen, H. (2019). Vulnerabilities relevant for commercial sexual exploitation of children/domestic minor sex trafficking: A systematic review of risk factors. *Trauma, Violence, & Abuse*. https://doi.org/10.1177/1524838018821956

Gerassi, L. (2015). From exploitation to industry: Definitions, risks, and consequences of domestic sexual exploitation and sex work among women and girls. *Journal of Human Behavior in the Social Environment*, *25*(6), 591–605.

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

Gossop, M., Stewart, D., & Marsden, J. (2008). Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: A 5-year follow-up study. *Addiction*, *103*(1), 119–125.

Greenfield, B.L., & Tonigan, J.S. (2013). The general Alcoholics Anonymous tools of recovery: The adoption of 12-step practices and beliefs. *Psychology of Addictive Behaviors*, *27*(3), 553.

Hopper, E.K. (2017a). Trauma-informed treatment of substance use disorders in trafficking survivors. In M. Chisolm-Straker & H. Stoklosa (authors), *Human trafficking is a public health issue: A paradigm expansion in the United States*. Cham, Switzerland: Springer.

Hopper, E.K. (2017b). The multimodal social ecological (MSE) approach: A trauma-informed framework for supporting trafficking survivors' psychosocial health. In M. Chisolm-Straker & H. Stoklosa (authors), *Human trafficking is a public health issue: A paradigm expansion in the United States*. Cham, Switzerland: Springer.

Hopper, E.K. (2017c). Polyvictimization and developmental trauma adaptations in sex trafficked youth. *Journal of Child & Adolescent Trauma*, *10*(2), 161–173.

Hopper, E.K., Azar, N., Bhattacharyya, S., Malebranche, D.A., & Brennan, K.E. (2018). STARS experiential group intervention: A complex trauma treatment approach for survivors of human trafficking. *Journal of Evidence-Informed Social Work*, *15*(2), 215–241.

Human Trafficking Leadership Academy 2017. (2017). *Survivor-informed practice: Definition, best practices, and recommendations.* Administration for Children and Families, National Human Trafficking Training and Technical Assistance Center. https://www.acf.hhs.gov/sites/default/files/otip/definition_and_recommendations.pdf

Human Trafficking Leadership Academy 2018, Cohort II. (2018). *Service recommendations for human trafficking survivors with substance use disorders.* [Presentation]. Administration for Children and Families, National Human Trafficking Training and Technical Assistance Center. https://www.acf.hhs.gov/sites/default/files/otip/htla_service_recommendations_for_human_trafficking_survivors_with.pdf

Humphreys, K., Blodgett, J.C., & Wagner, T.H. (2014). Estimating the efficacy of Alcoholics Anonymous without self-selection bias: An instrumental variables re-analysis of randomized clinical trials. *Alcoholism: Clinical and Experimental Research*, *38*(11), 2688–2694.

Jonikas, J.A., Kiosk, S., Grey, D.D., Hamilton, M.M., McNulty, J., & Cook, J.A. (2010). Cultural competency in peer-run programs: Results of a web survey and implications for future practice. *Psychiatric Rehabilitation Journal*, *34*(2), 121.

Kaskutas, L.A. (2009). Alcoholics Anonymous effectiveness: Faith meets science. *Journal of Addictive Diseases*, *28*(2), 145–157.

Kelley, A., Snell, B., & Bingham, D. (2015). Peer recovery support in American Indian communities: A qualitative intrinsic case-study approach. *Journal of Groups in Addiction & Recovery*, *10*(3), 271–286.

Kelly, J.F. (2017). Is Alcoholics Anonymous religious, spiritual, neither? Findings from 25 years of mechanisms of behavior change research. *Addiction*, *112*(6), 929–936.

Kelly, J.F., Bergman, B., Hoeppner, B.B., Vilsaint, C., & White, W.L. (2017). Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. *Drug and Alcohol Dependence*, *181*, 162–169.

Kelly, J. F., Stout, R. L., Magill, M., Tonigan, J. S., & Pagano, M. E. (2011). Spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Alcoholism: Clinical and Experimental Research*, *35*(3), 454-463.

Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: From theory to practice. *Social Work in Public Health*, *28*(3–4), 194–205.

Landers, M., McGrath, K., Johnson, M.H., Armstrong, M.I., & Dollard, N. (2017). Baseline characteristics of dependent youth who have been commercially sexually exploited: Findings from a specialized treatment program. *Journal of Child Sexual Abuse*, *26*(6), 692–709.

Macy, R.J., & Johns, N. (2011). Aftercare services for international sex trafficking survivors: Informing U.S. service and program development in an emerging practice area. *Trauma, Violence, & Abuse*, *12*(2), 87–98.

Magura, S., McKean, J., Kosten, S., & Tonigan, J.S. (2013). A novel application of propensity score matching to estimate Alcoholics Anonymous' effect on drinking outcomes. *Drug and Alcohol Dependence*, *129*(1–2), 54–59.

Marlow, E., Grajeda, W., Lee, Y., Young, E., Williams, M., & Hill, K. (2015). Peer mentoring for male parolees: A CBPR pilot study. *Progress in Community Health Partnerships: Research, Education, and Action*, *9*(1), 91–100.

Matusow, H., Guarino, H., Rosenblum, A., Vogel, H., Uttaro, T., Khabir, S.,…& Magura, S. (2013). Consumers' experiences in dual focus mutual aid for co-occurring substance use and mental health disorders. *Substance Abuse: Research and Treatment*, *7*, SART-S11006.

McCormack, L., & Katalinic, N. (2016). Learning to heal from those who know! The "lived" experience of a peer support program for adult survivors of childhood trauma. *Journal of Aggression, Maltreatment & Trauma*, *25*(10), 1021–1042.

Monica, C., Nikkel, R.E., & Drake, R.E. (2010). Alcohol & drug abuse: Dual Diagnosis Anonymous of Oregon. *Psychiatric Services*, *61*(8), 738–740.

National Human Trafficking Training and Technical Assistance Center. (2018). *Toolkit for building survivor-informed organizations.* https://www.acf.hhs.gov/sites/default/files/otip/toolkit_for_building_survivor_informed_organizations.pdf

Orchid Recovery Center. (2019). *The story of Alateen*. http://www.orchidrecoverycenter.com/alcohol-rehab/the-story-of-alateen/

Pfeiffer, P.N., Heisler, M., Piette, J.D., Rogers, M.A., & Valenstein, M. (2011). Efficacy of peer support interventions for depression: A meta-analysis. *General Hospital Psychiatry*, *33*(1), 29–36.

Polaris. (2018). *On-ramps, intersections, and exit routes: A roadmap for systems and industries to prevent and disrupt human trafficking.* https://polarisproject.org/sites/default/files/A%20Roadmap%20for%20Systems%20and%20Industries%20to%20Prevent%20and%20Disrupt%20Human%20Trafficking.pdf

Rajaram, S.S., & Tidball, S. (2016). Nebraska survivors speak: A qualitative research study. Report submitted to the Women's Fund of Omaha. https://www.omahawomensfund.org/wp-content/uploads/Nothing-About-Us-Without-Us-1.pdf

Reid, J.A., Baglivio, M.T., Piquero, A.R., Greenwald, M.A., & Epps, N. (2017). Human trafficking of minors and childhood adversity in Florida. *American Journal of Public Health*, *107*(2), 306–311.

Reif, S., Braude, L., Lyman, D.R., Dougherty, R.H., Daniels, A.S., Ghose,…& Delphin-Rittmon, M.E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65*(7), 853–861.

Roush, S., Monica, C., Carpenter-Song, E., & Drake, R.E. (2015). First-person perspectives on Dual Diagnosis Anonymous (DDA): A qualitative study. *Journal of Dual Diagnosis*, *11*(2), 136–141.

Sifers, S.K., & Peltz, K.M. (2013). What members of Alcoholics Anonymous really believe. *Mental Health, Religion & Culture*, *16*(7), 711–718.

Sprang, G., & Cole, J. (2018). Familial sex trafficking of minors: Trafficking conditions, clinical presentation, and system involvement. *Journal of Family Violence*, *33*(3), 185–195.

Stoklosa, H., MacGibbon, M., & Stoklosa, J. (2017). Human trafficking, mental illness, and addiction: Avoiding diagnostic overshadowing. *AMA Journal of Ethics 19*(1): 23–34.

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* https://store.samhsa.gov/system/files/sma14-4884.pdf

Substance Abuse and Mental Health Services Administration. (2017). *Peers supporting recovery from substance use disorders.* https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

Timko, C. (2008). *Outcomes of AA for special populations*. In *Recent developments in alcoholism* (pp. 373–392). New York, NY: Springer.

Timko, C., Cronkite, R., Kaskutas, L.A., Laudet, A., Roth, J., & Moos, R.H. (2013). Al-Anon family groups: Newcomers and members. *Journal of Studies on Alcohol and Drugs*, *74*(6), 965–976.

Timko, C., Halvorson, M., Kong, C., & Moos, R.H. (2015). Social processes explaining the benefits of Al-Anon participation. *Psychology of Addictive Behaviors*, *29*(4), 856.

Timko, C., Laudet, A., & Moos, R.H. (2016). Al-Anon newcomers: Benefits of continuing attendance for six months. *The American Journal of Drug and Alcohol Abuse*, *42*(4), 441–449.

Tonigan, J.S., & Rice, S.L. (2010). Is it beneficial to have an Alcoholics Anonymous sponsor? *Psychology of Addictive Behaviors*, *24*(3), 397.

Tracy, K., & Wallace, S.P. (2016). Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, *7*, 143.

Twigg, N.M. (2017). Comprehensive care model for sex trafficking survivors. *Journal of Nursing Scholarship*, *49*(3), 259–266.

Varma, S., Gillespie, S., McCracken, C., & Greenbaum, V.J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect*, *44*, 98–105.

Vatne Bintliff, A., Stark, C., DiPrete Brown, L., & Alonso, A. (2018). Lifelong wellbeing for survivors of sex trafficking: Collaborative perspectives from survivors, researchers, and service providers. *Dignity: A Journal on Sexual Exploitation and Violence*, *3*(3), 3.

Ye, Y., & Kaskutas, L.A. (2009). Using propensity scores to adjust for selection bias when assessing the effectiveness of Alcoholics Anonymous in observational studies. *Drug and Alcohol Dependence*, *104*(1–2), 56–64.