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Trauma-Informed Practices for Behavioral Health Leaders Serving Sex-Trafficking Survivors and Personnel

Evelyn Cordero Molina
Walden University

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<u>Walden University</u>

College of Management and Human Potential

This is to certify that the doctoral study by

Evelyn Cordero Molina

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University
2023

Abstract

Trauma-Informed Practices for Behavioral Health Leaders

Serving Sex-Trafficking Survivors and Personnel

by

Evelyn Cordero Molina

MS, Universidad Estatal a Distancia, 2009

BS, Universidad de Costa Rica, 2000

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

Walden University

August 2023

Abstract

Trauma-informed practices are essential to successful treatment outcomes and employee wellness in the context of sex trafficking clinical intervention. This single case study described the trauma-informed practices developed in a residential program for biologically-female sex trafficking survivors in the Southwest United States. The Baldrige excellence framework and the trauma-informed framework informed the study to comprehend organizational key factors and principles in the context of the residential program. Data were collected through semistructured interviews with four leaders at the senior and middle management levels, and internal documentation such as procedures, protocols, strategic plans, and yearly reports were included in the analysis. Data triangulation validated the findings related to the frameworks. Emerged themes from the study included identified trauma-informed practices at the organizational and entry-level, supporting that an organizational culture grounded in mission, values, open communication, and collaboration favors a humanizing experience at the entry level. The trauma-informed practices can also be mirrored for the survivor and employee to ensure their well-being. Faith and spirituality were protective factors and prayer was a coping strategy that benefited survivors and employees. Implementing trauma-informed practices promotes social change by building a new social narrative that encourages survivor and employee wellness. Positive social change may occur by strengthening nonprofit and faith-based organizations and informing public policy and legislation on the relevance of trauma-informed practices when fighting this social injustice.

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Dedication

To whom I am committed to honor with my life, my Heavenly Father.

Mom, your unwavering belief in me and the values you instilled in me have been the foundation of my accomplishments. With utmost gratitude, I honor the principles you sowed in my life, propelling me toward attaining my goals.

Dad, it is with deep honor that I carry the doctoral title upon your esteemed last name, forever enshrining your legacy within my academic achievements.

I am forever grateful, indebted, and proud to carry your names with me. I dedicate this doctoral study to you, my beloved parents.

Dedicatoria

A quien me comprometo a honrar con mi vida, mi Padre Celestial.

Mami, tu fe inquebrantable en mí y los valores que me inculcaste han sido la base de mis logros. Con suma gratitud, honro los principios que sembraste en mi vida, impulsándome hacia el logro de mis metas.

Papi, es con profundo honor que llevo el título de doctorado en tu estimado apellido, consagrando para siempre tu legado dentro de mis logros académicos.

Estaré siempre agradecida, siempre en deuda y siempre orgullosa de llevar sus apellidos, les dedico esta tesis doctoral a ustedes, mis amados padres.

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To my dear friends, you have witnessed my triumphs and trials, and your friendship has been a source of immeasurable comfort and joy. Your presence, encouragement, and shared laughter have lightened the load and made this journey all the more meaningful. Each of you holds a special place in my heart, and I am deeply grateful for your enduring friendship.

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Section 1a: The Behavioral Health Organization

The behavioral health organization (BHO) in the present study was a nonprofit organization that has served sex trafficking survivors in a residential program (RP) in the Southwest United States since 2019. In an 84-acre property located in a fairly-secluded area, the RP serves adult biologically females who have survived sexual exploitation, offering a safe environment and clinical care provided by behavioral health professionals and trained staff. The organization offers housing and 24/7/365 care to adult women survivors, with a maximum bed capacity of seven residents. The program lasts 12 to 24 months and aims to reintegrate the survivors into society. The faith-based (Christian) RP focuses on empowering women through therapeutic services and a compassionate environment with a trauma-informed framework. The RP offered clinical treatment, addiction recovery, and access to health and dental services in collaboration with other resources. According to the organization's website, expected clinical outcomes include a reduction of symptoms, increased self-management, and personal achievements, with the end goal of reincorporation into the workforce and independent living.

The RP is a branch of a faith-based nonprofit organization that aims to end this form of modern slavery through several services like outreach, prayer, and intervention. The nonprofit organization started in 2011 as a prayer meeting and has evolved to offer awareness, prevention, street intervention, and recently a residential program. The nonprofit organization's mission is the organization's driving force and foundation for the various programs. The nonprofit's culture is ruled by its faith stance and revolves around character and personal integrity, considered the organization's most valuable assets.

According to the BHO's documentation, the core values of respect, compassion, community, communication, resilience, restorative care, and responsibility create a safe environment to empower the survivors.

The organizational structure includes a governing board of directors, overseers of the operations and finances, and the executive director, who leads the different operation branches, such as prayer, awareness, communications, intervention, and the RP. The RP branch has 13 employees dedicated to serving the survivors by creating a safe environment and following regulatory requirements to stay accountable to health, safety, and confidentiality regulations at the state and national levels.

The RP has a program director who works collaboratively with a case management team. The BHO's internal documentation informs that the case management team led by the program director includes a psychologist, a case manager, a residential manager, and a recovery coordinator, entirely dedicated to assessing and managing each resident's progress. Additionally, residential coordinators and an education coordinator manage the day-to-day care and intervention. The BHO and its leadership are committed to improving their practices in collaboration with other community resources to improve the continuum of care for sex trafficking survivors. Internal and external collaboration is crucial to achieving the organization's mission.

Practice Problem

Behavioral health leaders serving sex trafficking survivors face different challenges when providing the services. Jain et al. (2022) stated that services required for survivors include housing, safe and confidential environments, needs assessment, and

case management. Recent research has confirmed that the trauma-informed framework is the priority when offering services to survivors because it will help recognize, respond, and resist re-traumatization (Chambers et al., 2022; Cloitre, 2021; Jain et al., 2022; Powel et al., 2018; Stanford et al., 2021). In addition, the Department of State of the United States of America (2021) indicated that trauma-informed practices involve the survivors and the staff working in an organization. Thus, due to the presence of trauma in survivors and the possibility of vicarious trauma in personnel, developing trauma-informed practices requires attention from behavioral health leaders.

Human trafficking is a growing worldwide concern. However, Chambers et al. (2022) stated that organizations and researchers face several challenges when identifying the prevalence of this form of slavery. Human trafficking is defined in the Trafficking Victims Protection Act as "the act of recruiting, harboring, transporting, providing or obtaining a person for compelled labor or commercial sex acts through the use of force, fraud or coercion" (Trafficking Victims Protection Act, 2000). Iqbal et al. (2021) stated that there are cases of human trafficking in all 50 states; however, Texas has the highest numbers, followed by California. Chambers et al. (2022) informed that the "Human Trafficking Hotline received 11,500 cases in 2019, of which 8,753 involved sex trafficking" (p.1). The International Labour Office (2017) reported that an estimated 3.8 million adults were victims of sexual exploitation in 2016, and 99% were women. Since most sex trafficking victims are female, academic research and intervention programs have primarily focused on women. However, other populations such as males, children, and special populations like LGBTQ are also victims of sex trafficking, and it requires

further research. The present study focused on biologically female survivors, as they are the population served by the BHO.

Sex trafficking victims experience serious health consequences, including physical health issues, sexual health issues, injuries, unwanted pregnancy, substance abuse disorders, and mental health consequences such as depression, anxiety, and increased suicide rate (Chambers et al., 2022; Talbot & Suzuki, 2021). Academic research has suggested that trauma and complex trauma is prevalent among sex trafficking survivors (Chambers et al., 2022; Evans et al., 2022; Hopper et al., 2018; Iqbal et al., 2021; Shepherd et al., 2022). Moreover, behavioral health professionals serving this population are more prone to experience burnout, vicarious trauma, and other mental and physical symptoms (Helpingstine et al., 2021). Therefore, trauma-informed practices are central to clinical intervention.

Nongovernmental organizations have developed efforts to serve this population alongside other entities like law enforcement and advocacy organizations. Additionally, public policymakers have increased their efforts to fight this crime and develop trauma-informed and survivor-centered services (Department of State, 2021). The global pandemic COVID-19 increased the number of people vulnerable to human trafficking due to financial hardship; moreover, sex trafficking victims and survivors were at higher risk of re-victimization, abuse, violence, drug abuse, and mental health disorders (Department of State, 2021). Nonprofit organizations are at the front line serving this population; however, there is no standardized treatment or protocols, which becomes a significant challenge for behavioral health leaders. Cunha et al. (2022) emphasized the

need to develop evidence-based programs, and Iqbal et al. (2021) suggested that trauma-informed care is the key to improving treatment adherence. Jirek (2020) also discussed the relevance of creating a trauma-informed culture at the organizational level to ensure the behavioral health workforce's well-being and consequently increase the effectiveness and quality of services. Faith and community organizations have taken the lead as first responders since the early 2000s and have increased their knowledge to serve the population based on their needs (Talbot & Suzuki, 2021), and their contributions have been significant. The RP, in this case study, has leveraged the knowledge acquired in other organizations, core values and the trauma-informed framework to develop its practices.

The RP services adult female sex trafficking survivors in the Southwest United States. The organization aims to create a safe environment to empower women by processing their trauma and reintegrating them into society. Trauma-informed practices assume that every human has experienced trauma at some level, and special considerations should be taken at the organizational and process level for survivors and personnel (Department of State, 2021; Scott et al., 2019). The entry process is the most challenging stage in the organization because the survivors are experiencing trauma symptoms and emotional distress. In addition, the personnel assessing and serving the survivor in this first stage are also exposed to trauma when listening to the stories and providing emotional support and guidance. Mumey et al. (2021) recommended being aware of the survivors' emotional state characterized by mistrust and developing rapport by addressing external needs such as housing and safety accompanied by physical and

mental health. In this research study I address the entry-level basic needs and the need to collaborate with other health providers in the continuum of care.

Behavioral Health Leader 1 (BHL1), who holds a management position, informed that the RP was established in 2019 and, by 2021, experienced a high employee turnover. There is no specific data available on the employee turnover rate for similar organizations; however, according to BHL1, based on a nationwide survey, employee turnover for direct care staff is about 8 months; furthermore, Behavioral Health Leader 2 (BHL2) confirmed the data and informed that the RP currently has a 9–10-month employee turnover rate, which is better than the national rate, but still difficult to manage when transitioning from one staff member to the other due to a detailed hiring process and training period. The COVID-19 pandemic fully unfolded during 2020, and the staff stayed through this challenging season, but the staff drastically dropped in 2021 due to personal changes, burnout, and compassion fatigue symptoms. The employee turnover and the connection with these symptoms was a concern expressed by the behavioral health leaders in the organization. A clinician in the organization stated that another challenge behavioral health leaders face is maintaining the survivors in the program for extended periods. For instance, just the entry process could take up to 8 months to ensure safety and stabilization. Therefore, the entry process remains the most challenging because of the complexity of the survivors' needs. The present study addressed these organizational concerns.

The specific organizational problem I addressed by this study was identifying trauma-informed practices to benefit the well-being of survivors and personnel. The

identification of trauma-informed practices at the entry level in the RP will be inquired by addressing the following research questions:

RQ1: What trauma-informed practices behavioral health leaders could apply to the entry process in a residential program for sex trafficking survivors?

RQ2: What are the key elements to promote successful treatment outcomes for sex trafficking survivors?

RQ3: What strategies could behavioral health leaders implement to ensure the well-being of the personnel working with sex trafficking survivors at the entry-level?

Purpose

With this qualitative case study, I aimed to explore the recommended trauma-informed practices for the entry process in a nonprofit serving sex trafficking survivors in the Southwest United States to promote successful outcomes for the survivors and ensure the personnel's well-being. Substance Abuse and Mental Health Services Administration [SAMHSA] (2014) stated that a trauma-informed approach encompasses trauma-specific interventions and integrates trauma knowledge into the organizational culture, where policies, procedures, and practices aim to prevent re-traumatization.

The study contributes to the current knowledge on the scarce topic of trauma-informed practices for organizations working with sex trafficking survivors. Researchers have recommended further development of trauma-informed practices to benefit survivors and personnel (e.g., Corbett-Hone & Johnson, 2022; Helpingstine et al., 2021; Marburger & Pickover, 2020; Mumey et al.,2021; Ramirez et al., 2020). Additionally, the Baldrige framework of excellence assesses healthcare organizations in seven categories

to improve performance; these categories establish the criteria for excellent service in healthcare organizations; such categories are leadership, strategy, customers, measurement, analysis and knowledge management, workforce, operations, and performance results (Baldridge Performance Excellence Program, 2021). Both frameworks facilitate the organization's assessment and development of recommendations.

The Baldrige framework (2021) comprehensively assesses the factors involved in delivering high-quality healthcare services. One critical challenge that behavioral health leaders face is the absence of standardized protocols when serving sex trafficking survivors (Iqbal et al., 2021; Koegler et al., 2021). Recognizing this need, the Baldrige framework offers a valuable systems perspective to organizations seeking performance excellence. By considering the unique needs of this specific population, the framework can guide the development of recommended protocols and procedures, enabling behavioral health providers to serve sex trafficking survivors better.

The behavioral health workforce demand and supply in the United States are transforming rapidly after the COVID-19 pandemic because of the predicted increase in mental health demand. One challenge the United States government identified is behavioral health employee retention, primarily due to burnout (United States Government Accountability Office, 2022). Behavioral health leaders serving sex trafficking survivors at the RP have expressed the same concern. The Baldrige framework (2021) allows addressing workforce capability, capacity needs, and the workplace climate to focus on the recommendations.

At the customer level, the Baldrige framework (2021) addresses the voice of the customer, which is particularly critical with sex trafficking survivors. Lockyer (2022) highlighted the importance of survivor voice, representation, and participation in decision-making. According to Lockyer, survivor perspectives can significantly contribute to shaping practices and enhancing antitrafficking efforts. The interaction between the survivor and the behavioral health provider is crucial to this case study as an environment of trust and safety benefits both and generates organizational resilience and growth.

Finally, the Baldrige framework (2021) was instrumental in evaluating trauma-informed practices at the entry level to improve organizational processes. For example, Jain et al. (2022) suggested ensuring privacy, minimizing waiting times, and expediting registration when serving survivors. The assessment and the identification of innovative practices lead to areas of development in the RP and other organizations.

I used several sources of information for this case study. I conducted initial meetings with the executive director to discuss the organization's characteristics and the practice problem's identification, followed by email communication, and then reviewed the organization's website and public documentation. The next step was to collect and analyze secondary data, including internal documentation, the mission statement, core values, policies and procedures, training, and employee protocols. I expressly collected information for the entry-level application and referral forms, initial intake questionnaires and procedures, mental health assessment, and other critical documentation. Lastly, I conducted semistructured qualitative interviews with behavioral health leaders in the

organization that provided information for the organizational profile, structure, and culture. Moreover, it provided in-depth information to address the research questions.

Significance

The qualitative case study benefited the BHO by recommending trauma-informed practices for survivors and personnel. Steiner et al. (2018) discussed the global practices to serve survivors, including individual approaches centered on empowerment, trauma-informed, and survivor inclusion; collaborative approach providing interdisciplinary treatment and reaching to community resources; and at the societal and public policy level to promote social change and positively impact funding for the treatment initiatives. Scott et al. (2019) emphasized the impact of legislation and language when investing in trauma-informed practices. Recknor et al. (2020) identified the best practices in different organizations, including a residential program, and introduced the need to research the employee-survivor connection further. In addition, Asongu and Usman (2020) addressed the impact of the COVID-19 pandemic on increasing domestic violence and sex trafficking among children and women. Academic research has emphasized the difficulty organizations face in developing best practices because there is no minimum standard for the delivery of services (Cunha et al., 2022; Iqbal et al., 2021; Koegler et al., 2021).

Further, the last 5 years of research have confirmed that trauma-informed practices are critical when serving sex trafficking survivors (Chambers et al., 2022; Cloitre, 2021; Mobasher et al., 2021; Powel et al., 2018; Recknor et al., 2020; Scott et al., 2019; Stanford et al., 2021; Steiner et al., 2018). Academic research has stressed the urgency to develop trauma-informed practices to serve sex trafficking survivors. The

present study intended to fill the gap in research by providing descriptive information from one residential program following a trauma-informed approach.

Behavioral health leadership will be able to identify strategies to increase employee retention by focusing on practices that encourage individual self-care and organizational resilience. Corbett-Hone and Johnson (2022) indicated that behavioral health professionals develop vicarious resilience by witnessing their recovery in the therapeutic exchange with survivors. However, professionals must be aware of the risk of burnout and vicarious trauma, especially when there is unresolved personal trauma (Corbett-Hone & Johnson, 2022). Helpingstine et al. (2021) stated that burnout and vicarious trauma are normative occurrences in the field; Muehlhausen (2021) estimated that 40-85% of mental health professionals could develop vicarious trauma and compassion fatigue. Furthermore, both authors stated that spirituality is an effective resource for improving compassion satisfaction and vicarious resilience.

Identifying trauma-informed practices in the entry process will improve the treatment plan and client success. Hopper et al. (2018) discussed that trauma-informed practices, such as interpersonal relationships, regulation, and identity, improve treatment outcomes. Mumey et al. (2021) suggested that the services provided to sex trafficking survivors must be sensitive to their experiences. Cunha et al. (2022) stated the imperative need to propose evidence-based practices for effective psychological intervention with survivors supporting the significance of the present research study.

Trauma-informed practices will promote social change at the organizational and societal level by promoting well-being in all groups fighting against this form of modern

slavery. For instance, Muehlhausen (2021) stated that burnout is an individual problem and an occupational phenomenon. Posluns and Gall (2020) warned about burnout producing a poor quality of life in professionals and consequently impacting the quality of services provided to the survivors. Knight et al. (2022) stated that several studies reported meaning-making processes, spirituality, and faith as resilience traits. The RP faith-based stance offered alternative ideas to improve compassion satisfaction and increase organizational resilience.

This doctoral study contributes to social change by providing insights for shaping public policy and legislation concerning trauma-informed practices. These insights aim to strengthen the credibility of understanding sex trafficking as a complex traumatic experience that impacts survivors and behavioral health workers. For instance, Mumey et al. (2021) recommended that professionals approach the survivors with sensitivity and take a nonjudgmental position. When survivors are treated with sensitivity and respect, it challenges the prevailing victim-blaming narratives and shifts the public understanding of the survivor and personnel experiences. Therefore, the study presents providers in medical, legal, mental, and social services trauma-informed language and recommended practices as they serve this population at any moment in the continuum of care. Lastly, the study contributes to the research evidence-based literature supporting the development of protocols and trauma-informed practices, advocating for sex trafficking survivors, and promoting social change.

Summary

The worldwide issue of human trafficking and particularly sexual exploitation that victimizes women are addressed at the governmental and public policy levels; however, nonprofit organizations are on the front line of the issue and encounter trauma daily. Sex trafficking survivors face several health consequences, including mental health. Trauma-informed care in an organization intends to manage the impact of trauma and resist re-traumatization in clients and personnel because trauma impacts every individual (Blue Knot Foundation, 2020). Due to trauma, sex trafficking survivors engage in treatment programs with a sense of mistrust and disconnection. At the entry level, survivors' needs are overwhelming, and that might impact behavioral health professionals by experiencing vicarious trauma, compassion fatigue, and burnout. Ramirez et al. (2020) stated that a sex trafficking survivor might need more time to recover, and behavioral health professionals must be knowledgeable of such needs to develop trust and address immediate needs to ensure safety. Hence, the RP has experienced employee turnover and difficulties maintaining the survivors in the program until completion. The RP, in this case study, encounter challenges because of the scarcity of evidence-based practices and minimum standards to deliver their services, as other organizations. Behavioral health leaders must address the interaction between survivor-behavioral health professionals to ensure their well-being.

Section 1b provides an overview of the RP that will serve as a profile framing the critical factors in the organization, background, and context. Based on the Baldrige framework (2021), this section will inform about the healthcare service offerings,

organizational structure and culture, the workforce profile, customers, and stakeholders providing information to support the need to address the practice problem.

Section 1b: Organizational Profile

Sex trafficking is a prevalent issue in the United States and worldwide. Behavioral health leaders face challenges in providing trauma-informed care to survivors and personnel. Trauma-informed practices are a priority for behavioral health leaders serving sex trafficking survivors as research has informed about the prevalence of trauma in sex trafficking survivors (Evans et al., 2022; Hopper et al., 2018; Mumey et al., 2021) and the possibility of personnel developing vicarious trauma (Corbett-Hone & Johnson, 2022; Helpingstine et al., 2021; Kelly, 2020; Namakula et al., 2021; Posluns & Gall, 2020). In addition, the well-being of the survivors and the personnel requires attention at the organizational level because it could prevent employee turnover, burnout, and compassion fatigue (Jirek, 2020). I aimed to identify trauma-informed practices at the entry level in a residential program by addressing the following questions:

RQ1: What trauma-informed practices behavioral health leaders could apply to the entry process in a residential program for sex trafficking survivors?

RQ2: What are the key elements to promote successful treatment outcomes for sex trafficking survivors?

RQ3: What strategies could behavioral health leaders implement to ensure the well-being of the personnel working with sex trafficking survivors at the entry level?

With this qualitative case study, I aimed to recommend practices that behavioral health leaders can implement to ensure the well-being of survivors and personnel when

they are most vulnerable to trauma at the entry level. In Section 1b I discuss the organizational profile and key factors of strategic importance. Moreover, the organizational background and context inform about the need for the practice problem.

Organizational Profile and Key Factors

Scope of Services

The Baldrige framework (2021) assesses key organizational characteristics, including the environment, relationships, and strategic situations. The RP is a branch of a BHO that at large includes street outreach and intervention, awareness, and prayer to accomplish its goal of ending modern slavery. The framework is an excellent reference to assess a growing nonprofit organization as the RP.

This case study's RP started in 2019 and offers residential services to adult (18+) biologically female sex trafficking survivors. The scope of services includes housing in a safe environment that empowers them for independent living and reintegration into society. According to the RP's internal documentation, the program is faith-based, program centered, empowerment-focused, and trauma-informed, aiming to help survivors journey from stabilization to independence through a 12-24 month program. The program has a limit of seven residents who can progress throughout the program's five phases to achieve stabilization, growth, and independence. The RP's scope of services description specified services like academic enrichment, spiritual instruction, therapeutic intervention, addiction recovery, social skills building, and daily life activities. Additionally, by partnering with other organizations or healthcare providers, the RP

provides access to health and dental services, mentorship programs, survivor engagement, volunteering, and internal internships.

The RP received weekly referrals from organizations nationwide, not only from the region. Iqbal et al. (2021) emphasized the need for collaboration in the continuum of care when serving human trafficking victims; therefore, the referral system is crucial to future success. The BHO's official website provides the application form to start the process of entering the program, which was tailored to expedite the process without sacrificing vital information, according to Behavioral Health Leader 4 (BHL4), a behavioral health professional who collaborated in creating the document. After completing the application, the case management team starts a process to evaluate the applicant's characteristics and the fulfillment of minimum requirements according to the RP's protocol. The requirements include 14 days without using any illicit substance, not taking narcotic medication, not having physical custody of children, or not being pregnant past 20 weeks. Such requirements facilitate a thorough entry process and allow the case management team to identify a good fit for the RP.

One crucial aspect is the Christian faith stance, which is communicated upfront. The organization is faith-based but serves people of all faiths, as stated in the BHO's website. Therefore, each resident is informed about the presence of spiritual instruction and Christian faith before they choose to join the program. After the initial application is approved, an intake process can take up to two days, including an interview and induction to the program, informed one of the behavioral health leaders. The case management team leads the delivery of services and accompanies the survivor until program

completion (or dropout). A case management team is suggested by research as a practice that will increase survivors' trust and safety (Jain et al., 2022; Koegler et al., 2021; Marburger, 2020). The trauma-informed practices developed in the RP's entry process encourage safety and trust building; the case management team is vital in that process.

Organizational Culture

The vision, mission, and core values define the organizational culture. The Baldrige framework (2021) states that the purpose of an organization guides the values and services provided. Jirek (2020) stated that organizational culture can be visualized in the daily experiences created in the organizational structure, including beliefs, values, assumptions, expectations, and language. Jirek further explained the positive correlation between organizational culture and quality of services, along with the positive interaction worker-customer; in contrast, employee turnover correlates negatively. The organizational culture in the BHO is a determinant of the delivery of services.

BHL2 informed me that the BHO’s mission statement is to fight against sex trafficking through prayer, awareness, intervention, and restoration. The vision for the overarching organization is to be change-makers by following four essential core values: fidelity to Jesus, humility, fostering innovation, and developing resilience. The core values revolve around statements of faith and personal character. The BHO’s mission, vision, and core values align with the faith stance.

As a faith-based organization, the organizational culture of the RP communicates to the employees since the hiring process that personal character and integrity is the most valuable asset they bring to the team. In addition, the RP internal documentation informs

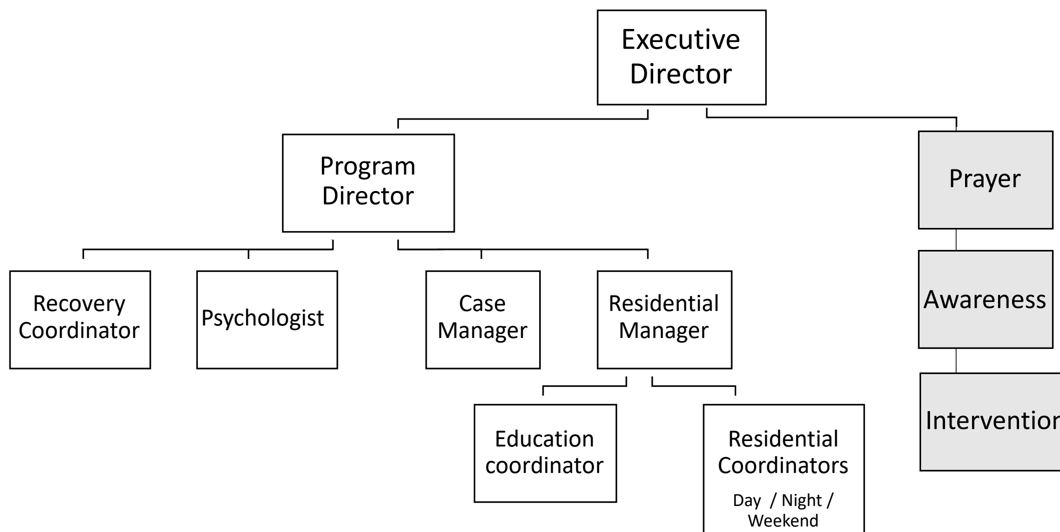
personnel about the specific set of core values, including respect, compassion, communication, restorative care, resiliency, and responsibility. Ramirez et al. (2020) indicated that a culture of excellence, trust, respect, professionalism, and openness in decision-making will prevent employee burnout when working with human trafficking victims. BHL1 stated, "we are unique as an organization because of the faith-based stance; we are committed to saying that we will stand on these principles, these core foundational values." The workforce and the survivors are aware of the faith approach; however, potential residents are only asked to consider faith as part of their recovery process, while employees are expected to adhere to the organization's core values.

Workforce Profile

The workforce profile includes 13 employees, eight direct care staff as residential coordinators for the day, overnight, and weekend shifts, and an education coordinator. The remaining employees form the case management team, including the program director, recovery coordinator, psychologist, case manager, and residential manager (See Figure 1).

Figure 1

Residential Program Workforce



According to BHL1, the culture might feel slightly different among the day employees, which includes the case management team, versus the overnight and weekend employees who barely interact with the weekday team. BHL1 informed that the overnight team had reported feelings of isolation, detachment, and a low sense of belonging. Helpingstine et al. (2021) stated that organizational risk factors for burnout include long work hours, high caseloads, and low support from peers and supervisors (p. 724). Therefore, the organization is looking for alternatives to bring together the teams, reinforcing a culture of collaboration and teamwork that correlates with trauma-informed practices.

Employee turnover is a major concern expressed by behavioral health leaders, especially among direct care staff. Burnout was classified in 2019 as an occupational phenomenon in the 11th revision of the International Classification of Diseases (ICD-11),

and it is contextualized exclusively in the workplace environment and characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy (World Health Organization [WHO], 2019-a). BHL1 informed that leadership had identified some of these symptoms in the employees before they make the decision to leave their positions in the organization.

Sex trafficking survivors' stories are particularly overwhelming because of the violation of individual rights and the traumatic experiences lived even pretrafficked. Ramirez et al. (2020) highlighted that healthcare providers might experience emotional distress and change in their worldview and conduct due to the exposure to trauma and its consequences expressed by the survivors. Helpingstine et al. (2021) emphasized the need to further research and address vicarious trauma and burnout in healthcare workers serving sex trafficking survivors. Vicarious traumatization is a response to continued exposure to traumatic content causing changes in behavior, relational connection, and self-image (Helpingstine et al., 2021). Consequently, the person might experience burnout, low motivation, less empathy, and compassion fatigue, resulting in decreased performance (Corbet-Hone & Johnson, 2022). Behavioral health organizations are responsible for addressing these challenges with their employees (SAMHSA, 2014), and ensuring their well-being is a priority to provide the best service to this population.

Assets

The nonprofit organization has their headquarters facilities and an 84-acre property where the RP is located. The RP house is fully furnished and has access to

utilities and basic needs. The 2021 financial summary reported in the BHO's website states a total income of $2,156,323, and 76% of the income is dedicated to the programs. However, insufficient information is available to report on equipment, technologies, and intellectual property.

Regulatory Environment

BHL1 informed me that no standard of care had been developed for long-term residential care for sex trafficking survivors at the state or national level. However, the RP has voluntarily submitted to the authority of healthcare regulations, such as HIPPA, to ensure confidentiality. All occupational and health regulations the city requires are followed and updated as needed, according to BHL1. Additionally, the BHO's website states a privacy policy for donors and provides public knowledge of the annual financial reports. Candid, the highest level of recognition by GuideStar for nonprofit organizations, awarded them the Platinum Transparency 2023; such recognition confirmed the organization's efforts to adhere to regulatory requirements.

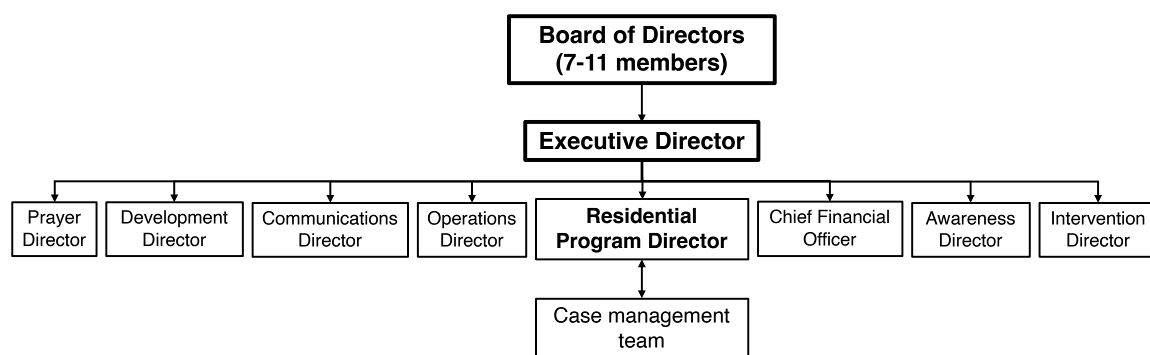
Organizational Structure

The organization is governed by the board of directors, currently formed by six members but planning to grow to 11, according to BHL1. The board reviews and establishes salary and benefits for the executive director position, review the strategic plan, and has specific committees to manage facilities, property development, finances, and spiritual development. The executive director oversees every branch of the nonprofit organization, including the RP. The hierarchal organizational chart (see Figure 2) establishes the executive director as overseer of the RP director; however, in practice, the

RP director has the freedom to operate in the program at the intervention and clinical level, as informed by the BHL1. A case management team followed the structure led by the program director and conformed of a psychologist, recovery coordinator, case manager, and residential manager. The residential manager oversees the day, weekend, and overnight residential coordinators.

Figure 2

Organizational Chart Behavioral Health Organization



Jirek (2020) explained that the organizational structure includes hierarchy, policies, information flow, and power distribution (p.213). BHL2, who holds a management position, emphasized the open communication encouraged in the organization and that every person has access to any management level, employees can even communicate with board members if they feel the need to do so. Open communication at the different levels, from the survivors to the board of directors, is a practice that creates a sense of safety and trust instead of a rigid system. Therefore, the hierarchical organizational structure does not describe a rigid organizational culture; instead, the organizational leadership encourages collaboration and open communication empowering employees and the survivors. In addition, such an approach compares with

trauma informed as it invites to create a sense of physical or psychological safety, where openness and transparency are vital in the organization (SAMHSA, 2014). The balance between organizational structure and culture is crucial in the context of trauma-informed practices.

Stakeholders

The primary stakeholders are the adult female survivors who receive the services. This vulnerable population is characterized by limited access to mental health social determinants of health, such as a reported history of childhood trauma, exposure to violence, poverty, gender and race discrimination, and difficulty supplying basic needs such as housing, food, transportation, and health services (Fink-Samnick, 2021). Therefore, because of the complexity of the service, several stakeholders must collaborate to assist and empower the survivors. The case management team tends to the basic needs of housing, food, transportation, and clinical needs. Additionally, the RP's case management team connects each resident with health care providers, addiction recovery groups, churches, mentors, advocates, survivors' support, and other community partners outside the intervention provided to address all possible areas of vulnerability. Every stakeholder plays a vital role in the continuum of care of the survivors.

Organizational Background and Context

The RP is a growing organization serving sex trafficking survivors, and trauma-informed practices are a priority for this population. The personnel are at higher risk of vicarious trauma because of the constant exposure to trauma content and symptoms. Koegler et al. (2021) stated that service providers must be aware of the complexity of

trauma symptoms, making the survivor vulnerable to re-victimization. Trauma-informed practices are specific to this client population. Koegler et al. indicated that comprehensive services, from safety and basic needs to trauma-specific interventions and empowerment, are essential to ensure clients' well-being. The organization aims to empower women by providing a safe environment, and trauma-informed practices from the entry level will improve treatment outcomes. Corbett-Hone and Johnson (2022) indicated that poor professional quality of life might cause therapist impairment and potentially harm the clients. Furthermore, Corbett-Hone and Johnson recommended giving special attention to self-care strategies and exploring the profession's meaning-making to increase compassion satisfaction. The recommendations on trauma-informed practices benefiting survivors and personnel will impact the organization positively.

Nonprofit organizations are on the front-line serving sex trafficking survivors, and because this is a relatively new service, there is scarce evidence-based research and practices that behavioral health leaders could implement. The BHL1 stated that no standard of care or program requirements are set at the state or federal level regarding serving an adult population in residential care, and it is also confirmed by academic research (Cuhna et al., 2022; Iqbal et al., 2021; Koegler et al., 2021). Therefore, the best practices they have developed are based on their experience and as the evidence becomes available. The organization has joined national studies to survey and collect data for its development and collaboration efforts. For instance, the regulatory environment concentrates on operational safety and confidentiality, as they comply with Health Insurance Portability and Accountability Act [HIPAA] by choice, not by obligation. The

organization manages all client information with compliant software to ensure privacy and confidentiality, informed BHL1. The goal of continuous improvement and innovation is a driving force for the organization.

Strategically the organization is aware of the need to bring structure and a performance improvement system. By reviewing the strategic plan available for the stakeholders, the number one goal is to write standard operation procedures (SOPs) for all processes by December 2022; another goal is to hire and train staff members to manage the program allowing healthy rest and rhythms and increasing staff retention. These two strategic goals confirm the growing stage of the organization and the need to focus on staff well-being and develop research-evidence practices.

Definitions

The organization and this study refer to key terms throughout the document that are defined as follows:

Burnout: A syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy. Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life (WHO, 2019-a).

Care Model: The program's five phases are to achieve safety, growth, and independence. Each phase has resident focus objectives and progress markers, individually tailored and overseen by the case management team.

Compassion fatigue: The burnout and stress-related symptoms experienced by caregivers and other helping professionals in reaction to working with traumatized people over an extended period. (American Psychological Association [APA], n.d.-a)

Complex trauma: Complex posttraumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent (a) problems in affect regulation; (b) beliefs about oneself as diminished, defeated, or worthless, accompanied by feelings of shame, guilt, or failure related to the traumatic event; and (c) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning (WHO, 2019-b).

Human trafficking: The act of recruiting, harboring, transporting, providing, or obtaining a person for compelled labor or commercial sex acts through the use of force, fraud, or coercion (Trafficking Victims Protection Act, 2000).

Resilience: The process and outcome of successfully adapting to complex or challenging life experiences, primarily through mental, emotional, and behavioral flexibility and adjustment to external and internal demands. (APA, n.d.-b).

Sex trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act (Trafficking Victims Protection Act, 2000).

Survivors: Individuals who have traded sex acts (including prostitution, stripping, pornography, etc.) to meet the basic needs for survival (i.e., food, shelter, safety, etc.) without the overt force, fraud, or coercion of a trafficker, but who felt that their circumstances left little or no other option.

Trauma-informed: This approach stresses the need for empathy, transparency, respect, consent, and patient empowerment, with a strength-based approach to patient care and a focus on the best interests of the individual (person-centered) (Chambers et al., 2022, p.2). The trauma-informed care follows five principles: safety, choice, collaboration, trustworthiness, and empowerment (Iqbal et al., 2021).

Vicarious trauma: Normative response to repeated exposure to traumatic content resulting in changes in how helping professionals view themselves (Helpingstine et al., 2021, p. 724).

Organization's Context

The BHO is a nonprofit organization registered as a 501(c)-3 in the United States and operates under a governing board, which establishes goals and oversees the accomplishment of the goals. The RP is a branch under the same structure and accountability processes. According to the BHO's website, annual planning and budgeting are based on expected income. The financial summary for 2021 available on the website informs that over 70% of the funding comes from direct donors, followed by

churches and foundations, and less than 10% comes from government and business funding. The organization designates 76% of its income to cover the programs' expenses. BHL2 stated that one of the implications of taking a firm faith stance is not having access to government funding because sometimes the requirements contradict the BHO's core values. Therefore, their strategic funding strategy requires high engagement with donors, and a privacy policy displayed on their website, ensuring the confidentiality of the data recorded and as a standard of transparency.

On the other hand, Talbot and Suzuki (2021) and Mobasher et al. (2021) recognized the contributions of the faith community in sex trafficking intervention and acknowledged their efforts to implement evidence-based frameworks, like trauma-informed care. BHL1 stated that collaboration is a pressing opportunity, as the field is new and the industry is evolving rapidly, for instance, the increase of online services or the introduction of new drugs; besides, the mental health of the survivors seems to be more severe and deteriorating. Collaborating with other nonprofit organizations, governmental institutions, and academia strategically positions the RP for growth.

The continuum of care for sex trafficking survivors, from prevention to residential programs, is a strategic concern. Healthcare providers in medical and social services must be trained to identify and serve this population from a nonjudgmental perspective, empowering the sex trafficking victims to start their journey to recovery. BHL1 mentioned that sex trafficking survivors coming to the program are often referred to emergency centers, hotlines, and street interventions. In any organization around the country, the entry process could last up to 40 days; however, the RP has a goal of two

weeks to complete it. The long wait to be admitted to a residential program increases the risk of these women being revictimized through violent acts and manipulation. The women may even be physically relocated by the trafficker, denying them the opportunity to get out of the exploitation, according to BHL1. The trauma-informed framework, language, and practices might improve the delivery of services to sex trafficking survivors in the continuum of care.

Finally, regarding legislation, there is a growing concern about decreased awareness of sex trafficking and other forms of sexual violence as a potential risk factor for their service offer. In terms of the trauma-informed framework, legislation is a step behind, Scott et al. (2019) stated that despite the efforts made by organizations to incorporate trauma-informed practices and language, legislation at the federal level has minimally used this framework. For instance, the "Trafficking Victims Housing Act of 2017 (S.2305) is the first and only bill to date that mentions trauma-responsive approaches in U.S. federal legislation" (Scott et al., 2019, p. 349). BHL1 identified challenges in legislation at the state and federal level, such as the promotion of prostitution or legalization of prostitution, a movement to legalize and completely decriminalize prostitution, pornography, and pimping. Also, as a faith-based nonprofit, carefully watching legislation that might impact or hinder the delivery of services is a priority for organizational leaders.

Summary

The organization's background and context confirmed the need to explore the best practices for a relatively new and growing organization. The mission and firm stance on

faith-based core values make this organization unique in fighting this form of modern slavery and offering a model of care aligned with the trauma-informed framework. The care model developed by the organization and targeting stabilization, growth, and independence correlates with the objectives of the trauma-informed framework, which are safety, choice, collaboration, trustworthiness, and empowerment (see Iqbal et al., 2021). In addition, the workforce composition and organizational structure allow training and collaboration to target the well-being of personnel. These key factors are relevant to understanding the organization and seeing the potential to develop other trauma-informed practices that will benefit survivors and personnel.

Section 2 provides the supporting literature to continue discussing trauma-informed practices, the survivor and employee's mental health, and the role of spirituality and faith at the individual and organizational levels. In addition, the leadership structure, the current strategy, and the characteristics of the population served by the RP will provide a context to understand the organizational implications at the entry-level.

Section 2: Background and Approach–Leadership Strategy and Assessment

Sex trafficking survivors experience trauma, and the Department of State of the United States (2021) highlighted the need to develop trauma-informed practices because of the impact of trauma on the different actors involved in the issue. Therefore, behavioral health leaders developing programs for sex trafficking survivors must focus on trauma-informed practices that benefit the survivors' and personnel's well-being. I aimed to identify trauma-informed practices at the entry-level in a residential program working with sex trafficking survivors. In addition, nonprofit organizations are looking for strategies to improve the different stages of care. The entry process is one of the most vulnerable for survivors and personnel, as trauma is present daily. For instance, Munsey et al. (2018) stated that the first 6 months define long-term outcomes and program retention; moreover, assessing the resident's well-being is critical for success.

Section 2 informs about leadership in the organization and the structure to assess outcomes. The subsection on workforce and operations is crucial to the practice problem, as it informs about personnel characteristics and practices. Trauma-informed practices aim to recognize the impact of trauma on the survivors and the vulnerability to revictimization that personnel must be aware of and address (Scott et al., 2019). Furthermore, it recognizes the impact of trauma on the personnel working with survivors and the presence of vicarious trauma (Ramirez et al., 2020). The interaction between sex trafficking survivors and personnel could positively impact both groups by developing organizational resilience and an inclusive worldview promoting societal transformation.

Supporting Literature

I started the research by locating peer-reviewed articles from the last five years using Walden University Thoreau Database search tool. The databases included APA Psyc Info, PubMed, and Science Direct. The initial search included general terms such as *sex trafficking, residential program,* and *best practices*, and the results were minimal. The combination of search words did not provide articles to support the research. However, other combinations, including search terms such as *sex trafficking, trauma, trauma-informed, best practices, leadership, vicarious trauma, survivor informed*, provided a more significant number of articles. The number of articles increased but not significantly. Between 2020 and 2022, the academic production on trauma-informed practices in sex trafficking intervention highlighted the importance of continuing the research and academic conversation.

The current literature focuses on the trauma-informed approach, the survivor, and the healthcare professional. Additionally, I searched for academic literature on spirituality and entry-level for organizations working with sex trafficking survivors based on the research problem and the organization's profile. The search included peer-reviewed articles, and the results were from the last 3 years, from the databases APA Psyc Info, PubMed, and Science Direct using keywords like *spirituality, vicarious trauma, coping strategies,* and *sex trafficking*. Finally, an additional search following the reference list in critical articles. Even though there was no specific research on the entry level, several articles presented models of care implemented to serve the population and recommended

best practices, especially for healthcare providers in emergency rooms and other primary care clinics.

The research in trauma-informed approach informs healthcare professionals who interact with sex trafficking victims/survivors. Based on the review, current literature states that healthcare professionals are not trained to identify and address the needs of sex trafficking victims/survivors and require more information about collaborating with others to offer a safe environment to assess and assist those needs (Jain et al., 2021). Munsey et al. (2018) discussed the scarcity of research on trauma intervention with sex trafficking victims/survivors and the findings in one nonprofit organization residential program using trauma therapy and assessing the survivor's outcomes. Furthermore, the trauma-informed approach is interested in developing public policy and law regulations, as Scott et al. (2019) discussed. The Department of State (2021) argued the value of trauma-informed practices that follow principles to ensure physical and psychological safety in organizations, recognizing the impact of trauma at all levels. The most recent research in 2022 addressed the need to implement trauma-informed practices. Corbett-Hone and Johnson (2022) explained that when behavioral health professionals' quality of life is reduced due to burnout and vicarious trauma, the risk of decreasing the quality of service increases. Jain et al. (2022) shared recommendations for survivor intervention based on different organizations following a trauma-informed approach. Cunha et al. (2022) and Evans et al. (2022) 's research addressed the need to develop holistic and trauma-specific interventions for complex trauma survivors. Lastly, Chambers et al. (2022) stated that there is a consensus in the literature that trauma-informed practices are

a priority in serving sex trafficking survivors. The trauma-informed approach is highly recommended among professionals working with sex trafficking survivors.

A second theme most research has focused on is the sex trafficking survivors, their needs, and successful intervention. The current evidence-based research informed about mental health needs, barriers to accessing healthcare services, the presence of complex trauma, and interventions, including trauma therapy, art therapy, group interventions, and outcome assessments (Hopper et al., 2018; Jain et al., 2022; Koegler et al., 2021; Marburger & Pickover, 2020; Mumey et al., 2021). The common ground in the current research for sex trafficking survivors is trauma-informed practices. At the organizational level, there is a recommendation to develop survivor-informed and inclusive practices; however, there is not enough evidence about how to develop this approach. The Department of State (2021) warned about the importance of organizations listening to the survivors' voices and including their perspectives on programs, policies, and interventions. The survivor's voice is also considered when analyzing coping strategies like resilience (Knight et al., 2022). Moreover, Lockyer (2022) emphasized the need to include the survivor voice at the decision-making level finding meaningful and ethical ways to inclusion. Research confirmed the need to address trauma as a priority due to increased mental health issues among survivors.

The third area of research developed in recent years is exclusively on the healthcare professionals working with survivors, considering the challenges and impact on their mental health. Behavioral health leaders are concerned about the well-being of personnel working with sex trafficking survivors because of vicarious trauma, burnout,

compassion fatigue, and consequent employee turnover. Helpingstine et al. (2021) discussed organizational factors such as work hours, caseloads, and unfair policies as risk factors for burnout and suggested further research on trauma's effect on personnel's mental health. Ramirez et al. (2020) and Corbett-Hone and Johnson (2022) also discussed the impact of vicarious trauma in professional practice. Muelhausen (2021) and Namakula et al. (2021) addressed recommendations to avoid vicarious trauma symptoms and burnout. There is a need to further research and develop protocols to benefit the healthcare worker's well-being.

At the organizational level in residential programs there is little to no information regarding guidelines and best practices, which is the practice problem I outlined in the present study. Jirek (2020) discussed the organizational responsibility with employees and its impact on the quality of services. Koegler et al. (2021) discussed the essential elements of the service offered in organizations working with sex trafficking survivors, such as having a case management team, including crisis and counseling services and medical assistance. Ramirez et al. (2020) also recommended organizational actions to prevent burnout, including training, a culture of excellence, trust, respect, and professionalism. In addition, research suggested a comprehensive treatment that ensures safety and minimizes the risk of retraumatization (Iqbal et al., 2021; Jain et al., 2022; Koegler et al., 2021; Marburger, 2020). Organizations working with sex trafficking survivors need more evidence-based strategies to serve this population.

Lastly, literature on spirituality as a crucial factor for coping with trauma includes religious beliefs and their impact on subjective health. Walters and Benjamins (2022)

identified prayer, God's will, and the sanctity of the body as the three core beliefs that will benefit people working in the context of trauma. Talbot and Suzuki (2021) also concluded that prayer, God, and the church are effective coping strategies. Jerome et al. (2022) and Vieten and Lukoff (2022) emphasized that having a sense of meaning and a core belief system helps to reframe experiences and find a new perspective. Spirituality and faith practices have started to be explored in the last few years, and their relationship with trauma-informed practices and health improvement requires further research. The faith stance at the BHO might provide additional information on incorporating spiritual practices in a residential program.

Sources of Evidence

The research study's evidence sources were secondary data and semistructured interviews with behavioral health leaders. The secondary data came from the website, internal documentation, and public reports. The internal documentation included the manual of procedures, strategic plan, assessments, and others. The most significant source of evidence is the semistructured interviews with organizational leaders.

The interviews were conducted with four leaders at the senior and middle management levels. Interviews with the executive and operation directors were critical leadership positions to address the criteria outlined in the Baldrige framework and provided insight into the practice problem. In addition, clinical personnel such as the psychologist and the residential manager who leads the case management team were interviewed to comprehend the current practices and protocol to support the survivors and

personnel and correlate with the trauma-informed framework. All participants sign a digital agreement.

The interviews were recorded, transcribed, coded, and analyzed to relate to the practice problem. Triangulation is a method to analyze the information and helps to increase the study's validity (Ravitch & Carl, 2021). Yin (2012) explained that triangulation in case study research allows the researcher to generate analytical generalizations by following a theoretical framework that can be used in other situations. Therefore, the Baldrige and the trauma-informed frameworks might apply to other contexts and situations to further the research.

Furthermore, triangulation allows the researcher to access data from different sources and examine where the information converges and diverges. Following this method, the case study provides a depth of information to address the research problem (Ravitch & Carl, 2021). The information collected from secondary sources and interviews with behavioral health leaders provided the data to analyze and answer the research questions.

The entry-level in a residential program is the most challenging for the victim/survivor and the personnel due to the exposure to trauma, trauma symptoms, distrust, and vulnerability. Therefore, collecting data on organizational practices at this stage helped to identify the gaps and needs following a trauma-informed approach.

Particularly for the entry process, secondary data included:

- the application and referral documents
- the initial intake questionnaires and procedures

- the mental health evaluation at the entry-level
- the client's entry process

Lastly, I developed the analysis by relating this documentation and the interviews with the Baldrige and trauma-informed frameworks to find the most beneficial practices for behavioral health leaders and organizations serving this population. Moreover, I created themes that summarized the results to suggest recommendations to the BHO's leadership.

Leadership Strategy and Assessment

As a nonprofit, the BHO has a hierarchal governing board and leadership; therefore, executive, and middle management leadership positions exist. The management positions lead each one of the branches to develop the vision, such as outreach, prayer, and the residential program. The leadership develops an annual strategic plan, and the governing board approves and supports it. In the headquarters, the leadership team leads and communicates any innovative project to the stakeholders involved, including staff and volunteers. The senior leadership encourages communication and involves all levels in the decision-making process. Transparency and accountability across the organizational system reinforce a culture of excellence. The organization encourages ethical behavior in all interactions and ensures compliance with regulatory requirements, even when they are not mandatory, establishing a higher standard of quality in the delivery of services. The BHO has worked to develop a place in the community and the city as a collaborator in the continuum of care for this population.

Governance System

The BHO has evolved throughout the years from a prayer gathering to standing firmly as a faith-based nonprofit. The leadership team evaluates the organization's vision, mission, and values to develop strategic plans and discuss innovation. All stakeholders, the board, and the leadership team have approved and supported a strong faith approach. (BHL2 stated,

> We have shifted more because it is more in our favor to be outwardly Christian than kind of playing the middle because we can now, we can hire whom we want to hire based off of our core values and our belief system, and we can handle our program how we want to.

Some of the challenges the organization has faced due to the faith stance are limitations in government funding and access to staff who would adhere to the organization's core beliefs. Governance for the organization has transitioned from a hands-on board to a governing board as they have developed. The board has six members with backgrounds ranging from accounting law firms to entrepreneurs; they intend to grow it to 11 members. BHL1 informed that board members have a year tenure, every position is voted yearly, and they can only serve on the board for two consecutive years. Following this paradigm, the organization ensures accountability and avoids any kind of abuse. The board is divided into committees like facilities and asset management, the development council, and the finance committee, which work to achieve specific goals. In addition, the governing board evaluates the executive director's position for hiring, salary, and benefits.

Lastly, the board reviews, approves, and oversees the annual strategic and financial plans. Each board meeting is recorded, and minutes are collected and distributed to the board members. Organizations' governance ensures accountability in senior leadership, strategic planning, and transparency (Baldrige Performance Excellence Program, 2021); the board of directors plays such roles in the BHO and RP.

The BHO's website, which displays to the public, acknowledges the annual fiscal report and a yearly report for transparency in operations. For instance, the 2022 report indicates that the organization has had 94,000 minutes in prayer meetings in the last 10 years, 15,000 interactions with sex trafficking victims, and 50 survivors housed in their RP. The financial report indicates income and sources such as individual donors, churches, or other businesses. In addition, reports are that over 70% of the income is designated to develop the programs, 18% to operations, and the remaining for fundraising activities. The organization is committed to financial transparency for all stakeholders.

Collaboration is the preferred leadership style, from the senior leadership to the direct care staff, by empowering employees in decision-making and encouraging teamwork. The senior leadership collaborates when developing innovative ideas for any of the programs. For instance, BHL2 explained a process to start a new initiative for street intervention that included volunteer feedback by following a process with an initial brainstorming meeting with volunteer teams and assigning objectives to create a new initiative, the second meeting review the research or documents prepared by the teams and define a plan, followed by assigned tasks to go and test and come back with feedback

about the experience. The BHO has developed a collaborative culture; as a grassroots organization, stakeholder participation is vital.

The RP follows the same culture of collaboration with some differences due to the clinical approach. Therefore, the program is led by a case management team that includes the program director, a psychologist, a case manager, an addiction recovery specialist, the house manager, and an education coordinator. They collaborate to assess and direct the care model case by case. The case management team is autonomous in program implementation and empowered in the treatment decision-making process. The senior leadership supports the RP by overseeing the operations and managing the staffing process and other logistics, allowing the case management team to focus on treatment.

In sex trafficking, the survivor's voice is essential and goes alongside trauma-informed practices. Because of complex trauma, Evans (2020) stated that developing healthy relationships is crucial to the survivor's recovery. Evans continued to affirm that the recovery process requires learning experiences of trust and safety. BHL2 shared a practice they have during the intake process when the applicants go to the headquarters for an interview. This practice aims to create that sense of safety and model a healthy and respectful relationship with male figures. BHL2 shared:

> So, there are three guys in our office. And a great way for, this is a small thing, but I think it means a lot but a great way for the guy's first interaction with our residents to be because sometimes there can be fear between a woman interacting with a man… we want them to see us serving them as the first thing that they know with us. So, the guys always unload their bags out of the car if we have

> their permission to touch their things, and then we take them into the intake center. So, like we let the residents stay with the care team while we carry their bags up a flight of stairs and put them in the intake center. And then we leave, the guys leave. But that is a small interaction. But it is the way that most of these women have never been served by a man before or shown respect or decency by men. So, it is just a small way for us to break the ice and let them know, hey, XX is a safe guy, and he is not going to hurt me. And XX is a safe guy. And XX is a safe guy. They are not going to hurt me because we don't want there to be them to be startled because I walk around in the care home a lot for maintenance. So, I don't want them to be startled by seeing me or taking me off guard.

The example provided by BHL2 showed that such practice helps to reduce the tension in the new relationships between the survivor and personnel and becomes a learning experience of trust and safety. Trust and safety are essential in the entry process to ensure the survivor stays longer and achieves stability. Every person in the BHO must be sensitive and committed to trauma-informed practices.

Additionally, Lockyer (2022) encouraged being inclusive of the survivor's voice, beyond helping them to share their story or giving them surveys, instead giving them a voice at the decision-making level in a way that the survivor feels empowered. The only concern expressed by Lockyer is the risk of retraumatization; therefore, behavioral health leaders must be careful about disclosing information and ensure fair compensation for the survivor as an expert. The BHO is exploring different avenues to incorporate survivors'

voices by letting them review the learning material and open spaces for survivors' participation and support.

Performance Evaluation

The performance evaluation runs across the organization by encouraging open communication, supervision, and mentorship. For instance, the leadership team at the managerial level uses software to stay accountable for action plans. BHL2 informed about the Asana system:

> It is like a tracking system, a collaboration list making more glorified than just a list, like a to-do list, but where you can collaborate and share documents amongst team members and status reports and things like that. So, we try to keep all of our projects in there.

Additionally, the system allows them to stay accountable and evaluate performance at the peer level; BHL2 stated, "if we are not seeing people respond or meeting their deadlines, then that is an indicator for us". Furthermore, it starts a conversation about the reason for not meeting such expectations. Even though these might be simple performance measurements they serve the purpose.

Additionally, the organization uses a 360 evaluation for all levels, from direct care staff at the RP to the executive director. The 360 evaluations are completed by a peer, a supervisor (or superior), and one who is underneath (when applicable). According to the RP protocols the 360 evaluation includes six areas of competency: achievement focus, communications, managing/resident survivor focus, teamwork, planning and organization, and problem-solving. In addition, each person rates the employee from 1 to

5, where 1 is unsatisfactory, and 5 is an exceptional performance. These annual evaluations are reported to the board of directors for review and additional comments.

Legal and Ethical Behavior

The lack of a minimum standard of service for sex trafficking residential programs is a concern expressed in literature (Cunha et al., 2022; Iqbal et al., 2021; Koegler et al., 2021) and by the behavioral health leaders in the BHO. The legislation on human trafficking has been developed in the last 20 years after the Victims of Trafficking and Violence Protection Act of 2000 was published and addressed sex trafficking as one of the forms of human trafficking. Later in 2015, the Trafficking Awareness Training for Health Care Act of 2015 was approved to offer a grant to develop best practices for health professionals and disseminate such results. However, the legislation confirms the research's early development, and evidence-based practices have not been established at the state or national level. In fact, there are significant differences between one state and other regarding anti-trafficking legislation. For instance, BHL1 explained that they recognize as a risk factor the legalization of prostitution, a movement to legalize and decriminalize prostitution, pornography, pimping, and that is getting much traction both on the East and West Coast. Behavioral health leaders and public policy must address these concerns.

Rather than discouraging faith and community-based organizations, these challenges have propelled their ethical practices and collaboration. BHL2 stated that every employee hired by the BHO signs a privacy policy, a code of conduct, and a statement of faith to ensure confidentiality. Other measures to ensure safety and

accountability include financial controls for team members, frequent protocol reviews among staff, and footage reviews from the security cameras. Moreover, especially the residents are aware that they could directly communicate with staff members up to the executive director position if there is an incident they cannot address with their direct care staff, emphasized BHL2. The policies and procedures section for employees includes anti-bullying and anti-harassment policies, as well as off-duty conduct, whistleblower, and other guidelines for appropriate conduct and ethics, among many others. The organization has developed detailed policies and procedures to address ethical behavior, reinforcing it consistently. The trauma-informed approach emphasizes the importance of creating a safe environment to resist retraumatization, and ethical behavior is crucial to such a result. Ramirez et al. (2020) suggested that professionals working with human trafficking survivors must develop the four fundamental virtues of professional practice: integrity, compassion, self-effacement, and self-sacrifice (p.3). The RP core values are respect, compassion, community, communication, resilience, restorative care, and responsibility which address the virtues suggested by Ramirez et al. and encompass the standard of ethics in the organization.

The organization is compliant with regulatory requirements at the city level, like sanitary and fire codes. Regarding confidentiality, HIPAA compliance in all health records is crucial to the quality of care. Additionally, a shared health record is in place to avoid retraumatization in the entry process, informed BHL4. Jain et al. (2022) also suggested a shared health record as a trauma-informed practice.

Societal Contribution

BHO has earned a position in the city in the last ten years of operation because of its diligent care for sex trafficking survivors, from awareness to recovery. The BHO is well-known in the city for its social impact and pioneer work in the field. The behavioral health leadership has developed a culture of collaboration with other nonprofit organizations, law enforcement, anti-trafficking groups, advocate agencies, the Human Trafficking Rescue Alliance, and national partners like the referral hotline, informed BHL1. Through these partnerships, the BHO collaborates in surveys and research to improve evidence-based practices as they work together to improve the quality of services.

Additionally, the BHO awareness and street intervention programs directly impact society; for instance, in 2022, the BHO had 2,309 interactions with women involved in commercial sexual exploitation, 79 interactions with sex buyers, and 40 interactions with traffickers, as stated in the BHO's website. In addition, only in the RP did 248 hours of clinical therapy and 713 hours of education directly impact sex trafficking survivors. The organization's societal contribution potentially transcends the sex trafficking survivors and reaches other disadvantaged populations and healthcare workers.

Strategy Development

The RP leadership team is still developing the intervention practices and protocols; therefore, strategy becomes essential. In an interview, the BHL1 stated that no standard care protocol had been established for residential programs in the United States. The scarcity of evidence-based interventions becomes an opportunity to incorporate

trauma-informed and survivor-centered practices. However, it requires strategic planning to innovate and ensure ethical considerations.

According to the BHL2, the strategic planning process started with the directors' meeting to define the organization's vision, mission, and plan, including the residential program. For instance, in a recent meeting, the organizational leadership decided to continue offering their faith-based service and be known as a Christian organization. Such a decision impacts the funding strategy, focusing on church and donors' support instead of governing funding. The leadership team at the managerial level is responsible for strategic planning and execution. The board of directors oversees the execution of strategy and supports funding opportunities.

The BHO still lacks a data-driven strategy development process because there are no data collection tools to consider the strategic challenges. However, open communication in the system favors the discussion of such challenges as a starting point for the strategic planning process. Data collection is a valuable resource in strategic planning.

The RP's strategic plan for 2022 focused on developing protocols. One of the goals was to develop a program focused on stabilization, growth, and independence. The details in the goal include establishing a curriculum for the program, developing staff and resident handbooks, training staff, and more. The language of trauma-informed practices can be identified in the strategic plan even though it is not explicitly used as a framework. For example, the Blue Knot Foundation (2020) suggests five guiding principles in trauma-informed practices: safety, trustworthiness, choice, collaboration, and

empowerment. When examining the care model, these principles are implemented in the RP.

BHL2 informs that at the RP level, feedback from direct care staff and survivors are considered by the case management team and taken to the leadership team to develop new initiatives to enhance the services provided. Open communication allows the flow of information in the organizational system to improve as they recognize new needs and more evidence-based practices are learned and implemented. The case management team maintains lines of communication with all stakeholders, including the survivors and volunteers.

Innovation is part of the organizational culture and core values, and the leadership works to assess the community's needs and develop strategies to respond to such needs. For example, the RP itself started in 2019 as a response to the needs in the city because there are not that many recovery programs for adult women in the area. In the same manner, behavioral health leaders are constantly informing themselves about the city's state and the program's particular needs.

In 2021, the RP went under review with the support of an external organization that consulted and trained the team. As a result, the program was relaunched to include new strategies and a strategic plan to accomplish goals that will solidify the services and provide a treatment model with a trauma-informed approach from the entry level to re-integration. The ability to bounce back as an organization considering its challenges speaks about organizational resilience.

Strategy Implementation

The BHO leadership develops action plans for each one of the programs based on strategic objectives. The RP case management team is responsible for developing all strategic objectives and action plans. For example, the 2022 strategic plan stated the organizational goal as writing 100% of SOPs, policies, and procedures by Dec.31, 2022, and then developing specific goals for the residential program by stating strategy, tactics, responsible, date, measurement, next steps, and cost. The goals for the RP include completion of procedures; creating and publishing the care program focused on stabilization, growth, and independence; hiring and training personnel to manage the program encouraging staff retention; operating the 24/7 program; creating and publishing a transitional care program to provide long-term recovery; make addiction recovery central to the program. The goals are comprehensive to the core needs when serving this population, and 2022 seemed to be a year to solidify the efforts and focus on practices that encourage healthy growth. The BHL1 shared that the organization when through an almost complete employee turnover in 2021; therefore, the efforts in 2022 were to ensure sustainable organizational growth.

The case management team is crucial to implement action plans and developing connections with partners and other collaborators inside and outside the organization. Unfortunately, no clear performance measures or indicators exist other than verbal accountability. However, the measurement described in the strategic plan is specific; for instance, for the goal to hire and train staff members, a tactic to achieve it is to schedule a training per team per year, and the measurement is staff member attendance to such

pieces of training. Therefore, a tracking system will be beneficial to measure goal achievement in the future and make the organization data-driven.

The case management team meets weekly to review the cases and address any policy and procedure matters that might need attention. The case management team is fully involved in the program intervention from intake to graduation. The case management team also facilitates training for the new personnel hired and ongoing training for the team and volunteers. The case management team is central to the strategy implementation.

Population Served

The RP serves adults 18 years and older, biologically female survivors of sex trafficking. The program understands sex trafficking following the definition by the Victims of Trafficking and Violence Protection Act of 2000 (2000) which defines "sex trafficking" as the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. The RP serves exclusively biologically female survivors. BHL1 informed that the first encounter with the population is through a street intervention program or referral in collaboration with other agencies. During the street intervention, the team approaches the women offering essential resources to supply their immediate needs and develop trust through the relationship. During these encounters, the intervention team provides information about the program and the way out of "the life." The application process starts once a survivor shows interest in entering the program.

The BHO's website informs that the four steps include filling out the application, interview, acceptance, and program intake. However, the majority of the applicants come from a referral form, which means that survivors from all over the country might come to the program referred from other partner organizations; Behavioral Health Leader 3 (BHL3) stated that typically the women that are coming to the program have already been in a stabilization program, emergency safe house. So, they have already had have started to adjust to a program like an environment. That benefits and expedites the entry process because most women who have experienced drug dependence have already overcome the detox stage when entering the RP.

According to the RP protocols, the entry process could take up to two weeks. The first step requires filling out an application and approval of a background check. BHL2 informed that the interview includes background history, medical evaluation, and other assessments. Next, at least two case management members meet with the applicant to interview. Having several team members interview the applicant is crucial in the trauma-informed framework. Ramirez et al. (2020) warned that healthcare professionals working with sex trafficking survivors might experience affective and behavioral responses, and the survivors face several psychological challenges due to the trauma exposure. Therefore, a coordinated and collaborative effort to interview the potential resident is a trauma-informed practice that benefits the survivor and personnel's well-being.

Customer Expectations

Once in the program, the resident joins the care model developed by the program aiming for stabilization, growth, and independence. A series of activities focusing on

their personal goals, spiritual instruction, academic enrichment, addiction recovery, and therapeutic intervention provides a safe recovery environment. The Blue Knot Foundation (2020) included the clinical guidelines that facilitate client safety as the treatment priority. BHL2 discussed the importance of inquiring into details such as likes, dislikes, and triggers and communicating that to the staff to ensure the individual feels safe and supported. The intake process and orientation phase are all about physical and psychological safety. The RP aims to ensure a safe environment to develop trust and stabilization. From a trauma-informed approach, the Blue Knot Foundation (2020) proposes a pivotal question to evaluate safety in the organization "Do consumers receive clear explanations and information about each task and procedure? Are the rationales made explicit? Does each contact conclude with information about what comes next?" (p.23). The procedures established by the RP positively answered those questions and clearly provided safety and choice to the residents.

According to the internal documentation, the program's philosophy is faith-based (Christian), program-centered, empowerment-focused, and trauma-informed. The residents have been informed about the program's philosophy since the application process. BHL3, who leads the intake process, states:

> We say we are faith-based from the very beginning. Yeah, I know that there's there's um, ladies out there who have been come from like a cult. They have experienced things like that. So if, say I have an applicant or someone an advocate calling in who has a lady who is been, uh, had satanic ritual abuse, you know, a ton of it, or has been in a cult I always tell them you need to tell them and make it

> very clear to them that we are faith-based. Are they okay with that? Is that going to trigger them? Is that going to make it hard for them? I have actually have had advocates say like, you know what, they thought about it, and they are not ready, and that is okay.

BHL3 continued to explain that throughout the program, they give them the power of choice; they are never forced to participate in any spiritual activity; for instance, if they do not want to participate in the Sunday service experience, the residents can just wait in a designated area until the rest of the group is ready to return to the home, they are not forced in any activity because incidentally, that is precisely how they have been victimized. One of the trauma-informed principles is choice; the Blue Knot Foundation (2020) proposed questions to evaluate the implementation of the trauma-informed principles; one key question they address for choice is: "Does the program build in small choices that make a difference to consumer-survivors" (p.25). The RP offers that choice ability from the application process, which increases trust.

Moreover, BHL3 expressed the impact of those small choices on the survivor and the organizational culture by sharing the following:

> Because I always tell, I even tell the residents, love is not love without a choice. And a lot of times for these ladies, choice was given in the way of manipulation, like, oh, you know, or just not giving at all. So, we have the beautiful opportunity of giving, like showing choice, authentic choice.

Furthermore, the program develops trustworthiness, empowerment, and collaboration in the interventions following the care model and creating a service for this

specific population. The adherence to a trauma-informed framework is evident in the language and in the daily practices.

In addition, the organization is highly committed to confidentiality, and employees must sign a privacy policy to ensure it. BHL1 stated,

> We do comply with HIPAA. We're not forced to comply with that. But we really are, so like all our medication logs, all of the ways that we communicate about resident personal and private health information, all of that is HIPAA compliant, and we have a compliance software as well with Limited access to stuff.

The clients are aware of the confidentiality policy, and that increases trust. The clinical psychologist establishes even a higher standard of confidentiality, stating:

> So on the front end, to safeguard residents and to be very ethical and clean in our practice, we have individual consents for the various aspects of care that I individually go over and explain each piece in plain language and discuss. So, they are first consenting for psychotherapy, which is its own document. And I think this is a piece that a lot of programs miss, but it's so important. I am incredibly explicit about what information I will share as part of their program participation, particularly because I'm a psychologist, right? I'm not; I'm not there as like in some other in some other like unlicensed role. So, I am like holding myself to a higher standard.

The other unlicensed personnel are also trained on HIPPA compliance even when they are not bound to comply, but they understand the ethical considerations associated with their intervention. Such commitment to confidentiality and ethics is crucial in the

entry process to maintain safety. The RP goes beyond expectations to create a safe environment for the survivors.

Customer Engagement

The particularities of the sex trafficking survivor population call for a different approach to the relationship between the healthcare provider and the customer/patient. Hershberger (2021) addressed the particular needs of sex trafficking survivors in terms of relationships because the trafficking experience distorts their understanding of safe relationships, creating a sense of shame and self-blame in the victims. Hershberger stated that the sex trafficking dynamics is the ultimate anti-relationship due to marginalization, sexism, racism, classism, and unfettered commodification (Hershberger, 2021, p.457). Hershberger proposed the relational-cultural approach based on developing an authentic relationship, mutual empathy, and mutual empowerment. Therefore, healthcare providers could create new relational images and model healthy relationships. Evans (2020) also stated that the provider could model healthy attachment by offering a supportive relationship to the survivor. Evans also encouraged the presence of other survivors as crucial to the recovery (Evans, 2020). Therefore, the challenge for staff working with sex trafficking survivors is developing trust and empowering them to grow psychologically.

The organizational culture plays an essential role in customer engagement; for instance, open communication and clear channels to address concerns and complaints are vital to relationship building. In the RP, the residents are encouraged to communicate their needs to the residential staff, and if there is any issue, they can communicate with the program director. The hierarchy does not limit communication; instead, there is

access to all levels, and openness is encouraged. The residents can also communicate in a private channel with the psychologist, ensuring confidentiality; the psychologist, shared that residents are given access to a patient portal, which is very like healthcare model oriented so that they can always have private and HIPAA compliant communications with me. Access to confidential communication with the clinical staff is a reliable form to engage with the residents/survivors.

Zavaleta et al. (2021) emphasized that the lack of survivor participation in developing protocols and best practices might increase the inconsistencies in the intervention at multiple levels. Lockyer (2022) also stated that including survivors' voices and representation at the decision-making level is crucial. BHL3 informed that the RP is developing strategies to incorporate the survivor voice at different levels; at the intervention level, the residents interact with other survivors in a group setting throughout the program, and they might interact with alumni (other women who have graduated from the program), and currently, the organization has hired a survivor as part of their staff. Also, survivor consultation at the program level was done as they developed the care model, according to BHL4. The organization could work further on developing a survivor-centered program as they continue to grow.

The survivor's voice is a priority to the case management team, and it impacts even the language; BHL3 shared these experiences:

> I even listen to our residents if they are like like I had one who was like, Why do you say clients? I feel like I'm working. I was like, okay, fair. I was trying to be

> like like give it give you value by saying client. And you're looking at it through the perspective of like a client. And so, I shifted my language to residents.
> We were being real cautious to make sure we didn't make the program. Um, like we wanted to say, the completion of the program but we have where all of our residents are like: No, I want to graduate. And so, I'm like, okay, we're going to have to shift that because they want the title graduate on it, because to them, that's how important this is. And so, we're listening to those things and shifting, as we're listening to them.

Listening to the survivor and making adjustments to build trust and healthy relationships is a trauma-informed practice encouraged in literature. Language plays a vital role in developing trauma-informed practices, and the survivor's experience and voice are essential to comprehend and build an empowering narrative.

Analytical Strategy

The qualitative research used the case study method to find in-depth information on one behavioral health organization working with sex trafficking survivors in a residential program. Yin (2012) explained that an in-depth case study provides a multitude of variables to explore further or describe a phenomenon. A case study might be exploratory, descriptive, explanatory, or evaluative; the descriptive mode allows the researcher to present a unique situation (Yin, 2012). I aimed to describe the trauma-informed practices in a residential program serving sex trafficking survivors. The case study followed an embedded single case design, according to Yin (2012). I used several sources of evidence in the case study, including interviews and secondary data, such as

internal documentation (Ravitch & Carl, 2021). The data sources included semistructured interviews with four organizational behavioral health leaders, detailed interview notes, the RP procedures handbook, application and intake forms, website information, and email communication.

Theory plays a crucial role in research because it provides a framework to comprehend and contrast the data collected, allowing the researcher to generalize (Yin, 2012). Yin also explains that when using a case study is possible to arrive at an analytic generalization by following two steps, one, the case study informs a set of concepts, and two, apply the same framework to other situations where it might be relevant. For that, triangulation is a practice that can be used throughout the study to corroborate the findings (Yin, 2012). Triangulation was the strategy I followed in this case study.

The Baldrige and trauma-informed frameworks are crucial to understanding the practice problem in the present study. The Baldrige framework offered a set of helpful principles and included seven categories to assess healthcare organizations: leadership, strategy, customers, measurement, analysis and knowledge management, workforce, operations, and results. In addition, the framework offered a criterion to improve the services and functions as a reference to assess the residential program service offer. The trauma-informed framework is based on five principles: safety, choice, collaboration, trustworthiness, and empowerment (Iqbal et al., 2021), and they are crucial to understanding the practice problem and answering the research questions. Yin (2012) suggested a pattern-matching logic comparing the findings with the pre-existing

principles, in this case study, provided by the Baldrige and trauma-informed frameworks in this case study.

Another source of evidence was the semistructured interviews with behavioral health leaders in the organization. I interviewed behavioral health leaders in the senior and middle management levels to assess the Baldrige framework's different areas and inquire about the practice problem. The behavioral health leaders consented to the interview and signed the agreement digitally; the interviews were recorded in the Zoom platform and transcribed using the cloud-based software called Sonix.

After being transcribed, I transported the data to an Excel document to code in three phases manually. Ravitch and Carl (2021) stated that there are different approaches to coding, but in general, it means assigning meaning to the data collected. Coding is the first step to analyzing the data; later, it generates themes or categories and continues to identify if the data diverge or converge with the Baldrige and trauma-informed frameworks, using triangulation.

Lastly, the researcher plays a role in interpreting the data; therefore, as a researcher I kept a record of the interviews and further analysis. Ravitch and Carl (2021) stated that researchers must be aware of their interpretation of the world and position themselves on a critically reflexive process. Therefore, as a researcher, I kept a record of the interviews and secondary data analysis and followed the ethical standards established by Walden University, including consent, confidentiality, and organization masking.

Archival and Operational Data

Following the Baldrige framework to assess the seven categories, the secondary data collected included the website, internal documentation such as strategic plans, minutes, protocols, and employee manuals, that were accessible because of permission granted by the senior-level management. Most of this documentation was developed by the case management team and senior management, and it is accessible to the personnel. Having easy and full access to this documentation was beneficial to the research.

Additionally, the research problem focused on the entry level. Therefore, revising entry process data was essential to analyze the practices. Some documentation reviewed was the application and referral documents, the initial intake questionnaires and procedures, and the mental health evaluation at the entry level. Also, statistics and yearly reports as performance measures were considered for analysis. The organization granted permission to review the documentation.

Participants

Data was collected in semistructured interviews with two behavioral health leaders at the senior level and two middle management leaders in the residential program. The behavioral health leaders at the senior level were relevant to address the criteria from the Baldrige framework and some specifics about the practice problem; the leaders who are part of the case management team were crucial to the practice problem regarding trauma-informed practices benefiting the survivors and the personnel well-being. The senior and middle management leaders combined provided a complete perspective on the organizational culture and practices.

The interviewees consented via email to participate, the research problem was discussed with each person, and time was dedicated to answering questions regarding the research and the interview. A confidential environment was ensured. The interviewees consented for the session to be recorded and transcribed. Some information was corroborated via email to ensure accuracy. The participants did not receive any compensation for participation.

Data Collection

After receiving approval from Walden University's Institutional Review Board (#08-30-22-1038177) and under the partner's agreement with the organization, interviews were arranged at the convenience of the organizational leaders. The executive director granted access to the internal documentation to use as secondary data. The revision of internal documentation led to analysis and informed the interviews with behavioral health leaders in the organization. The secondary data requested included:

- Strategic Plan 2022
- Procedures Manual
- Protocols
- Website
- Yearly reports (public access)
- Financial reports (public access)
- Care model curriculum
- Training material

The executive director authorized access to a web-based table of contents of all protocols and procedures for the residential program. The table of contents is linked to other documents, and access was granted as needed. In addition, communication via email with senior management allowed me to cross-check information and ensure accuracy.

Summary

Section 2 describes the supporting literature on the relevance to the practice problem. There is a growing need to further research the practices within a trauma-informed framework in the context of sex trafficking survivors. The scarcity of evidence-based guidelines for residential programs is the first challenge for behavioral health leadership in this kind of organization. The nonprofit organization works in collaboration with other entities at the government and community level to establish protocols and better serve the population. The organization clearly defines the population and works intentionally to ensure positive outcomes. Trauma-informed practices were identified when the organization engaged with the sex trafficking survivors.

Section 3 will address the workforce, the second group to consider from a trauma-informed framework since they are as vulnerable to trauma as the client. The workforce environment is crucial to the personnel's well-being and the clients. Therefore, it is vital to research the workforce characteristics in the residential program and how they engage in operations. Lastly, knowledge management and organizational learning are assessed for future recommendations.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

Sex trafficking is a growing worldwide concern, and women are the most affected by this form of modern slavery (International Labour Office, 2017). Nonprofit organizations are on the frontline reaching these women on the streets and empowering them through programs like the RP offered by the BHO of this case study. Cuhna et al. (2022) stated that addressing the psychological trauma in human trafficking victims is a priority and concluded that there is a need for further research on this topic. Additionally, Helpingstine et al. (2021) stated that due to the long-term treatment required by sex trafficked survivors and the presence of complex trauma, the personnel might experience vicarious trauma and burnout. Therefore, the case study researched the trauma-informed practices that behavioral health leaders could implement in organizations benefiting survivors' and personnel's well-being, specifically at the entry level, when there is more vulnerability.

Section 1 provided the organizational profile and key factors following the Baldrige framework, and Section 2 presented the leadership, strategy, and population served. Section 3 addresses the workforce, operations, and knowledge management. The Baldrige framework offers criteria for excellent performance in healthcare organizations. These three sections considered such criteria.

The research method focused on semistructured interviews with behavioral health leaders to gather information about the organization and relate it to the practice problem. Additionally, secondary data, such as internal documentation, were a source of evidence

provided by the organization's leadership. The sources of evidence provided in-depth information needed to analyze the organization.

Analysis of the Organization

The RP is one of the branches of the BHO, whose mission statement stated on the website is to end human trafficking through prayer, awareness, intervention, and restoration. The mission is the organization's driving force, leading the workforce environment. The RP is the restoration piece in the mission by housing female survivors to re-integrate them into society.

Workforce Environment

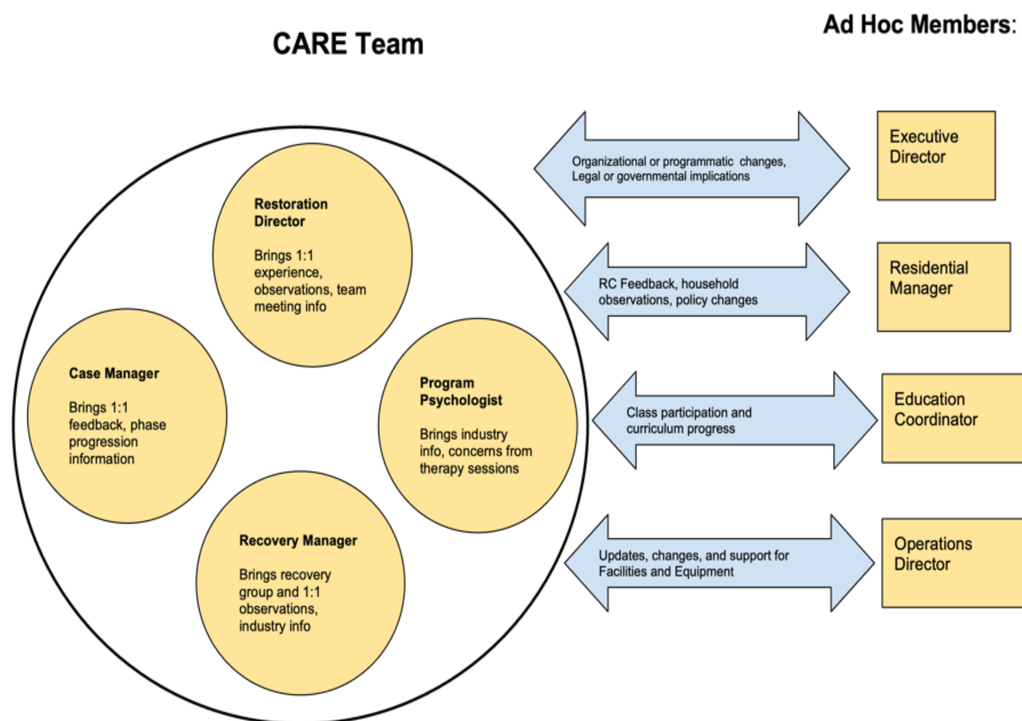
The workforce is encouraged to join the BHO's vision as change makers in four ways: fidelity to Jesus, innovation, humility, and resiliency, according to BHL2. In addition, the workforce is challenged to engage with the organization's core values. The agreement with core beliefs and values is a priority in the hiring process. Behavioral health leaders at the senior management affirmed that engagement with the core values and beliefs is non-negotiable in the hiring process.

The RP has 13 employees, with eight direct care staff as residential coordinators for the day, night, and weekend shifts. Five employees formed the case management team, which handles the progress in the care treatment model on a case-by-case basis. Figure 3 shows the distribution of responsibilities for the case management team, who carry most of the responsibility of internal work processes, including education, mental health treatment, addiction recovery, and coordination of other health services. Some Ad

hoc members do not participate in the daily operations but rather alleviate administrative tasks, allowing the case management team to focus on treatment.

Figure 3

The Case Management Team and Ad Hoc Members



The BHO has developed a hiring process which takes around 4 to 6 weeks; it is a thorough process that includes several interviews, assessments, background checks, references, and an interview with the case management team to evaluate affinity and make the final decision. The BHL2 stated that a deal breaker is an agreement with their faith statements and core values. The faith statements include a commitment to Jesus Christ and boldness, fostering innovation, justice, and mercy. BHL2 informed that after the initial interview, the applicant must answer three questions regarding the core values.

There are simple questions and short answers; however, around 50% of people do not continue with the hiring process when asked to follow this step. Knight et al. (2022) concluded after interviewing several Christian organizations working with this population that there are shared values with social work and that many of the ideas about a Christian antitrafficking discourse motivated by disrespect and a disempowering narrative do not reflect all individuals or organizations, a concern that other health professionals might have expressed. Instead, the approach to social justice based on Christian values seems favorable to addressing this population and workforce engagement.

BHL2 shared how the managerial team met for strategic meetings and retreats to analyze developing the mission and vision in the context of their nonnegotiable core values and Christian beliefs. In the last 2 years, the organization has been even more outwardly spoken about as being Christian and a faith-based organization. However, BHL2 clarified that they do not turn people away because of their belief system; if the person fits the criteria and agrees to the care plan and expectations, they can join the organization, even if they participate in another religion. One of the challenges encountered by standing in this position is staffing because, within the nonprofit space, there is a limited spectrum of people willing to help; many might be altruistic and self-motivated. However, their experience has shown that such motivation runs out quickly, and the people experience burnout because the demand of working with sex trafficking is so taxing. Therefore, the BHO's leadership believes that a person with a robust belief system who joins their program will have additional resources, spiritual strength, and motivation to work with the survivors longer, bringing stability to the residents and

themselves. Knight et al. (2022) stated that Christian faith-based agencies are among the first service providers for sex trafficking survivors. Therefore, the faith stance is a strength and a protective factor for the employee.

The RP's leadership is fully aware of the risk of burnout and is actively searching for strategies to increase employee retention. The metrics for 2022 indicated that 11.83 out of the 13 employees have stayed in the organization, which is a positive employee retention rate and an improvement compared with 2020-2021 data with an almost complete employee turnover. The organization's culture and climate are also crucial to the professional's well-being. Corbett-Hone and Johnson (2022) emphasized the need to find organizational strategies to prevent burnout instead of only leaving it on the shoulders of the professional. The organization must be proactive in creating a positive workplace climate, and behavioral health leaders must be aware of demand and workload, which frequently are the cause of burnout. Paying attention to these factors is a determinant of the employee's well-being.

Regarding trauma-informed practices that foster a culture of open communication, resilience, and compassion satisfaction, the RP hosts weekly team meetings to discuss the residents' progress and address any concerns or policies' clarification. A quarterly meeting to develop team-building activities and review training to refresh or learn new concepts, according to BHL3. In addition, the RP benefits all employees with 52 therapy sessions with the professional of their choice. The employee manual also references vacation days and sabbaticals, encouraging self-care practices.

Workforce Engagement

The Baldrige framework (2021) suggested assessing workforce satisfaction based on measures or indicators; however, the organization has not developed such instruments. On the other hand, the organizational culture of communication and empowerment informs about these criteria. For instance, training is a crucial element of workforce engagement, and from the hiring process, the organization promotes the trauma-informed framework; hence the new employee must follow a training process with established goals for the first 2 weeks, within 30 and 60 days, described in the employee manual. Furthermore, BHL3 informed that personnel can access the EDU Hero Mental Health platform and mentorship with the Samaritan Women Mentorship. The training process benefits the employee by obtaining certifications and personal growth in trauma; such benefits transcend the current workplace and are a lasting benefit for the employee.

On the other hand, internal documentation established the distribution of responsibilities using tools like the RACI Matrix Chart, which includes daily operations tasks and the corresponding assignment to each staff member as Responsible, Accountable, Consult, and Inform. The RACI matrix allows internal accountability and encourages collaboration. The internal documentation also provides job descriptions for each staff member and SOPs to ensure the quality of the service. The BHL3 stated, "we measure the effectiveness by what type of impact it has on the residents in our program and by feedback from staff who are implementing the daily operations." These indicators are relevant to assess performance and additional tools might be developed in the future.

Behavioral health leaders in the organization expressed concern about employee turnover due to burnout and vicarious trauma. Corbett-Hone and Johnson (2022) concluded that burnout is consistent among providers serving sex trafficking survivors. They identified that professionals with a history of trauma or shared trauma had higher vicarious resilience than those without. Furthermore, Corbett-Hone and Johnson concluded that providers might use these experiences as a source of strength and growth. However, PTSD symptoms increase the risk of burnout, and professionals must be aware of this. In the RP, the program director stays in touch with every employee not only to evaluate performance but primarily to address any concerns in their daily life and mental health; for instance, BHL3 stated:

> So, what I am seeing is this job, like, if you have a lot of, um, troubles, personal troubles or issues that are happening outside, it does not leave a lot of room for the, like, professional troubles. Yes. So, if someone is struggling. It is like a cup. Their cup is already full, and then a little bit at work will tip it over, and then you start to really see the burnout. So, to have a like an understanding of not to get too much because we always want to maintain a level of professionalism. Sure. So, um, so but just to be aware, my car broke and I'm going to be late. Okay. That mental note, they're going to be dealing with car issues. So, keeping that in mind, if okay, I know because of the shift change notes that yesterday was a really hard day. They had to deal with a lot of issues. I know that they're dealing with car issues personally, so I need to make it a point to have my house manager checking in with them more frequently.

Behavioral health leadership is aware of the need to address performance from a different perspective due to the trauma environment and increased risk of burnout. Moreover, self-care strategies are crucial for the employee's performance and, therefore, the quality of service provided (Corbett-Hone & Johnson, 2022; Posluns & Gall, 2020). To increase workforce engagement, the organization also evaluates workload and schedules, which is an essential practice with direct care staff, who might be at higher risk of burnout.

Work Processes

The RP has developed a culture of collaboration and innovation in their service delivery based on the survivors' needs. Koegler et al. (2021) stressed the relevance of addressing basic needs, physical health, and assessing mental health at the entry level. The organization considers the entry process since the online application form is completed until the survivor achieves emotional stability, which might take up to 6 months, according to BHL4. After that, the resident moves up to the phases of growth and independent living, which is the final goal.

The case management team has established nonnegotiable resident services, including identification, medical and dental, addiction recovery, mental health, legal, other benefits, education, and employment. However, the organization does not guarantee to provide services such as cosmetic dental work, elective medical surgeries, pregnancy termination services, acupuncture, massages, management of debt forgiveness, car buying, or rental assistance. Besides, the organization partners with community resources to supply some of the survivor's needs, such as family reunification, long-term housing

support, employment support, and mentorship programs. The residents know the service offered, which clears their expectations from the entry level.

The care model program establishes resident-focus objectives, progress markers, and case management objectives to lead all work processes. The day-to-day operations followed the processes. According to BHL3, the daily routine in the RP includes the following:

7 am. Wake up time. Monday through Friday. – Get ready, take medications, and eat breakfast.

9 am. Daily devotional

"Someone leads a lot of times they have a little daily devotional book they'll read out of their prayer. You don't have to pray out loud. You don't have to read out loud. But we do ask each resident coming in to be present at that time," explained BHL3.

10 am – 12 pm. Classes (Bible, faith-based, life skills, trauma-focused, academic)

12 pm. Lunch

Afternoon. One-on-one meetings with the case management team, therapy, and tutorials with the education and recovery coordinator. Meeting with advocates and mentors.

5 pm. Dinner

Evening. Celebrate Recovery group (Mandatory on Monday). Tuesday rest day or AA meeting in person (optional). Wednesday, attending church service. From Thursday to the weekend is rest time.

Saturday. Late wake-up time. Survivor-led meetings. Activities planned by the house manager.

Sunday. Church service. Grocery pick-up. Relaxation. Clean the room and get ready for the next week.

The daily operations reflect the RP's philosophy as faith-based (Christian), program-centered, empowerment-focused, and trauma-informed. All activities revolve around the philosophy and service offered. Additionally, the residential coordinators keep track of medical and dental appointments, which are outsourced. Partnership and collaboration are essential to the achievement of objectives. The case management team looks for partners who can supply different needs; for instance, one person comes to do physical activity program with the residents, some advocates help the residents with specific needs, and additional spiritual mentorship and healing process are available. Collaboration with partners is essential to achieve goals in the organization.

Regarding innovation, the case management team constantly assesses needs and processes. The RP was relaunched in July 2022, and they are affirming the work processes. Accordingly, during the weekly meetings, the case management team discusses if new ideas or processes are required as the residents move up in the program and the processes are implemented. For instance, BHL3 stated that two of the residents are now allowed to go on a bus by themselves to the recovery meeting or a new job, and this required establishing a series of protocols and procedures to ensure their safety. The direct care staff does not lead the innovation processes; however, they communicate the needs and ideas as they encounter new challenges in the delivery of services. BHL1

stated that an open communication culture allows them to discuss such ideas and needs with the case management team, who will establish new procedures, implement, and evaluate them. The accomplishment of daily operations and processes relies on collaboration and communication.

Operational Effectiveness

The daily operations in the RP are managed by 8 residential coordinators who are full-time (40 hours) on up to 13 shifts. However, the program director aims to schedule no more than 12 shifts to prevent burnout. BHL3 informed:

> But what I had tried was trying to bring down their shifts, so. The way it works is technically for per 40 hours, per full time status. I could put a Residential Coordinator on shift, 13 shifts per month, but I never put anyone on 13 shifts. Typically, it's 12 shifts. I leave that 12 hours because I know that they're going to actually have to get on and talk about work on Fridays on our weekly meetings. And so, we're giving room for those training pieces to be covered in that full time status, those 40 hours per week, so to speak, if you break it all up. Yeah, I tried when I started to see burnout happening, I tried to pull people down to maybe 11 shifts if possible. I don't think that worked. So now what I'm trying is to go back up to the 12 but have more coverage to where it's overlapping… I'm hoping that because there's two, it won't feel as taxing on just the one. And I'm suspecting that that will actually be successful because when we start to see a more burnout, we jumped in and started to be real, real present. And I feel like we've kind of come back from that. So, um, we'll see if it works.

The statement by BHL3 speaks about the intentionality of behavioral health leadership in the organization to prevent burnout because it directly connects with the quality of services. Ramirez et al. (2020) concluded that organizations working with trauma survivors must implement interventions to prevent burnout, such as training. Furthermore, the organization must promote a culture of excellence, openness in decision-making, a culture of trust and respect, and access to mentorship. The RP's awareness of mental health risks is critical to operational effectiveness.

Security and cybersecurity are priorities for the RP because of the population's characteristics. First, the RP location is not disclosed on the website or any other online format; only trained volunteers and personnel know the location and are asked not to share it with others. There are electronic safeguards; for instance, BHL1 indicated:

> There are firewalls on the computers and access to the internet and all that stuff in an effort to keep the residents safe from or reaching back out to their pimps or whatever…And then we also have cameras in non-private areas, so we can always access that 24/7. It's streaming all the time and it gets reviewed by leadership as well periodically.

Safety is crucial for sex trafficking survivors; these measures protect the residents and personnel. Protocols and procedures to address sexual harassment, bullying, confidentiality, and ethics are discussed with personnel in the hiring process and enforced in the organization. Additionally, the personnel is trained on safety measures in case of a crisis; for instance, they have on their person at all times an ID card, and on the back of the card, there is an acronym SAVED that indicates the immediate steps the employee

must take: Stabilize the situation, Ask and Assess, Verify the severity with the matrix, Execute next steps, and Document the incident, according to BHL1. The personnel can also access panic alarm buttons and emergency contact numbers and dial 911 on their phones if needed. These measurements ensure safety in the residential program.

Researchers have stated that sex trafficking survivors experience mistrust, fear, and shame, making it more difficult to establish connections with others (Hershberger, 2021; Mumey et al., 2021; Stanford et al., 2021). So, therefore, creating a safe environment goes beyond the practical aspect of security to psychological safety. The entry process in the RP is very intentional in developing trust; for example, BHL1 stated,

> Always having like two people on staff at any given time. And so that really creates there's never going to be like one staff in the home with a bunch of residents. And then it becomes like this weird power dynamic that we are trying to stay away from that… also, no men are ever allowed or able to be with a resident alone at any time.

Furthermore, the residents are encouraged to learn safety in the initial orientation phase, as they face people from outside the program, as explained by BHL3:

> So, like with the classes, you are introducing different perspectives. What does safe people look like? Seeking safety? safety. safety. safety into the, um, the classes. And then with case management, she is introducing like what is like the, the let's look at now that you're settled and that you have decided to move into a new life, what are goals, what do the goals look like you know, so she's starting to

> build that out with them what are safe contacts so we have where she's she's cleaning up like is mom a safe contact? Has did you think mom was a safe contact? But you're actually starting to notice that Mom is not a safe contact. So, does she not need to be on the list? So we're just, you know, we are working on that recovery.

The organization has overcome significant challenges, such as the COVID-19 pandemic, and recovered with new ideas and strategic planning for the future. They have also experienced natural disasters like a storm freeze that caused house damage. The personnel, especially the leadership, have addressed these issues and found solutions to ensure safety. The RP leadership and residents have endured such hardships thanks to the partnership support and organizational resilience.

Knowledge Management

The Baldrige framework (2021) states that measurement, analysis, and knowledge management are the foundation for a fact-based, knowledge-driven organization. Even though the RP is in its early development, there are essential practices to manage the information they have already implemented. For instance, as part of the induction process, the employee must learn to use software to manage information with confidentiality. Confidentiality is a crucial aspect when serving sex trafficking survivors.

Physical safety is essential for the survivors; however, information safety carries the same relevance for this population. The trauma-informed framework emphasizes that in the stabilization stage, the person needs to feel safe, and the environment must be confidential to ensure the survivor's well-being (Blue Knot Foundation, 2020). The RP

receives a referral from other organizations, and even from that process, confidentiality is assured by securing digital files and coding personal information. In addition, the employee in the hiring process must sign a confidentiality agreement.

Technology training is part of the induction process, and each employee must learn to use the following programs:

- Asana: web-based work management platform (https://asana.com). It is mainly used to manage tasks and projects as a team.
- Bamboo: is a human resource platform to manage employee data, manage the hiring process, manage payroll and benefits, and measure the employee experience (https://www.bamboohr.com). It is unknown the extent that the RP utilizes this resource.
- Slack: is a platform for work communication (https://slack.com). The case management team uses it.
- Grasshopper: is a virtual phone system for small businesses with features like business texting and forward calling. It allows for keeping business separate from personal communication (https://grasshopper.com). Another layer of confidentiality, but also a safety feature for the employees.
- Trainual: This is a web-based platform to manage processes, policies, people, and the company; it is designed for small businesses (https://trainual.com). It is unknown the extent that the RP utilizes this resource.

- Google Suite: is a cloud computing, productivity, and collaboration tools market by Google (https://workspace.google.com/lp/business). The secondary data accessed for this research was retrieved from this platform.

The RP has established several web-based software to manage human resources, communication, and data. For instance, the software Asana was explicitly mentioned by BHL2 in an interview, indicating that it is mainly used at the executive level to manage projects and deadlines. Furthermore, the internal documentation that includes employee and resident manuals is managed on google workspace; this resource allows the management team to give specific privileges to the team members to view, edit and comment.

The case management team handles with extreme confidentiality the information about the survivors' progress in the program and has specific folders designated to each survivor and stored digitally. The documents are secured on the online platform, and only the case management team can access such documents. Even though it is not required for the nonprofit organization to be HIPAA compliant, the RP follows the requirements to ensure confidentiality and manage the information correctly. The case management team uses the web-based software Therapy Notes (https://www.therapynotes.com) to keep the electronic records of the survivors.

The psychologist explains HIPAA compliance and the importance of these methods to develop trust with the survivors; they can access their information at any given time; regarding privacy and confidentiality, BHL4 indicated:

> They have their own patient portal to communicate, and they are given a checklist for all mental health services that will be provided to them as part of their rights to, you know, a high standard of care. So, they are given that any form or policy that they ever have to sign is given to them as well.

Evans (2020) discussed the crucial role of relationships in sex trafficking survivors, as the provider creates an ongoing experience to learn trust and safety because it was damaged in the relationship with the trafficker. BHL4 explained it based on their practice:

> Because women that come in with sexual trauma have been dehumanized on almost every different level. So, we're trying to give those pieces back wherever we can, you know, at any interaction. Um, okay, so the consents are the first portion. And just like you had said, the basic way we're interacting with them and we're trying to form those initial bonds of trust right from the front end and how we receive them, and I explain to them what EMR *(Electronic Medical Record)* I use and and what HIPAA compliance is like. I go that far to say I even turn my, my, you know, my laptop around and I'm like, this is what I'm going to use and this is what it looks like and this is how it safeguards your information. As a clinician, I'm just really transparent in that way.

The Baldrige framework (2021) criteria identified best practices and organizational learning. However, there is no information in the internal documentation on this concern, and it is a topic not addressed by the behavioral health leaders interviewed; therefore, this might be an area the organization needs to develop further.

Organizational learning would allow the leadership to strengthen the procedures and protocols.

Summary

Section 3 analyzed the workforce environment, the work processes, and operations that ensure high performance and operational effectiveness. The RP is still in its early development stage; however, some foundational principles and practices were identified. In addition, this section included information about how the organization measures and manages data, with particular emphasis on confidentiality and trauma-informed practices.

The organizational culture includes open communication in daily operations, tracking progress, and accountability. The strategic plan is the ruling document for the organization's projects, and the RP employees go back to these goals and work to achieve them under the supervision of the senior management. Collaboration is the goal at all levels; therefore, weekly meetings and personal communication are at the core of daily operations.

In terms of knowledge management, the organization has worked since its onset on quality by incorporating several web-based platforms that provide reliability to communication, processes, and task management. Additionally, confidentiality is a high priority, and it is ensured from the referral process to the case management by using coding, safe electronic records, and other resources to manage sensitive information.

Section 4 will focus on the research questions and the presentation of findings, implications, and limitations of the study.

Section 4: Results–Analysis, Implications, and Preparation of Findings

Human trafficking, and especially sex trafficking, is a growing worldwide concern. The Department of State (2021) recommended approaching this issue from a trauma-informed framework. The possible presence of trauma in the survivors and vicarious trauma in the personnel requires researching the best practices to ensure their well-being. The nonprofit organization of the study serves female sex trafficking survivors in a RP.

The case study's practice problem was identifying the trauma-informed practices that will benefit the survivor and employee's well-being at the entry level for a residential program serving sex trafficking survivors. The research questions were:

RQ1: What trauma-informed practices behavioral health leaders could apply to the entry process in a residential program for sex trafficking survivors?

RQ2: What are the key elements to promote successful treatment outcomes for sex trafficking survivors?

RQ3: What strategies could behavioral health leaders implement to ensure the well-being of the personnel working with sex trafficking survivors at the entry-level?

The study's qualitative nature prompted the analysis of the secondary data, including internal documentation and the information collected from semistructured interviews with behavioral health leaders at the management and clinical level. Revising secondary data such as the procedures manual, strategic plans, and other internal documentation facilitated the analysis of current practices and possible enlightened recommendations. The information was collected with the consent of the executive

director, who provided online access to internal documentation. Behavioral health leaders consented to the interview via email and agreed to record the interview via Zoom. Each interview was transcribed using an online software called Sonix and later I reviewed the transcripts for accuracy. The analysis process implied coding, theme generation, and triangulation. Ravitch and Carl (2021) stated that there are different approaches to coding, but in general, it means assigning meaning to the data collected. Coding is the first step to analyzing the data; later, themes or categories are generated, and triangulation completes the analysis to identify if the data diverge or converge with the Baldrige and trauma-informed frameworks. Triangulation was a strategy I used throughout the research.

The topic of sex trafficking has not been explored academically for many years. Only 23 years ago, in 2000, the U.S. Government published the Victims of Trafficking and Violence Protection Act, and this was the first time that the issue of human trafficking was addressed in legislation. Therefore, academic research has been scarce but, fortunately, has increased in the last 5 years. The body of research addressed the need to provide evidence-based information to organizations working with this population because there is no standardized protocol of service (Cuhna et al., 2022). Moreover, the literature reviewed confirmed the need to develop trauma-informed practices when serving sex trafficking survivors (Chambers et al., 2022). Furthermore, recent research (2020-2022) has focused on the personnel because of burnout, compassion fatigue, vicarious trauma, and the consequent employee turnover (Corbett-Hone & Johnson, 2022; Helpingstine, 2021; Ramirez et al.,2020). Along the same line,

behavioral health leaders in the RP stated the need to establish standard protocols when serving sex-trafficking survivors and reported employee turnover as a significant concern.

Analysis, Results, and Implications

Munsey et al. (2018) initiated the conversation on developing a comprehensive treatment model for sex-trafficked women and concluded the need to research further and establish processes and procedures to improve the delivery of services. Mumey et al. (2021) and Chambers et al. (2022) elaborated further on recommendations for the intake process. The RP gives special attention to the referral, application, and intake process; therefore, I concentrated the results on the entry-level processes related to the practice problem. BHL4 indicated that even though the care model establishes a 30-day mark to the orientation phase, achieving stability might take up to 7 months. Flexibility and considerations to the individual process to achieve the goals is crucial to the survivor's clinical outcomes.

The RP considers the entry period from referral to stabilization, this includes 2 weeks of the application process after referral. In the first 2 weeks of the application process most women might be already in other program going through detoxication; however, some women may be on the streets increasing the risk of not reaching the program if the pimp knows they are trying to leave. The first 30 days in the residential program focus on assessing and establishing goals, and the following months to achieve psychological stabilization and manage other needs. Stabilization focuses on immediate

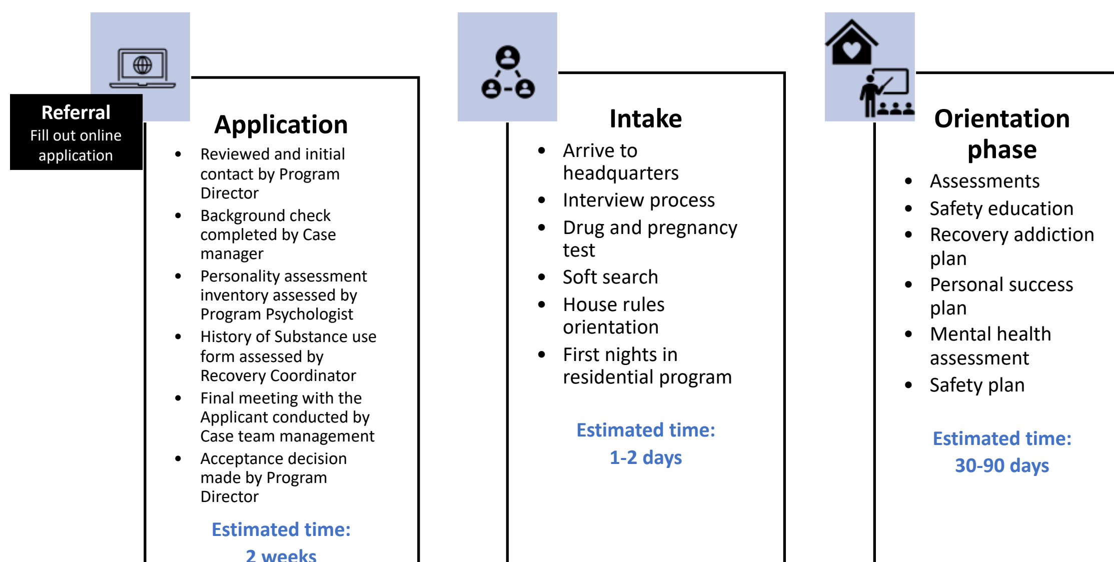
health needs and safety, and mental health somewhat gets a bit of a back seat, stated the psychologist.

Patient-Focused Service

The RP offers a patient-focused approach as defined by the Baldrige framework (2021) by considering factors such as patient safety, patient relationships, ease of access to care, and patient engagement with their care, among others; additionally, patient-focused organizations recognize the unique characteristics of the population they serve and develop innovative processes to ensure excellent service (p. 39). The RP has dedicated time and effort to developing a solid entry process that considers the uniqueness of sex-trafficked women and is highly committed to breaking the barriers to accessing care and services. Figure 4 describes the entry-level process followed by the RP:

Figure 4

Residential Program Entry-Level Process



The RP keeps statistics for each one of these steps in the process; the data from July to December 2022 is as follows:

- 112 referrals received.
- 32 Applications filled out - 22 applicants did not finish the application process, and one was not accepted.
- Nine acceptance letters were sent.
- Eight applicants completed the application process and intake.
- Eight applicants stayed for more than 3 months in the residential program.

These statistics suggested that the thorough process facilitates a sense of safety and trust, two crucial aspects in the entry process according to the trauma-informed framework. In addition, Jain et al. (2022) stated that ensuring privacy, minimizing wait times, and expediting registration is crucial when serving survivors. Another suggested practice is using a collaborative approach and a shared clinical database to help prevent retraumatization (Jain et al., 2022), a practice implemented at the RP. The psychologist informed that the case management team assesses the applicant, and each member completes the section in Apricot, cloud-based software, and HIPAA compliant. Only the psychologist, case manager, and program director have access to the information, ensuring the applicant does not have to share their story several times through the intake process, preventing retraumatization. Furthermore, the psychologist can keep confidential communication with the other team members to update them through another HIPAA-

compliant software called Slack. These methods of communication are essential as trauma-informed practices.

The intake process explores information about the applicant's immediate health needs and initiates the process to create a sense of safety. Safety is the first priority in trauma-informed care as this helps to increase trust and ensure the client's success in the treatment (Blue Knot Foundation, 2021). For the orientation phase, the case management team continues to assess the physical and mental health of the now resident and start working on goals at the resident's pace. The personal success plan establishes the goals based on the resident's expectations and needs in congruence with the care model. The Baldrige framework (2021) inquired about the key indicators for health care outcomes, and the organization has documents that state the client's focus objectives and the progress markers based on the care model, which in conjunction with the personal success plan serve to evaluate the progress in such health measures. Focusing on key indicators allows the organization to promote successful treatment outcomes.

Process Effectiveness

The care model developed by the RP has resident-focus objectives and progress markers around the main domains: stabilization, growth, and independence. The RP adopted the care model from The Samaritan Women Institute for Shelter Care. The care model set specific goals for each subdomain within the three domains, as outlined in Figure 5. Following the domain and subdomain goals, the model defines resident focus objectives and progress markers for each phase.

Figure 5

Treatment Goals

	Goal Mindset
MAIN DOMAIN	SUB DOMAIN
STABILIZATION Goal is to bring down; release what is harmful	**SAFETY:** Mitigating stimuli that threaten or provoke's one perception of being unsafe
	SELF-MANAGING: Managing harmful thoughts, behaviors, and relationships
	SOOTHING (SUFFERING): Attending to personal distress and building relationships of support
GROWTH Goal is to spread out; establish a new foundation	**SPIRITUAL:** Exploring identity, meaning-making, and belief systems
	SELF-CARE: Valuing and attending to one's personal well-being
	SOCIAL: Practicing safe, healthy empowered interactions with others
INDEPENDENCE Goal is to build up; invest in the future	**SCHOLASTIC:** Acquiring cognitive achievements and confidence
	SELF-SUFFICIENCY: Exercising personal agency and independence
	SOCIETAL: Re-integrating into society with belonging and contribution

Note. From TSW Care Model, Intensive 3 by Allert, J.L., Institute for Shelter Care, 2021.

https://instituteforsheltercare.org/roadmap-to-shelter-planting/

In addition, the case management team establishes objectives to pursue each phase with the residents. For instance, Figure 6 describes the objectives for phase 1, orientation.

Figure 6

Case Management Orientation Phase Objectives

Case Management	Orientation/Phase 1
SAFETY	Important doctor visits (physical exam, dentist, OBGYN, etc), gain medical insurance, drug test
SCHOLASTIC	Complete 'Personal Success Plan', gather employment history; Gather educational background history, Administer personality/gifts assessments or academic placement testing (if needed)
SELF-MANAGING/ SOOTHING (SUFFERING)	Develop a Safety Plan, Obtain documentation (IDs, SS card, birth cert) Identity Recovery Legal support (i.e., Divorce, Custody, Clemency, Warrants, Parole/Probation reporting) Coordinate with immigration services, as needed Connect with CR/NA/AA group Close-out Social Media Accounts CPS agency connections and support
SELF-SUFFICIENCY	Explore and apply to applicable gov financial assistance, Present expectations about savings and program financial support, close out out of state social services
SPIRITUAL SELF-CARE SOCIAL SOCIETAL	Check-in with resident and other staff on status, provide support as needed

Note. From TSW Care Model, Intensive 3 by Allert, J.L., Institute for Shelter Care, 2021. https://instituteforsheltercare.org/roadmap-to-shelter-planting/

In the entry process, the case management team focuses on the basic needs of housing, physical health, transportation, and a safe environment. Koegler et al. (2021)

emphasized that to promote the well-being of sex trafficking survivors is crucial to meet their basic needs, address their physical needs, screen and treat mental health, facilitate an empowering environment, promote skills development, and initiate trauma interventions (p. 722). Therefore, the case management team objectives described in Table 2 relate to literature recommending addressing basic needs, assessing needs, and establishing goals (Chambers et al., 2022; Jain et al., 2022). The basic needs are the first priority in this stage; the case management team partners with external sources to look for medical and dental examinations and arranges transportation to those appointments, according to BHL3.

Internal documentation in the RP informs about safety and emergency preparedness. The organization has protocols that include an emergency action plan, evacuation route floor plan, fire emergency, active shooter, tornado, and other unique safety measures such as keeping the location undisclosed, internet use, house phone, and security cameras to ensure traffickers do not reach residents. Safety measures in all these areas are crucial in the entry process and benefit not only the residents but also the personnel.

Moreover, the RP is committed to ensuring psychological safety and providing trauma-informed care. The personnel are trained to address any crisis, and the psychologist is on call 24/7 if a crisis requires professional support, either to the direct care staff or directly with the resident. Direct care staff is trained to take safety measures overnight and, on the weekend, if an emergency develops during the night. Each day and night residential coordinator must fill out an incident report and keep communication

open with the other residential coordinators and the case management team; BHL3 informed:

> We have our avenues of communication like Slack, and I have those guys doing shift change notes every single time. So, you constantly have that communication of what is going on with medical, with discipline, like off privilege, on privilege, with just how the day has gone for each resident. One was struggling today. One was in a great mood today. Two of them got in a fight earlier. It is good for them for the incoming to know that that tension is going to be in the in the room. So, and then it also gives us at headquarters that are doing the 9 to 5 what is going an active what is going on to see if we need to interject and how we can support.

The faith approach of the RP offers a new initiative to the weight placed on direct care staff due to the survivors' crises or mental health state by taking time to pray for each other as they exchange shifts. Muehlhausen (2021) suggested that prayer increases compassion satisfaction and helps professionals to manage burnout. In addition, there is a sense of support and meaning making when including spirituality, consequently increasing the quality of service delivered.

Client-Focused Results

The RP started in 2019; however, a decrease in staff between 2020 and 2021 forced the leadership to close the program for a period, review it, and relaunch it in full force in July 2022. BHL1 informed that after reviewing the causes of employee turnover of direct care staff, they realized that the lack of understanding about what the role entails is one cause because even if described, the daily exposure to trauma is not easy to grasp

until experienced. Additionally, BHL1 indicated that staff not dealing with their trauma is another cause of turnover. There are implications for clients if there is not enough staff to care for the residents.

The leadership keeps track of metrics that inform client engagement. For instance, in the entry process from July to December 2022, the organization received 112 referrals, the program sent nine acceptance letters, and eight applicants completed the process and stayed in the program for more than three. Additional metrics collected by the RP include 796 nights of safe housing, 248.25 hours of clinical therapy, 1,017.25 hours of curriculum and biblical discipleship, and 620.75 hours of case management, reported in 2022 documentation. However, the organization has not yet developed any customer satisfaction measurements.

The organization's metrics are an initial measurement of client engagement and satisfaction because the metrics respond to the healthcare service offer and the organization's goals. For example, the RP aims to offer a safe environment to sex trafficking survivors with the goal of social reintegration using a trauma-informed framework. Koegler et al. (2021) indicated that the service offered for sex trafficking survivors should include case management, counseling, crisis services, and medical assistance; however, the most critical need identified was having a shelter, with 93% demanding but only 27% offered. In addition, the RP offers a 24/7/365 program focused on stabilization, growth, and independence. Even though there are no customer satisfaction measurements, the RP is fulfilling a need for this population by providing housing and treatment.

Furthermore, the entry process is the most challenging because of this vulnerable population's diverse needs, such as medical attention and mental health. Munsey et al. (2018) concluded that because of the lack of standard procedures, organizations should collect as much data as possible to achieve standardization at some point. More recently, Chambers et al. (2022) assessed the intake process on trauma history and basic needs. At enrollment, most participants reported the need for housing, and 89% reported a history of trauma with one or more events (Chambers et al., 2022). The services offered at the RP address the housing need and the clinical attention, which is essential to this population by offering case management to tend to physical and health needs, a psychologist who offers therapy, and an addiction coordinator who leads their recovery process. A holistic approach is essential to client satisfaction, especially in the context of trauma.

Additionally, the RP promotes a culture of communication, choice, and empowerment for the survivors to engage in their own recovery process by developing their personal goal plan and giving access to different resources inside and outside the organization to achieve such goals. For instance, BHL3 stated that there is an established curriculum, but it is the resident's choice to develop it:

> We do have a set of curriculum [sic] that we use for all orientation. Like you're going to go through safe people, you're going to start seeking safety. Those are pieces that we start to introduce, um, that introduce what we're looking for as far as those markers that we're hoping that you hit in phase one… and then with case management, she's introducing like what is like the, the let's look at now that

you're settled and that you have decided to move into a new life, what are goals, what do the goals look like?

Lastly, in the client's engagement, one unique perspective the RP gives is spirituality as a protective factor for clients. Vieten and Lukoff (2022) argued that involvement in religiosity and spirituality practices had been linked to health improvement, and spiritual practices provide a sense of meaning, purpose, resilience, happiness, and satisfaction. Jerome et al. (2021) described four themes that women who endorse spiritual beliefs as a strategy to overcome trauma: the importance of a relationship with other people who have endured trauma, integration of psychological and spiritual practices, acknowledging divine intervention, and reframing the traumatic experience. Jerome et al. stated that spiritual practices such as prayer and meditation are effective coping strategies when facing trauma. Hence, spiritual practices implemented in the program might benefit mental health outcomes.

Workforce-Focused Results

The RP's workforce is a team of 13 employees. Except for the clinical psychologist, who is licensed, the other employees are not required to have a higher education degree. However, certifications in trauma-informed care or addiction recovery are encouraged. On the other hand, the emphasis when hiring staff is the agreement with the organization's core values; BHL2, which leads the hiring process, assures their focus on staff knowing and agreeing with the statement of faith and core values. BHL2 stated “that is the foundational part of any staff member coming in and working for BHO”.

Focusing on core beliefs and values has helped the organization to involve the employees in the BHO's vision and even advocate for issues related to sex trafficking.

The hiring process takes a long time and requires careful assessment of different areas. The operations director oversees managing the process and involves case management team members in the last phase to receive feedback regarding future teamwork. BHL2 described the hiring process, which takes several steps:

1. Post positions on online job platforms.
2. Phone call with potential applicants with the operations director. The phone call is an initial assessment of job ethics (i.e., punctuality), self-awareness, and self-care strategies.
3. If the applicant gives a good impression, they will receive an email asking them to write a 200-word essay based on the statement of faith and core values.
4. If the person moves on with the process, a Zoom interview is scheduled, and there are more questions to clarify that the person agrees with core beliefs and values. And a set of questions about trauma management and coping. Also, the person is asked about their response to possible scenarios in the residential program.
5. The person comes to an in-person interview with the operations director and other case management team members to make a final decision.
6. The person approves a multistate background check, and the operations director checks references.

The hiring process could take up to 6 weeks; therefore, the organization requests the person to commit to taking the position and to give at least 30-day notice if they are going to resign; BHL2 explained:

> Once an employee is offered a position and they come in. We really try to encourage them to give us at least a 30-day notice that they're going to resign just because scheduling is so difficult. And hiring can be a long process, as you know, that we can't just have because we don't have a ton of extra employees that are just waiting to work. Like you have our staff basically to cover all the holes that we need. So, if a staff member leaves, it creates a big void and then everyone else has to step in, which can lead to more burnout and more staff turnover. So, we really try to say, hey, I know this job can be difficult and if you need to exit and you need to leave because of your own mental health or own life circumstances or whatever. We bless you. We bless you and and will bless you out where we know no hard feelings. We get it. But we need you at least to give us a 30-day notice because it does take time to find your replacement.

The workforce is one of the most significant categories in the Baldrige framework for researching the practice problem. In the last 5 years, researchers have stated a concern about behavioral health professionals' mental health due to burnout (see Corbett-Hone & Johnson, 2022; Helpingstine et al., 2021; Kelly, 2020; Posluns & Gall, 2020). The behavioral health leaders in the RP also expressed concern about burnout as a cause of their employee turnover. The organizations working with sex trafficking survivors must research the causes of employee turnover and address them to increase retention.

Considering employee turnover in the context of sex trafficking, Helpingstine et al. (2021) discussed the inevitability of burnout and vicarious trauma among behavioral health professionals working with trauma and complex trauma. In addition, Muelhausen (2021) estimated that 40-85% of behavioral health professionals develop vicarious trauma symptoms and compassion fatigue. Therefore, recommendations for trauma-informed practices are a priority for behavioral health leaders. Posluns and Gall (2020) proposed establishing self-care as a prevention strategy, not only for intervention.

The RP develops training on self-care, and the program director oversees their self-care plan. In addition, BHL3 stated that in their experience, they had noticed a connection between personal stress with professional burnout and that when the professional start showing burnout symptoms, intervention is more complex and less successful; BHL3 stated:

> The personal intersects with the professional, and then you have that burnout. What I'm noticing is that when we start to see physically responses of burnout there, it's, it's too late. The, the consistent crying, the, um, looking like a zombie staring into space type thing that I don't feel well. I don't feel well. I'm getting sick. I'm getting sick and getting sick to my stomach. Those type of things. Um, it's, it's almost like it's, I hate to say this because it sounds very, um, dismal, but it's, like, too late.

The Baldrige framework (2021) evaluates workforce engagement; in the RP, a system of accountability and personal check-in is in place; additionally, supervision and consultation are available to personnel, a practice recommended by Ramirez et al. (2020)

stating that because trauma survivors need more time to recover, the professionals must be aware of such needs and engage in self-reflection, supervision, and consultation as a practice. The leadership in the organization must take the initiative in employee engagement strategies, from accountability to training. The program director in the RP must coach the employees and encourage them to see the purpose and meaning of their work.

Another critical element discussed in the literature is workplace climate. The RP offers a climate of open communication and constant supervision, and as part of their benefits, the organization covers each employee with 52 counseling sessions per year, additional support for their mental health. In addition, the managers at the RP are intentionally keeping the employees in check regarding their emotional state, BHL3 informed:

> We are always talking about self-care across the board, organizational wide just because of the nature. I have personally sat down with our residential coordinators, um, to do that staff, that staff care plan or self-care plan, rather self-care plan with them. We have from our mentorship with TSW [The Samaritan Women, a training program], we have a lot of, you know, scale your burnout. Where are you, how are you feeling … And then we have our house manager who's also doing those check ins, which is talking about that self-care piece, all of that information that was in training.

One element that literature is starting to recognize is spirituality as a tool to prevent burnout and vicarious trauma (Helpingnstine et al., 2021). Muelhausen (2021)

also stated the importance of spirituality and practices like prayer to improve compassion satisfaction and help manage burnout. Spirituality and prayer are common practices in a faith-based organization like the RP. BHL3 stated: “organizational-wide like prayer, we do nothing but by prayer, you know, So it's a huge piece. It's the beginning of [BHO] it started out of a prayer movement. So, it's a huge piece”. Prayer is a practice that residents and personnel are encouraged to use in their daily life at the RP, and it has shown positive results in the workplace climate. Specifically, among the direct care staff, BHL3 explains the use of prayer as a strategy to maintain mental health:

> So, when they do check ins, um, when they debrief and switch shifts, what we do is the oncoming *residential coordinator* (RC) will debrief with the RC that has been on shift. And then what we've just implemented that we've seen is effective is they'll pray each other, one will pray the other one in, one will pray the other one out, and that has lent to building that team. Uh. That just that team connection and also helping the person like okay, I'm I am doing something if physically that is saying to my brain my shift is ending and I'm leaving this and I'm going home.

Finally, training is a crucial element in the workforce. The RP establishes a training program that the personnel must engage in their first two weeks, within 30 and 60 days, plus ongoing training with the case management team, as outlined in Table 1.

Table 1

Training Program

First 2 weeks	Within 30 days	Within 60 days
Technology training Asana/Slack/Bamboo/ ER Help center		
Courses EDU Hero Human Trafficking awareness Sex trafficking and sexual exploitation Trauma-informed care Suicide Assessment and Intervention "On Watch" Trafficking Prevention	Courses Crisis management How to work with shame De-escalation and nonviolent crisis intervention	Books Fallen by Annie Lobert
Videos Nefarious The body keeps the score. Understanding complex trauma Complex trauma Learning about emotions De-escalation strategies	Videos Girlhood The making of a girl	Certifications CPR/First Aid/ AED Active Shooter
Articles Avery Center – Houston, we have a problem. The Track Parts 1, 2, 3 Prostitution and trafficking	Articles Sex trafficking prevention Myths and Facts about legalized prostitution Pornography, prostitution, and trafficking	
In-house Spiritual roots Crisis simulations BHO Culture and prayer		In-house History of the Abolitionist Movement Van tour Fire drill/fire extinguisher Tornado drill

Additionally, the direct care staff must receive a certification in the first two weeks on mental health first aid and Narcan-Overdose drill, a complete course on grounding skills for PTSD, panic, and anxiety, and in-house training on room and bag search, safety, and security training and communication with resident 101. Within 30

days, the direct care staff is expected to watch a series of videos that will inform them about the trauma recovery process, and within 60 days, they must complete a course on addiction recovery, according to the internal documentation. Even though the organization has a low demand for higher education for employees, there is a high demand for training and a well-structured development program. The trauma-informed framework guides the employee development process.

Leadership and Governance Results

Governance for the organization has transitioned from a hands-on board to a governing board as they have developed. The board has six members with backgrounds ranging from accounting law firms to entrepreneurs; they intend to grow it to 11 members. BHL1 informed that board members have a year tenure, every position is voted yearly, and they can only serve on the board for two consecutive years. Following this paradigm, the organization ensures accountability and avoids any kind of abuse. The board is divided into committees like facilities and asset management, the development council, and the finance committee, which work to achieve specific goals. In addition, the governing board evaluates the executive director's position for hiring, salary, and benefits. Lastly, the board reviews, approve, and oversees the annual strategic plan and the financial plan. Each board meeting is recorded, and minutes are collected and distributed to the board members for final approval. Organizations' governance ensures accountability in senior leadership, strategic planning, and transparency (Baldrige Performance Excellence Program, 2021); the board of directors plays such roles in the BHO and RP.

Collaboration is essential to the organizational culture; open communication and empowering decision-making processes are encouraged from the managerial level to direct care in the residential program. Even though there is a hierarchical structure, the organizational structure is collaborative and empowering. The RP works autonomously under a case management team conformed of the program director, a psychologist, a recovery coordinator, a case manager, and a residential manager. The residential manager oversees the day, weekend, and overnight residential coordinators. The case management team has decision power over the intervention with the survivors and reports to the executive director for accountability and further support.

Recent literature has suggested a collaboration, openness, team-oriented, patient-centered treatment when serving sex trafficking survivors (Iqbal et al., 2021; Ramirez et al., 2020) and the presence of a case management team as a priority (Jain et al., 2021; Koegler et al., 2021; Marburger, 2020). In addition, the RP organizational culture has been developed under the principles of a trauma-informed approach, ensuring the well-being of the survivors and employees under leadership and governance based on the core values of integrity, respect, compassion, communication, and responsibility, as stated in their internal documentation. The adherence to collaboration relates to a trauma-informed framework benefiting the well-being of the residents and employees.

The organization follows a format of constant evaluation by supervision, weekly meetings, and a yearly 360 evaluation for each employee. The 360 evaluation reports on core strengths and areas to improve, and it shares comments that other colleagues have made about the person; for instance, one employee received this feedback on her 360-

evaluation report: "Employee demonstrates good characters in her responses to sudden changes to plans. Employee is dependable and completes tasks efficiently". These practices encourage accountability and transparency along the organizational system and build positive relationships.

Financial Performance

The BHO is a 501-C3 nonprofit organization officially registered in the United States. The board of directors approves and oversees the financial performance. A designated financial chief officer manages the financial affairs of the BHO, including the RP. As a faith-based organization, governmental funding is not the first source of income; instead, individual donors and churches fund the organization's programs and operations.

The BHO's website displays to public knowledge the annual financial report and a yearly report for transparency in operations. The financial report indicates income and sources such as individual donors, churches, or other businesses. In addition, reports are that over 70% of the income is designated to develop the programs, 18% to operations, and the remaining for fundraising activities, according to the BHO's website. The organization is highly committed to transparency, and the website states a privacy policy that commits to safeguarding donors' information. Additionally, Candid, the highest level of recognition by GuideStar for nonprofit organizations, awarded the organization Platinum Transparency 2023. The commitment to financial transparency is also a trauma-informed practice because it maximizes trustworthiness with all stakeholders.

The Baldrige framework (2021) assesses financial performance indicators; the primary measures of financial performance, income, and expense are published on the BHO's website. Also, the fiscal documentation is available to the public. In addition, the BHO reports the leading indicators of income and expenses every year, as seen in Table 2. The financial performance indicators outlined the commitment of the leadership to focus on the programs and serving sex trafficking survivors.

Table 2

Financial Performance Indicators

YEAR	INCOME	EXPENSE	DISTRIBUTION EXPENSES		
			Programs	Operations	Fundraiser
2020	$1,440,781	$1,183,143	76%	15%	9%
2021	$2,156,323	$1,450,085	76%	14%	10%
2022	$1,923,121	$1,590,936	71%	18%	11%

Note. Adapted from yearly reports available on the BHO's website.

There is not enough available information regarding the annual budget and detailed description of expenses. For instance, one behavioral health leader informed that salaries do not exceed 50% of program expenses; however, it is unknown if these salaries are competitive. However, the behavioral health leaders in the organization informed that employees have benefits, including 52 mental health sessions; these sessions are covered by the BHO, as per the employee's request, and it speaks of the importance given to the employee's mental health. In addition, other considerations such as vacation time, sabbatical, maternity, and paternity leave are addressed in the employee manual. These considerations aligned with employees' rights and benefits and, simultaneously, with trauma-informed practices.

Strategy Implementation Results

The annual reports published on the BHO's website inform about how the programs are a priority when defining finances, which aligns with the organization's strategic plan because more than 70% of the expenses are dedicated to the programs (see Table 4). Furthermore, the Blue Knot Foundation (2020) discussed the considerations of applying the trauma-informed framework at an organization's system level and identified and reviewed funding requirements as one of those elements. Even though following trauma-informed practices is an attitudinal change, the Blue Knot Foundation (2020) stated: "The impact of research and data gathering should be part of infrastructure funding. The cost-effectiveness of implementation of trauma-informed principles should also be part of budgetary assessment" (p. 19). Under such consideration, I found that the BHO considers the budget implications in the strategic plan to implement trauma-informed practices coherent with the suggestion by the Blue Knot Foundation.

The RP's strategic plan includes the aspect of cost for each one of the strategies to achieve the goals; for instance, one strategy for 2022 was to send staff to visit other programs and report back the learning experience, and there is a designated cost of $3,000 while completing the staff handbook establishes a cost of $0 because the current staff will carry such task. The organizational strategy and action plans are coherently related to the financial demands; however, there is not enough information on achievement indicators because of their recent and current development.

Findings and Implications

The findings regarding the practice problem were organized by themes. The data collected in eight semistructured interviews with four different behavioral health leaders in the organization was coded, and secondary data like a strategic plan, protocols, and procedures, employee manual was requested from the organization and analyzed. The analysis incorporated all sources of evidence and using triangulation with the Baldrige and trauma-informed frameworks identified themes to describe the research findings.

The practice problem was identifying the trauma-informed practices that would benefit the survivor and employee's well-being at the entry level for a residential program serving sex trafficking survivors. Table 3 describes the trauma-informed practices at the organizational and entry-level that might be considered by behavioral health leaders serving this population. The organizational level considers culture and structure practices that benefit residents and employees. At the entry level, assessing needs and humanizing the experience are the most beneficial practices. The faith stance of the organization and the incorporation of those elements in the practices have also determined the development and effectiveness at the organizational and entry-level. Table 3 summarizes the findings by themes.

Table 3

Trauma-informed Practices at the Organizational and Entry Level

Trauma-informed Practices	
Organizational	Entry level
Organizational culture - Mission, vision, and core values - Open communication - Collaboration	Assessment - Health needs - Mental health - Collaboration
Organizational structure - Governance and leadership - Compliance	Humanizing the experience - Safety - Trust - Empowerment – goals - Comprehensive and expedite
Faith stance - Funding implications - Staffing	Faith stance - Choice

Organizational Trauma-Informed Practices

The initial problem and research questions did not address organizational practices; however, the data collected and the literature review led to the relevance of organizational culture and structure when serving populations who have experienced trauma and its implications on survivor outcomes and employee well-being. The ultimate goal of the trauma-informed framework is to resist retraumatization, and the organizational system plays a crucial role in achieving it. Jirek (2020) stated that the organizational response is crucial to ensure the employee's well-being and increase the effectiveness in the delivery of services. Jirek expanded on the concept of organizational structure and culture, including values, beliefs, expectations, and behavioral norms as the culture and hierarchy, policies, power, and flow of information as part of the structure. Jirek's qualitative case study of one organization that works with trauma victims, such as

domestic violence survivors, demonstrated that deficiencies in the structure, such as lack of policies on secondary trauma, resources, and education caused an unhealthy environment that shamed the employee and made them felt less valuable than the customer. In the organizational culture, Jirek informed that the belief of secondary trauma was an unavoidable result of the work (Jirek, 2020). This research needed to address the value of organizational culture and structure to trauma-informed practices considering the data collected.

In contrast with Jirek's findings (Jirek, 2020), the RP's organizational structure in its governance and leadership encourages transparency, collaboration, and open communication. It has established policies and procedures to ensure the employee's well-being, from a personal self-care plan to a continuous communication of personal needs. BHL2 stated, "it is not uncommon that we will stop in our workday to pray for each other if someone feels they are struggling at the moment." In the RP, employees develop their self-care plans and access weekly therapy sessions if requested. The leadership is mindful of workload and responsibilities to prevent fatigue. In the organizational culture, the BHO is highly centered on the mission, vision, and core values which focus on human worth and character. The employees are encouraged to model respect and care; BHL4 stated:

> I would say that the whole way our staff interacts with residents is so different, like contextually different than a lot of residential care. So, we all are encouraged to interact with residents where we don't pull authority, where we don't raise our

own voice, or we don't use any kind of intimidating language, where we are gentle and conscientious and we are constantly modeling this.

That same respect and care define the interaction between colleagues and leadership through open communication and collaboration. A healthy organizational culture might prevent burnout and secondary trauma, as Jirek (2020) suggested. The RP and case management team collaborate to ensure the survivors/residents and employees are in a safe environment and that the program adjusts to their needs. BHL4 stated:

> And then, the house manager is the one with direct reports that would be checking in on all of her RCs *(Residential Coordinators).*And so one of the ways of caring for, say, like the RCS at our level is if they are feeling particularly taxed by some dynamic that's present, then we can also put that on the agenda to kind of team tag and figure out what policy we need to flex. We will rewrite something if it's necessary, right? If it is causing too much strife, it is no longer working. We can make those decisions right then and there that something needs to be updated or changed based on employee feedback. This is taking too much time. This is difficult. That's not working. You know, we're very quick to say, well, it looks good on paper, you know, but like, what can we figure out that that will be better suited?

One last finding in the organizational practices is the faith stance of the RP. Knight et al. (2022) compared the values of social work agencies and Christian faith-based organizations serving human trafficking survivors. They concluded that social justice is the core value for both approaches and that several shared values, such as

compassion, faith, forgiveness, identity, hope, and authenticity, were essential to their interventions. In addition, three themes emerged from Knight et al.'s research: "dignity and worth of the individual are paramount, the church needs to change for the better, and authentic faith is expressed through social justice and service" (Knight et al., 2022, p. 200). The BHO strong faith stance was discussed in a leadership retreat, and BHL2 shared the questioning process and rationale behind it:

> So, does that look like we are more faith-focused, or does it look like we're more project focused? Do we take government grants that are not are more geared toward your traditional nonfaith-based nonprofit, or are we relying more heavily on church partnerships and individual donors? And so, having to navigate which way are we going to go? And we landed that we want fidelity to Jesus, we want to pursue him in his kingdom, that there's no lack in heaven with God, and that we want to be able to be known for people who love Jesus and love people, regardless of where they are on their journey, their faith journey, or whether they don't even have a faith journey, but that they're still loved by Jesus and loved by us.

The faith stance seems to enhance the intervention rather than undermine it. Knight et al. (2022) stated that Christian faith-based leaders had the urgency to serve this vulnerable and oppressed population because of God's love for people and that integrity, diversity, and competence were inherent to the service (p. 203). The RP requires the new staff to adhere to the core values and beliefs but gives freedom of choice to the resident to

even participate in any spiritual activity. BHL3 explained the interaction of both approaches:

> Facing obstacles, not necessarily with staff, because we really try like we have when they're hiring in like we have our statement of belief, so to speak, like our tenants. You're reading over that. You're giving an essay. We're you're coming into prayer with us. We're asking in the interview not just logistical questions, but spiritual questions. And so, we we like to have not not just. So let me put this little caveat on there. You don't have to be this cookie cutter Christian like, oh, this is the mold we want you to fit in. Because personally, the body of Christ, I believe there's you know, you can be a different denomination and love Jesus just as much as I love Jesus. So, I'm not going to discredit you because you're of a different denomination. That's ridiculous. But, um, we try to look for the maturity and the alignment and thinking on those pieces of like, the Holy Spirit is active and moving. What is it in Amos? How can two men walk the same road unless they be in agreement? So, with we haven't seen a lot of differences that would be a make or break as far as the the staff go.

BHL2 stated on the same direction:

> And so but let me let me also preface this is that like we don't turn people away based off of their religious viewpoint so they can be anywhere on the spectrum. And if they fit our criteria and agree to our care plan, that we would lay out with them in their intake and in the application and they know what all of our expectations are, then they can come in even if they don't know the Lord or even

> if they're a Buddhist or a Hindu or a Muslim. Like it doesn't matter as long as they hit the criteria that we have and they're open to being in the same room as a Bible study going on just so that … And like, we all go to church together on a Sunday morning because usually we have one staff member on shift on Sunday mornings. So, they'll take everyone to church. And if you don't want to go into the service, that's fine, but we'll still need you to come with us and sit in the lobby. And so as long as you're comfortable with that, you don't have to be our faith background.

The two approaches to the employee's faith adherence and the resident's choice seem to bring balance to the organization. Despite their success, behavioral health leaders in the BHO recognized additional challenges, such as limited government funding and the need to monitor legislative changes that might affect faith-based organizations. Additionally, the organization might encounter resistance from societal stereotypes that portray Christian faith followers as closed-minded and self-centered. However, Knight et al. (2022) concluded in the study that concerns about victim stereotyping within the Christian community do not necessarily apply to all organizations and that many organizations value survivors' voices and dignity. Overall, the organization's approach has demonstrated a healthy balance between employees' faith adherence and residents' choice, and it continues to navigate the challenges of such a stance to fulfill its mission.

Entry Level Trauma-Informed Practices

Behavioral health leaders in the RP have given relevance to the entry-level and created a format that facilitates the process for the survivor ready to exit the trauma experience; additionally, the organization's leadership has intentionally resisted

retraumatization when assessing the different needs by humanizing the experience. The vulnerability of sex trafficking survivors can be attributed to various mental health social determinants, as supported by scholarly research. Fink-Samnick (2021) comprehensively outlined these determinants at multiple levels, including individual, socioeconomic, environmental, and basic needs domains. Sex trafficking survivors encounter substantial challenges within nearly every social determinant of health, and it is under these circumstances and history that they enter the residential program.

At the individual level, these women have endured a history of trauma and extensive exposure to violence. These experiences profoundly impact their mental health and well-being. Furthermore, at the socioeconomic level, survivors often face multiple barriers, such as poverty, limited access to alternative employment opportunities, and inadequate education. Moreover, the environment where sex trafficking survivors find themselves is frequently characterized by neighborhoods with heightened delinquency rates, prevalent drug abuse, and other socio-environmental challenges. Additionally, many individuals within this population may have encountered gender and/or race discrimination. Lastly, the control exerted by traffickers restricts survivors' access to necessities, including housing, food, transportation, and healthcare. The lack of autonomy and agency over their lives exacerbates their vulnerability, making it challenging to break free from exploitative circumstances.

The assessment at the entry level must consider the history and experiences of each of these social determinants of health and mental health. For instance, what are their medical needs, where are they academically, and have they experienced poverty or

discrimination? Koegler et al. (2021) suggested that at the entry-level, the assessment must include meeting basic needs, addressing physical health, and screening mental health. Jain et al. (2022) suggested ensuring privacy, minimizing wait times, expediting registration processes, having a shared database, not asking survivors to share their stories several times with different providers, and promoting collaboration. The RP has a protocol to assess health needs in the intake process and start the process to meet those needs as a priority, considering the vulnerabilities mentioned in the social determinants of health. BHL4 emphasized the need to prioritize the needs assessment:

> Individuals that have a trafficking history tend to have health care needs that keep them in a vulnerable position, like I said, for like six, seven months. Extensive dental work. And we all know how much our teeth impact quality of life and can make us miserable too, like chronic illnesses that need to be managed, you know, metabolic disorders that need to be managed, old injuries and things that need to be corrected and looked into. So much head trauma that has never been appropriately assessed. And you have to understand the implications. I mean, heart disease in incredibly young women is really common. And so, if you have this high level of need and it's incredibly overwhelming to manage, you know, 7 or 8 specialists, um, while trying to meet your mental health needs and not having insurance and not having transportation and it all just being too much.

Mental health needs are a concern and are addressed as soon as these physical needs are met or at least in progress. Having a psychologist and a case manager in-house

allows the program to assess mental health needs and offer therapy as soon as the survivors enter the program. BHL3 explained:

> You know, we have the privilege. The privilege, of walking past at a certain phase, the safe contacts and it just it's getting them geared up and really they dive in. Um, if we were an emergency safe house, there would probably be more of a let them sleep for days. Let them not necessarily jump in a program right off the bat. But we're not, we're long-term program. So typically, the women that are coming to us have already been in a stabilization program, emergency safe house. So, they've already had have started to adjust to a program like environment. And for our program being long term, we actually move pretty quick. We move a little quicker than most long term, but it's, I believe it's because we have, um, a pretty good system and we have an in-house program psychologist.

The in-house psychologist starts the mental health assessment when the resident is in the orientation phase and establishes a 30-day mark to complete the psychological battery, including 16 different assessments. However, the psychologist is flexible and adjusts to the rhythm of each resident. The psychologist explained:

> Every single thing should have been touched, so all aspects should be finalized within that 30 days is the goal with the history taking aspect and information aim to be completed in about two weeks. But again, don't rush people if there's reasons why we have to take longer here or there, we can. It's all can be flexible. We just have these different general standards so that we can stay on top of the, you know, the logistical parts. Um, but so the patient portal, their checklist that

> they get and, and then the assessments that I do, there are a total of 16 assessments for the whole battery… And again, I aim to do these within the first 30, but depending on, depending on a lot of different individual factors, it can take double that long. They're not rushed and it's never alliance is never compromised in order to gain information.

The delivery of services aims to be comprehensive and expedited from the online application to the orientation phase. Parallel to the logistical management of the entry-level procedures, the presence of trauma-informed principles, such as creating safety, developing trust, defining goals to empower, and collaborating with different providers and the case management team, humanize the experience. The trauma-informed framework establishes five principles: safety, trustworthiness, choice, collaboration, and empowerment. These five principles were identified in the interviews with the behavioral health leaders with specific practices that applied such principles. Evans et al. (2022) stated that because of the prevalence of complex trauma in human trafficking survivors, safety, stabilization, and relationship building are fundamental to the treatment, which is the focus of the RP's treatment. The most relevant finding in the research is that the RP focused on humanizing the experience by following the trauma-informed principles. Here are some extracts from the interviews with behavioral health leaders that informed about these principles:

Safety

> We do have a set of curriculums that we use for all orientation. Like you're going to go through safe people, you're going to start seeking safety. Those are pieces

that we start to introduce, um, that introduce what we're looking for as far as those markers that we're hoping that you hit in phase one. And we have the safety self-managing, soothing that stabilization. So, orientation, what is, what is crafted into the classes, into therapy, into the beginning one on one with recovery coordinator and case management are all geared to start to introduce those markers to them as they move through that. Our orientation is from 30 days to 90 days. So, as they move through that by the 30 day mark, we're doing an assessment.

Trustworthiness

I go test by test and tell them what I saw and what I think. And then I share PAI [Personality Assessment Inventory]. I share the actual report, you know, that I've written and, you know, say like this is this is some of the stuff that we used to understand you better and accept you into the program. Again, like that transparency that not anything that they did isn't theirs and a part of their experience they usually love the the going over the PAI. They think that I'm like like a fortune teller or something. Like a psychic. How do you know? You told me. That's how I know it, like you told me. But they love that part. So, at that point, I give them, you know, my diagnostic impressions to the next time we meet. After that is like pure treatment planning based on, you know, what what what's found inside of those assessments. And so, at somewhere between 30 and 45 days, I'm doing an intricate treatment plan that's highly tailored.

Safety and Trust

> So, there's three guys in our office. And a great way for this is a small thing, but I think it means a lot but a great way for the guys first interaction with our residents to be because sometimes there can be fear between a woman interacting with a man is we want to see them, we want them to see us serving them as the first thing that they they know with us. So, the guys always unload their bags out of the car if we have their permission to touch their things, and then we take them into the intake center. So, like we we let the residents stay with the care team while we carry their bags up a flight of stairs and put them in the intake center.

Empowerment and Goals

> And then with case management, she's introducing like what is like the, the let's look at now that you're settled and that you have decided to move into a new life, what are goals, what do the goals look like you know.
>
> Another example of empowerment and goals as follow:
>
> So, we actually just did vision boards at the beginning of 2023, so they just finished those. But like at the beginning of every year we'll do a vision board. What, what do you want this year to look like? And they'll cut pictures out of magazines and print some pictures offline. And like these are my words for the year. This is what I want to see happen this year… So, we try to fill the gaps in their education. So, if we have someone who has never graduated from high school, then we will help them get their GED. Or say you were just kind of in the education system, you were just kind of passed on, but you never really like fully

learned how to read or fully learned math, but you just kept getting pushed to the next level because wherever you're at in society, you know, sometimes that happens more often than not. And so, we'll we'll find their gaps and like, Hey, do you need just some focus on simple math? Like, okay, great. We've got an education coordinator and she'll work with some curriculum, find curriculum for that resident and help them with their math, like simple math or algebra two, if they need that to get there… So that's the goal of the Ed Center and also to teach some life skills that maybe they missed. So, like, how do you file taxes? How do you make proper relationships? Like how do you set healthy boundaries with people? How do you how do you practice proper hygiene … The goal of our program is healthy, independent living when they exit.

Choice and Collaboration

So like ultimately, each resident gets to choose what they want to do with their future, but we're going to give them the resources and then help them put it in kind of their court on when they're going to call or when they're going to move forward and help push them and make little goals of like, okay, why don't you fill out the application this week? And then after that we'll call next week or make little goals. So, it's not as overwhelming, but we're going to get to the end. But we just have to break it up into a lot of little goals.

Another example of collaboration as follow:

Yes, we have every other Saturday survivor led meetings. They're actually an outsourced, a resource that's outsourced. They are survivor led…And so we're

> able to host that meeting for this area here at the campus. But it will have our residents will be in community with other survivors that are not actually in our program. So, it's a really safe way of being able to get them to connect so that they have those connections outside of the program and when they graduate program, that is awesome.

Lastly, as discussed in the organizational findings, the survivors are informed from the beginning about the faith stance of the organization and given a choice to accept such a framework; furthermore, there is no obligation to follow the Christian faith, only an agreement to join the faith-based practices such as Bible studies, prayer and attending church services. In addition, other spiritual practices, such as inner healing, are an option for the resident, as BHL3 explained:

> So, we introduced these ladies who are actually trained in inner healing. And as they build relationships, if the resident reaches out and says, you know what, I actually want to do inner healing because I am struggling with unforgiveness, we'll set up a one on one with the ladies who are trained in inner healing and and allow the resident to go through that. But it's always like we're, we're giving it as an option, but it's never pushed because someone absolutely has to be ready to deal with the spiritual aspect of that. So, some jump right in or like I want to do that and some it's actually taken months and months before they um, like okay, I actually do want to sit down with them. So, it's, it's introduced with discernment and, and put on the table as an option but never forced.

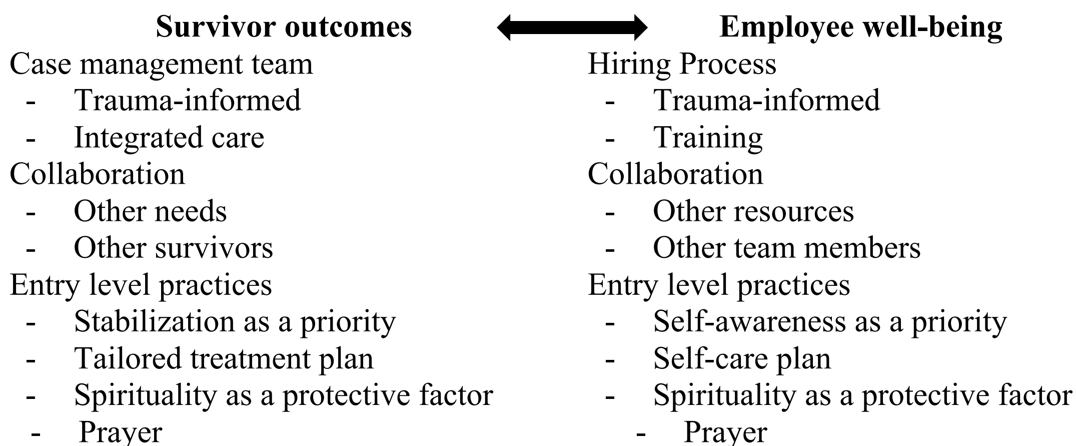
The practices in the RP's entry-level are coherent with the trauma-informed framework and allow the case management team to assess the mental and physical health needs of this vulnerable population; at the same time, they humanize the experience of the sex trafficking survivor and promote collaboration at the internal level and with other healthcare providers.

Survivor Outcomes and Employee's Well-Being Findings

The trauma-informed framework establishes that every individual has been exposed to trauma in some form, and therefore, the organizations must be sensitive in all interactions to the impact of trauma on the survivors and personnel (Department of State, 2021). The RP and BHO are aware of this assumption and have developed a program that recognizes the impact of trauma on the survivors, the risk of vicarious trauma, burnout in the employees, and the effect of their personal trauma experiences. Table 4 summarizes and presents the parallel in the interaction between survivor-employee within a trauma-informed framework.

Table 4

Survivor Outcomes and Employee's Well-Being Findings



Survivor outcomes	Employee well-being
Case management team	Hiring Process
- Trauma-informed	- Trauma-informed
- Integrated care	- Training
Collaboration	Collaboration
- Other needs	- Other resources
- Other survivors	- Other team members
Entry level practices	Entry level practices
- Stabilization as a priority	- Self-awareness as a priority
- Tailored treatment plan	- Self-care plan
- Spirituality as a protective factor	- Spirituality as a protective factor
- Prayer	- Prayer

The expected treatment outcomes in the RP include reduction of symptoms, independent living, and reincorporation into the workforce. The entry-level that goes up to the sixth or seventh month aims to achieve stabilization, and tracking the symptoms is one of the practices the psychologist has implemented by screening monthly and repeating specific assessments when the individual is ready to exit the program, according to BHL4. Additionally, by ensuring healthcare needs are met, the survivor can take responsibility for her care.

The RP works with a case management team fully trained in trauma-informed practices to achieve the expected outcomes and offers integrated care, including mental health, education, and addiction recovery. BHL4 expressed how crucial the interaction in the case management team to offer integrated care:

> We actually do a very nice integrated model of care during our meetings, so that each of us speak within our roles, and that creates a really nice compliment because it's all different types of perspectives. I think that's a very unique that's a health care model taken into residential care.

Furrow et al. (2018) explained that integrated healthcare care breaks the traditional idea of fragmented services and encourages collaboration among healthcare providers. It is indeed unique that the residential program developed a model of care that integrates different providers. The RP reaches out to medical and dental providers outside of the organization to cover those needs, and internally the case management team coordinates those connections and follows up on the survivor's progress.

The case management meetings allow each person to provide their perspective on one case and, together in collaboration, determine the best next steps in the treatment. BHL4 explained:

> Each of these people represents each aspect of the person's care, their case management needs, their mental health needs, their educational needs, their recovery and addiction specialists. So, everybody kind of gets to come and contribute those different perspectives. All of those are present on the front end as well. So, we all come together.

The program director oversees all and leads the case management team. At each meeting, the team discusses the resident treatment plan, and they do not move on to the next one until they have considered every aspect of that one case. This procedure has been incorporated since the application process. Based on the interview, the program director identifies if the person has an addiction history, and the recovery specialist will be notified to start working on a program. The psychologist will have the initial assessments with the potential resident and share a summary of results with the case management team to inform the decision on granting admission. In addition, every person on the case management team has access to electronic records that report the interviews, history, and assessments, avoiding retraumatization. The integrated model of care is crucial to the survivor's success.

On the other hand, the case management team models a healthy relationship. Researchers have emphasized the survivor's relationship with the healthcare provider or worker as essential to success; for instance, Evans (2020) stated that the relationship with

personnel becomes an ongoing learning experience of trust and safety for the survivor. Hershberg (2021) proposed the relational-cultural theory that invites an authentic relationship to model growth and the behavioral health worker developing a connection based on authenticity, mutual empathy, and mutual empowerment. Hershberg's study connects with the need to collaborate with other survivors as part of trauma-informed practices (Hershberg, 2021). The development of healthy relationships in the RP is a priority.

The trauma-informed practices are the framework in the RP. Following the principles of safety, choice, collaboration, trustworthiness, and empowerment, the intervention prioritizes the survivor's success, prevents retraumatization, and improves treatment adherence (Iqbal et al., 2021). The RP is an excellent example of an organization applying and transforming those principles into daily practices. An integrated, comprehensive, team-oriented, trauma-informed treatment is the most beneficial paradigm for sex trafficking survivors.

The RP encourages collaboration at all levels, internally among the case management team and with other healthcare providers outside the organization. Medical and dental needs are a priority, and the RP partners with other healthcare providers to ensure these needs are covered. Residents can access a health portal to see their appointments, medications, and follow-up. BHL4 explained that the goal is that when the person finishes the process, they will be well advanced in those needs and able to take care of those health needs independently. Collaboration with external providers is essential for survivors who might not have access to these resources.

The survivor's inclusion is another collaboration practice encouraged by research and the trauma-informed framework. The Department of State (2021) affirmed the urgency to include survivors' voices at all levels. Lockyer (2022) suggested the inclusion of survivors at the decision-making level, ensuring voice, representation, and power. The RP recognized the value of the survivor's voice and leadership is intentional in including survivors in different levels, as BHL3 explained:

Alumni Participation

> We actually have our alumni that has, we had one graduate who has been over to the house and hung out with the ladies every now and then. Now, of course, it's she doesn't just show up. She does ask like, hey, can I come over and hang? We've had another alumni actually get on the phone and encourage one of our current residents because our current residents is literally facing something that she had to face. And so, we reached out to our alumni and said, are you in a good place to where you're able to speak to her a little bit about this? And she did. And it was beautiful. So, we definitely welcome that piece from our alumni.

Hiring Survivors

> Now, as far as hiring survivors, we actually do have, um, we have a survivor on staff right now. We do. I'm going to, of course, pay closer attention not because I don't trust them, but because I want to make sure that she is staying healthy and that things are not hitting too close to home. Um, we have a lot of staff who have a recovery background, like I'm this many years sober. We have staff who have some, some trauma, not necessarily like, um, uh, sexual exploitation trauma, but

> sexual abuse trauma on staff. So everybody has their story. Now, what we do say in training is that you do not. Like, don't get in the don't tell your story. It's not about you. And at any point, we do not want trauma bonding in the storyline like I can only talk to so and so because she's been through this before. So, she gets me.

Survivor Consultation

> We've had survivor consultation on believe some of our program pieces. Now, the program pieces were really built out before I stepped into this role. I did help edit it, but I want to say that, yes, we did have survivor consultation. We've had survivor consultation into everything our van tours. Like it's just that the executive director has really given room for that piece.

Survivor's Voice

> I even listen to our residents if they are like like I had one who was like, why do you say clients? I feel like I'm working. I was like, okay, fair. I was trying to be like like give it give you value by saying client. And you're looking at it through the perspective of like a client. And so, I shifted my language to say residents.

Behavioral health leaders working with sex trafficking survivors must consider survivor inclusion because of the positive implications of improving the program. Knight et al. (2022) reviewed the literature on resilience in trauma survivors. They concluded that the survivor's experience of resilience might be unique in overcoming trauma and positively adapting to achieve their desired outcomes, suggesting that survivor-centered research becomes a priority. Knight et al. concluded that positive interpersonal relationships with providers, mentors, survivor leaders, and other positive role models are

the most defining factor in resilience (Knight et al., 2022). Survivor inclusion is an area the RP can continue to improve and incorporate.

The next set of themes summarized the RP practices at the entry-level to ensure successful outcomes for the survivors: stabilization as a priority, a tailored treatment plan, and spirituality as a protective factor. BHL4 emphasized the importance of the first phases in the program, what is considered entry level to the successful exit and reintegration:

> If a person can stay put there, their chances of being successfully integrated are 90%. If they can stay put, if we lose them, if they drop out for some reason before then, then, you know. Other residential programs have shared information that people tend to do worse, having had a little bit of hope, a little bit of help, and then, you know, kind of feeling like they crashed and burned or failed again, um, and going back. So if we can get them to stay put, if, if our staff can can treat people, you know, with so much dignity and love and respect and patience for them to not leave, then I think they have a wonderful they have a wonderful chance because someone's success story might look like affordable housing, you know, where another person we're sending them off to, you know, a local university and they're, you know, working in, you know, a part time job and getting their own place. So, you know, success looks differently across the board, but they have to stay put long enough so that all of us can work together, get everything stabilized that needs to be stabilized and then successful, and then hand it back over to someone in a way that they can understand how to maintain

> it. And so, our phases, like four and five, is all geared towards handing the responsibility back to the resident, back to the client, back to the patient so that they know how to manage it and keep it going.

The RP follows a program called The Samaritan women's care model, and it includes three phases: stabilization, which intends to bring down or release what is harmful to the resident; growth, which aims to spread out or establish a new foundation; and independent looking to build up or invest in the future. Stabilization is the first domain focusing on safety and self-managing. Based on these objectives, the program develops specific goals for each phase; for instance, phase one of orientation includes goals like creating a personal safety checklist, learning individual coping skills, understanding triggers and types of trauma reactions, exploring spiritual options by participating in the activities offered, maintain a clean living space, learn pro-social behaviors, explore academic goals, understand needs for everyday finances and develop relationships with residents, staff, and volunteers, according to the treatment plan. A most exhaustive list of goals for each phase is provided to the residents, and the case manager follows up with each resident to oversee the results. Alongside the curriculum, the case management team works on a tailored treatment plan that might emphasize addiction recovery, education, or other personal goals. The psychologist also developed a plan for the therapy sessions, which might include trauma-focused interventions, cognitive therapy, and group sessions.

Lastly, the RP is characterized by using spirituality as a protective factor, specifically prayer, as a coping strategy. Vieten and Lukoff (2022) argued that religion

and spirituality play an essential role in people's lives, and research has confirmed the link to wellness and health. Jerome et al. (2022) also affirmed that spiritual beliefs served as an effective coping strategy for women who have experienced trauma and suggested that mental health professionals consider and incorporate religious and spiritual beliefs in their intervention. BHL4 explained the role of spirituality in the RP:

> And BHO just has a necessary component of building your spirituality and so will respect. They say we're Christian center right that's our beliefs. But build your own spirituality. Make that an important factor. And as a clinician, we know that it is a it's one of the most heavily weighted protective factors for people in keeping themselves safe and making good decisions. So not even not even just the support that it provides of having that community. And that's a huge piece for us because they're integrated into their community through these various church networks and such. But just at a baseline, having a sense of faith builds a sense of purpose and self-worth in a way that has, you know, unique implications. So, I let it's absolutely at someone's comfort level when that's an important, important piece. It's regularly integrated into counseling as a support, as an individual, a factor for for their growth and for their meaning or their purpose in life. But other people, it plays a much smaller role and will actively say, I really don't want this to be a piece of my counseling and I will 1,000% respect that as well.

On the other hand, the employee's well-being followed a similar pattern in characterizing the practices. First, the hiring process purposefully considers trauma when assessing new staff by inquiring about trauma history and self-care strategies and even

providing possible scenarios with residents to ensure the new staff can manage the survivor's vulnerabilities and trauma symptoms. BHL2, who oversees the hiring process, explained:

> But like I look at the holistic picture of what are you doing to really take care of yourself? And then also like, how do you recognize the signs of burnout in yourself is another question that I ask. Like what? What do you notice about yourself when you're feeling tired? Like, how do you respond when you're tired? Do you get more short with people? Do you do you just zone out? Do you become apathetic? Do you? All of those things like do you get more tired? Do you just sleep a lot more? Are you more grumpy? Are you more addicted to coffee? Like, do you need more coffee when you're getting burned out? Or is a monster energy drink a triggering thing for you? You know, kind of those types of things so that we know as well.
>
> Tell me about a time where you dealt with a crisis. How did you respond? What was the last time that you got cussed out or yelled at? Or tell me about how you've overcome a personal struggle in your life. Or a story of triumph in your life? Or how do you feel like you would relate to these women or some scenario questions? It's like, I don't want to scare them, but I also want to give them a real expectation of like, oh, this could happen. And what would they if they've never thought about it before? But in the moment, what would your response be? A resident stole the keys and a credit card and left. What would you do? What would you be your first thought to be if you found out the car was stolen?

The interview process includes various critical questions about the future staff member. By asking these questions, behavioral health leaders are better informed about the skills and personal strategies personnel needs to navigate the inevitable challenges of burnout and vicarious trauma symptoms. According to Muelhausen (2021) and Helpingstine et al. (2021), it is widely acknowledged that vicarious trauma, fatigue, and burnout are everyday experiences in the field. Additionally, an integral component of addressing these challenges is implementing a comprehensive training program, for which the employees must attend a two-week immersive training program on trauma-informed practices and develop their self-care plan.

Collaboration is a pillar in the trauma-informed framework. The RP encourages access to other resources to tend to the survivor's needs but also for the employee's well-being, for instance, the personnel have access to 52 therapy sessions as one of the benefits, and they can choose the therapist outside the organization; the in-house psychologist is available 24/7 to assist in any crisis job-related. The personnel is also encouraged to develop relationships with other team members to discuss the survivor's needs and share their burdens. A collaborative atmosphere is encouraged across the board in the organization.

The interaction between the survivor and employee is crucial to the treatment's success and the well-being of both parties. The practices to ensure survivor's outcomes are stabilization as a priority, a tailored treatment plan, and spirituality as a protective factor. These practices are mirrored to ensure the employee's well-being; self-awareness

is a priority, a self-care plan, and spirituality is a protective factor. The interaction between survivor-employee is the determinant of successful treatment and well-being.

Self-awareness is essential to healthcare providers working with trauma and complex trauma. Ramirez et al. (2020) stated that trauma survivors need extra time to recover, which might negatively impact healthcare workers, and recommends engaging in self-reflection as a practice to prevent burnout. For instance, during the interview, the psychologist stated her self-care practices as follows:

> Daily practitioner of yoga. Solid friend group of psychiatrists. I married a psychiatrist. Um, and so it's nice to have friends that work in similar fields so that you can talk in ways where you feel heard, understood. Um. A big piece of my self-care is kind of giving back in various ways. So, I do a good amount of volunteer work even outside of my work. It brings a sense of calm and community integration.

Alongside personal practices, the program director oversees a self-care plan with each direct care staff and works with the residential manager to check their emotional state and manage specific needs regularly. BHL3 stated:

> That's my my job with the direct care to make sure. How are you doing? How are you feeling? Um, you know, is there anything we can pray with you about? Are you implementing your self-care plan? So just this past, I've, I just finished doing self-care plans with our RC [Residential Coordinators]. Just taking them out, having a cup of coffee, going through their self-care plan with them. Who do you call for support? What do you do whenever you have self-care? What do you do

whenever it's an emergency? Self-care like okay, today was horrible. I plan to go get my nails done this week, but today was horrible. What do I do right now whenever I get off of work? Those type of things so that it's constantly before them.

Finally, prayer is the most critical practice implemented in the RP and BHO as a protective factor against burnout. Muelhausen (2021) stated that prayer improves compassion satisfaction and helps to manage burnout. Several examples from the interviews show that prayer is a common practice in the organization and is valued as a strategy to improve the emotional and mental state. BHL3 shared:

> So, when they they do check ins, um, when they debrief and switch shifts, what we do is the oncoming RC will debrief with the RC that has been on shift. And then what we've just implemented that we've seen is effective is they'll pray each other, one will pray, the other 1 in 1 will pray the other one out, and that has lent to building that team. Uh. That just that team connection and also helping the person like okay, I'm I am doing something if physically that is saying to my brain my shift is ending and I'm leaving this and I'm going home.

BHL2 explained:

> So, like prayer, making prayer, our focus. Um, and like, really making sure that prayer is something that we, um, do and believe and push for. Like, we carve an hour out of every workday for prayer at night, and it's just everyone knows, and you don't miss prayer kind of thing. So, we fight for it. Um, and yeah, perfect. We fight for, like, believing for each other, like believing in prayer. And when

someone's sick or when someone's not feeling well or having a tough time, it's not uncommon that we'll stop and pray as an office. Yeah. So, like, that's a core value of who we are. Um, well, not a core value, but a core like part of our core of who we are as believers is to pray.

BHL1 emphasized prayer as an expected practice from the employees:

We do make sure that all of our staff spends at least 10 to 15% of their time in the prayer aspect of what we do. But that's the only thing that we really try to protect the direct care stuff from doing all this other stuff *(like awareness and street intervention)*.

According to Talbot and Suzuki (2021) and Walters and Benjamins (2022), prayer is an effective coping strategy. Employees can rely on this practice as a coping strategy in moments of crisis. Muehlhausen (2021) stated that healthcare professionals might find purpose and meaning in their work when developing their spiritual health and that spiritual practices like prayer guide them and improve their well-being. The RP has incorporated prayer as a practice and protective factor. Further research on the effects on the employees and the relation with vicarious trauma and burnout.

Social Change Implications

Implementing trauma-informed practices in a residential program has social change implications by building a new social narrative that resists retraumatization in the context of sex trafficking survivors' treatment and encourages employee wellness. The RP has intentionally incorporated trauma-informed practices in the organizational culture in the entry-level responding to the survivor's needs and the potential risk of vicarious

trauma in the healthcare workers. Trauma-informed care can potentially improve health treatment adherence and outcomes and staff wellness.

The lack of standard protocols and procedures is a social concern when serving this population; however, the RP provides an example of developing protocols and procedures following the trauma-informed framework for a more humanized service for the survivor and prevention of burnout and vicarious trauma for personnel. In addition, the interaction between survivor-employee to ensure their well-being creates an organizational culture with the potential for social transformation. Organizations centered on the survivor and aware of the personnel needs to create positive social environments and develop the community.

The RP, as a faith-based organization, also contributes to strengthening nonprofit and faith community organizations in the front line fighting against this social injustice. In addition, bringing awareness and education on trauma-informed practices will impact other organizations. The spirituality developed by the RP and their strong faith stance has positively impacted the survivors, the employees, and the community. The RP is recognized in the city for its contribution to social change.

Lastly, the findings inform public policy and legislation on the relevance of trauma-informed practices and the appropriate language. Legislation on this issue in the United States is still in development, and this research supports the efforts to integrate trauma-informed practices in residential programs. Appropriate language and suggested procedures might impact standard protocol development, an identified research gap. Sex

trafficking is a worldwide concern, and the societal implications might be global as other organizations are working to serve this vulnerable population.

Strengths and Limitations of the Study

The case study generated rich and detailed data using multiple sources, such as interviews and secondary data. The case study method provides the opportunity to explore a phenomenon in depth by examining the complexities of a real-world situation (Ravitch & Carl, 2021). The behavioral health leaders detailed accounts during the interviews and the availability of critical secondary data helped provide in-depth information and nuanced perspectives on the practice problem, strengthening the study.

The research provided new insight into trauma-informed practices working with sex trafficking survivors, an identified gap in the academic literature and the practice field. The trauma-informed practices in the residential program provided a better understanding of the practical application of trauma-informed principles. Additionally, the study evaluates these practices' impact at the organizational level.

The in-depth information provided by the case study might encourage further research. Behavioral health leaders have expressed the need for more evidence-based knowledge in their organizations. The present study fills a gap in the research continuum, and other scholars might continue to explore the impact of trauma-informed practices, the role of spirituality in residential programs, the relevance of procedures at the entry-level, practices to ensure personnel wellness, and survivor health outcomes. Therefore, the case study promotes the continuity of research.

The case study approach is often criticized for lacking external validity, which means that the findings may not apply to other settings or contexts, which is a limitation of this study. However, given the global nature of the sex trafficking issue and the diverse ways it is experienced across different cultural contexts, the findings might not apply to other contexts. Yin (2012) explained that analytic generalizations are reliable as they are found in a theoretical framework that might apply to other conditions. Therefore, even though the findings might not be generalized, using both frameworks in other contexts is applicable. Future research could address this limitation by conducting comparative studies using the same frameworks across different regions and contexts.

Another limitation of the study is the potential for bias due to using interviews with only behavioral health leaders. As the information collected came strictly from organizational leaders, it may not fully represent the perspectives and experiences of other stakeholders, such as direct care staff or residents. However, the secondary data and literature analysis provided the study with an additional layer of validity.

Section 5: Recommendations and Conclusions

A healthy organizational culture that promotes employee retention and mission accomplishment must prioritize trauma-informed practices at the organizational level. The current research indicates that the case study's organization demonstrated a trauma-informed culture centered around the mission and core values and encouraged by open communication and collaboration. However, I discuss several recommendations to enhance these practices and improve organizational effectiveness. For instance, a suggested strategy is boosting compassion satisfaction by creating meaningful recognition programs. The entry-level stage is particularly challenging due to a higher risk of patient drop-out and employee burnout. Integrating data into the strategic planning process is recommended to address these challenges. By analyzing patient outcomes, employee satisfaction, and organizational performance, the organization can identify areas of improvement. Additionally, aligning policies and procedures to the trauma-informed framework can help create a supportive environment for patients and employees. Improving the hiring and recruiting process is also crucial, and continuing to apply a trauma-informed framework can enhance the organization's ability to identify and attract individuals who deeply understand trauma and its impact.

Based on the findings regarding the interaction, survivor-employees adopting a survivor-centered approach by actively seeking to include more survivors in different levels of the organization can bring unique perspectives and insights, fostering a culture that recognizes the value of survivor voices and experiences. Employee wellness should be a priority, and strategies to increase knowledge management can significantly ensure

business continuity and resilience. Collecting and applying burnout prevention practices, offering ongoing training, and providing trauma-informed supervision are essential for supporting employee well-being and preventing burnout. Spirituality as a protective factor and specifically the practice of prayer is also addressed by literature, and it is recommended to continue developing it in the organization.

Finally, the organization has the potential to become an asset to other nonprofit organizations by sharing its expertise and offering community support. By sharing best practices, providing guidance, and collaborating with other organizations that are starting to develop trauma-informed practices, this organization can contribute to creating a trauma-informed network and positively impact the broader community. Societal contribution is a critical factor in strengthening the organization, which could potentially improve community health.

The following recommendations focused on the employee and organizational practices that might be implemented according to the Baldrige framework and trauma-informed approach. The organization has established a robust trauma-informed program for survivors, and continuing those practices will ensure the expected outcomes. Nevertheless, the recommendations focus on addressing both employees and the organizational culture to foster a balanced survivor-employee interaction, prioritize employee well-being, and ultimately enhance the quality of service provided.

Recommendation #1: Strategy to Boost Compassion Satisfaction

Compassion satisfaction is the counterpart of compassion fatigue: the professional is engaged in the work and there is a sense of pleasure and fulfillment from the job and

caregiving to others (Kelly, 2020). Compassion satisfaction goes further than self-care strategies. In the organizational culture, compassion satisfaction is part of the core values and is reflected in policies and procedures. Research has confirmed that the organizational culture centered on compassion satisfaction will increase the quality of care the professionals give (Corbett-Hone & Johnson, 2022) and increase vicarious growth and resilience (Kelly, 2020; Muelhausen, 2021). The organization might create specific strategies to boost compassion satisfaction.

For instance, Kelly et al. (2017) proposed a *code compassion* model among nurses. The code compassion cart would be called to the unit when a crisis arises. The chaplain would bring the cart, which is full of items that will promote relaxation. The cart is in the breakroom and the nurses can come and enjoy the chair massage, a healthy snack, and other relaxation items. At the same time; they can debrief with another team member the events of the day (Kelly et al., 2017). The code compassion cart is a resource to address compassion fatigue directly. The RP and other organizations might adapt this idea to encourage compassion.

A program like the code compassion project could be implemented at the RP, where some volunteers that usually come to serve could prepare the cart for the RCs, the direct care staff. As part of the code compassion, they could have access to call a mentor or psychologist to debrief when critical situations emerge in the RP. Muelhausen (2021) indicated that prayer improves compassion satisfaction and helps professionals to manage burnout. Considering the predominant role of spirituality in the organization, prayer is a coping strategy that could be added to the compassion code in the RP. The direct care

staff could have a personal time of prayer or reach out to some of the prayer partners the organization already has, stimulating collaboration.

The key to compassion satisfaction is meaningful recognition (Kelly, 2017), and a recommendation would be that the compassion cart carries a jar of notes written by the residents being grateful for the personnel and notes from the other employees recognizing their team members for their work. The direct care staff could approach the compassion cart at any given moment, not only when facing a difficult situation, but as a real boost to the joy of the performed job. Access to a boost of compassion satisfaction at any time is a preventive strategy for burnout and compassion fatigue (Muelhausen, 2021). The direct care staff needs meaning-making strategies to stay engaged and provide survivors with the best care.

The toolkit for building survivor-informed organizations developed by the Administration for Children and Families (2023) also suggested incorporating sensory-based grounding tools and resources that incorporate the five senses, such as aromatherapy, stress balls, music, and art (p. 43). The RP case management team and volunteers involved in developing the code compassion project can be creative and adjust according to the needs of the direct care staff. Since the organization will continue to offer opportunities for survivors' inclusion, strategies to manage burnout and trauma symptoms will be helpful.

Recommendation #2: Continuous Improvement

Continuous improvement requires the availability and openness to assess the organizational culture and adopt the policies and practices to improve (McNamara,

2005). The Administration for Children and Families (2023) suggested that evaluating policies regarding paid leave for mental and physical health needs is essential. They also recommended establishing clear policies regarding self-care and taking proactive measures to prevent burnout. Furthermore, the organization should assess the effectiveness of wellness benefits such as paid staff breaks, flexible schedules, and mental health leave. Additionally, fostering a culture of learning and knowledge sharing among all employees is highly encouraged (Administration for Children and Families, 2023, p. 43). The RP is also already working on those areas, but it will be essential to include them in the strategic plan for the following years.

The recommendation for behavioral health leaders in the organization is to assess and focus on action, adjusting policies and procedures as needed. Documenting these processes and communicating the improvements is essential for further improvement. The continuous improvement model is based on making small and incremental changes to improve processes and/or removing unnecessary practices continually (McNamara, 2005). The suggested process to start the model of continuous improvement in the RP is as follows:

- *Assessment of current policies and culture*: Engage the case management team and senior leadership to evaluate existing policies, procedures, and organizational culture. Identify areas where improvement is needed to enhance employee well-being and effectiveness.
- *Identify areas of improvement*: Involve the case management team and direct care staff in identifying areas where improvements can be made. Seek their

input and insights regarding potential changes that positively impact their well-being and performance.

- *Implement small changes*: Start by implementing small, manageable changes based on the identified areas of improvement. These incremental changes can lead to significant positive impacts over time.
- *Remove unnecessary activities or pract*ices: Continuously evaluate existing activities and practices to identify any that are no longer effective or beneficial. Remove or modify these unnecessary elements to streamline processes and improve overall efficiency.
- *Document changes*: It is crucial to document the changes made, including the reasons behind them and the expected outcomes. This documentation is a valuable resource for future assessments and helps track progress.
- *Identify the next incremental change*: After implementing the initial changes, engage the case management team and direct care staff in identifying the following incremental change toward improvement. This process ensures continuous growth and positive development within the organization.

By implementing this recommendation, the organization can cultivate a culture of continuous improvement, prioritizing employee well-being and optimizing overall organizational effectiveness. The behavioral health leaders can manage change in small increments instead of provoking significant distress in the organization. In an atmosphere of collaboration, the organization will continue to focus on wellness and development.

Recommendation #3: Integrating Data

The recommendation is to enhance the evaluation process and gather valuable feedback from residents and personnel in the RP. To achieve this, behavioral health leaders should expand data collection by implementing several instruments to collect data. For instance, a semiannual anonymous survey could include basic questions that assess organizational practices, strengths, and areas for improvement. Establishing regular surveys will allow behavioral health leaders to compare data and evaluate progress (see Baldrige Performance Excellence Program, 2021).

Additionally, it is essential to incorporate trauma-informed practices by creating a survey or hosting a group discussion to evaluate their application in the program. The toolkit for building survivor-informed organizations developed by the Administration for Children and Families (2023) and the guidelines provided by the Blue Knot Foundation (2021) are resources for developing effective data collection instruments. Furthermore, collecting patient and employee satisfaction data will provide valuable insights to improve service quality and the work environment. By implementing this recommendation, the RP can enhance the evaluation process, gather comprehensive feedback, and promote a trauma-informed and supportive environment.

Recommendation #4: Enhancing the Hiring and Advancement Processes

The first part of the recommendation is to implement trauma-informed hiring practices. In consideration of including survivors in the workforce, the Administration for Children and Families (2023) advised incorporating trauma-informed principles into hiring, which can be achieved by asking relevant questions that assess the candidate's

skills necessary for the position and addressing their self-care plan from the interview stage. Additionally, ensure that confidentiality agreements are signed and avoid questioning applicants about their experiences with trafficking. If such information is voluntarily shared, do not ask for the trafficking story, as it can be re-traumatizing.

The next step would be to *promote advancement opportunities*. Defining clear job descriptions, establishing performance measures, and conducting annual evaluations fosters employee growth and motivation (Administration for Children and Families, 2023). The organization can facilitate career progression and professional development by providing employees with a transparent understanding of their roles and expectations. Furthermore, ensure that raises and incentives are fair, consistent, and transparent, which helps recognize and reward employees' contributions (Administration for Children and Families, 2023). Survivors' inclusion ensures every employee can access the same benefits and incentives.

An additional step would be to *address essential characteristics*. The applicant's interview should address essential characteristics outlined by Ramirez et al. (2020): health professionals caring for sex trafficking survivors should demonstrate knowledgeability, trustworthiness, and a commitment to self-reflection and teamwork (p. 4). By assessing these qualities during the interview process, the organization can ensure that new hires align with the specific needs and values of the RP. The hiring process in the RP is already detailed; however, establishing these practices in a protocol that includes the key questions and identifies the candidate's strengths and values. Inquiring

about their trauma experience might be beneficial; however, avoiding retraumatization is a priority.

The RP can enhance its hiring practices by implementing these recommendations to align with trauma-informed principles and promote employee retention. Additionally, establishing clear job descriptions, performance measures, and fair advancement opportunities contributes to employee satisfaction and professional growth. Finally, by addressing essential characteristics in the interview process, the organization can ensure that new hires possess the necessary qualities to provide adequate care and support within the RP.

Recommendation #5: Survivor Leader Engagement

The RP is open to survivors' participation at different levels; however, the organization could explore further and intentionally include survivor leaders in all stages. For instance, search for survivor expertise on developing policies, procedures, project implementation, and evaluation. Another recommendation is to designate a portion of the budget (suggested 2-3%) to implement a survivor-informed plan (Administration for Children and Families, 2023, p. 22-23). By implementing these recommendations, the RP can deepen its engagement with survivor leaders and promote their active involvement in shaping policies and programs. This approach enriches the organization's decision-making processes and helps create a more survivor-centered and inclusive environment.

Recommendation #6: Employee Wellness

The interaction between survivor-employee in the context of sex trafficking implies exposure to trauma; leaders in behavioral health must recognize the necessity of

prioritizing employee well-being. These recommendations outline practical approaches to safeguard the employees' mental health consistently.

Self-Care Plan

Posluns and Gall (2020) suggested that self-care practices in employees must be encouraged as prevention, not only as intervention. Therefore, developing a self-care plan is highly suggested as a practice. Plans should be discussed with the supervisor and updated as needed. In addition, it is recommended to allocate 1 hour per week for staff members to engage in self-care activities. Employees can prioritize their well-being by providing dedicated time, contributing to overall job satisfaction and productivity. The organization should also consider offering various self-care activities and actively model participation to encourage employees to prioritize their well-being. The RP can create a supportive environment that promotes employee well-being and self-care by implementing these recommendations, ensuring employee satisfaction, reducing burnout, and fostering a culture of understanding and resilience within the organization.

Trauma-Informed Supervision

To further enhance the supervision system within the RP, it is recommended to implement trauma-informed supervision practices and provide advanced training for the program director and supervisors involved. This training should focus on identifying personal biases and prejudices, understanding their impact, and implementing strategies to mitigate them effectively. Additionally, specialized training in trauma-informed supervision techniques is essential (Administration for Children and Families, 2023). Trauma-informed supervision should prioritize the principles of confidentiality, trust, and

empowerment. Supervisors must create a safe and supportive space where staff members feel comfortable expressing themselves and identifying personal and professional growth areas. Supervisors should be vigilant in recognizing signs of trauma triggers and be proactive in providing support when staff members are experiencing distress, which might involve adjusting schedules or workloads to accommodate their needs (Administration for Children and Families, 2023).

Another valuable recommendation by the Administration for Children and Families (2023) is to establish a regular, voluntary process for debriefing at the end of challenging days. This practice aims to reduce trauma triggers and foster a culture where trauma responses are understood and destigmatized. The RP already addresses crisis and trauma responses; this debriefing practice might just need to be formally established. Ultimately, trauma-informed supervision's primary goal is to promote staff wellness. Supervisors can contribute to their staff's overall well-being and professional development by fostering a supportive and empowering supervisory environment.

Ongoing Training

The orientation phase is vital to employee retention and should be strengthened by incorporating comprehensive guidance on updated policies and procedures. Furthermore, implementing a peer support program during the first three months can facilitate the learning process and provide additional guidance and support to new employees. Ongoing training is highly suggested, including conflict resolution and best practices for controlling the disclosure of trauma and personal experiences (Administration for Children and Families, 2023). In addition to the initial training, fostering a culture of

continuous learning and professional development is essential. Encouraging employees to pursue growth in various areas, including leadership, client services, and specific certifications, can contribute to their personal and career advancement.

Recommendation #7: Prayer and Other Spiritual Practices

Vieten and Lukoff (2022) stated that religious and spiritual practices are linked to better health and psychological functioning improvement as they increase the sense of meaning, resilience, and satisfaction. Furthermore, participation in organized religion and spirituality has been associated with psychological well-being and lower rates of mental, medical, and substance abuse disorders (Vieten & Lukoff, 2022). Talbott and Suzuki (2021) and Jerome et al. (2022) identified spiritual practices as effective coping strategies, especially when facing a crisis or overcoming trauma. Prayer was identified as the most prevalent practice to improve well-being and as a protective factor. The RP is strongly anchored on spiritual practices, especially prayer.

Vieten and Lukoff (2022) addressed the lack of training in religion and spirituality; for instance, 75% of psychology programs do not include it, and other studies indicate that spirituality is the least area of diversity addressed in APA-accredited programs. It is recommended that personnel and other stakeholders develop spiritual competencies that will allow them to serve the residents without biases and prejudices. A suggested spirituality assessment includes screening for religious/spiritual relevance, religious/spiritual strengths, organized and personal practices, and problems with religious/spiritual practices (see Vieten & Lukoff, 2022). The religious and spiritual areas

might be included in the formal mental health assessment in the entry process to improve intervention and encourage using these practices as effective coping strategies.

Lectio Divina – Meditation

In their study, Knabb et al. (2022) investigated the effects of two different meditation approaches, namely Lectio Divina (a Christian-based model of meditation) and loving-kindness meditation (derived from Buddhism), on trauma survivors. The purpose was to assess the effectiveness of these approaches in alleviating trauma and PTSD symptoms. The findings revealed that Lectio Divina, a culturally sensitive alternative specifically designed for Christian trauma survivors, demonstrated positive outcomes among individuals who identified as Christians and had experienced trauma and PTSD symptoms, suggesting that implementing Lectio Divina can be an effective intervention for this particular population.

These are the steps suggested in the model of Lectio Divina:

1. Reading, which includes "slowly [reading], phrase by phrase," a selected passage in Scripture.
2. Meditating, which includes reflecting on, pondering, and meditating on a passage in Scripture by letting the "text soak in."
3. Praying, which includes conversing with God in order to speak to him, listen to him, and commune with him; and
4. Contemplating, which includes resting in God, that is, contemplating God, by slowly, softly, and simply reciting a key word from the passage, before sitting in

loving silence with God (Wilhoit & Howard, 2012, as cited in Knabb et al., 2022, p.235).

The Lectio Divina model of meditation, rooted in Christian practices, is known for fostering positive emotions, such as Christian contentment and gratitude, while simultaneously reducing trauma symptoms and related emotions (Knabb et al., 2022). Given the RP's alignment with this approach, incorporating the Lectio Divina model may be recommended for trauma survivors and employees who may experience vicarious trauma and burnout symptoms. By engaging in Lectio Divina, individuals can potentially benefit from its positive effects on well-being and trauma recovery.

Knabb et al. (2022) emphasized this model's effectiveness, consistent with the recommendation to develop stabilizing strategies in the first stages of treating trauma. The positive outcomes observed in their research suggest that incorporating the Lectio Divina model can be particularly beneficial during entry, providing a Christian-based approach for trauma survivors. By integrating Lectio Divina into the RP's practices, individuals can benefit from its potential to foster stability, emotional well-being, and spiritual growth. This Christian approach offers a valuable resource for creating a supportive and culturally sensitive environment that addresses the unique needs of trauma survivors within a faith-based framework.

Recommendation #8: Societal Contribution

One of the main concerns identified in the research is the lack of a minimum standard of care and protocol to serve this population (Cuhna et al., 2022; Iqbal et al., 2021; Koegler et al., 2021). Also, current research has a consensus that trauma-informed

practices are the best approach for organizations working with trauma survivors (Chambers et al., 2022; Cloitre, 2021; Stanford et al., 2021). The RP of this case study has taken the first steps in creating a trauma-informed approach protocol to serve sex trafficking survivors. The research findings described the guiding principles of trauma-informed development in the program.

Therefore, the organization can potentially become a valuable asset to other organizations striving to eradicate this form of modern slavery. Drawing upon their experiences, the RP can contribute to the community by providing training and collaborating with others who might be using the trauma-informed framework. Additionally, they can raise awareness and promote the use of appropriate language among care providers in the continuum of care. The organization could facilitate strategies to resist retraumatization and stigmatization when the survivors encounter other healthcare providers. The organization's leadership should also assess the extent of their influence and involvement in improving practices and leverage their core competencies to support other organizations beyond mere networking. Lastly, the leadership should consider advocating for a minimum standard of care at the public policy level. The organization has pioneered in the city serving this population, their presence is crucial to advocate and improve the continuum of care.

Future research

The practice problem of identifying trauma-informed practices to ensure the well-being of sex trafficking survivors and the employees developed in a RP that serves women who have experienced sex trafficking is a relatively new topic in the field. Even

though the Department of State (2021) suggested implementing trauma-informed practices, the research evidence is scarce, and there are no uniform protocols for intervention. The case study of the RP provided in-depth information about trauma-informed practices implemented in a program.

One unanticipated finding of the doctoral study was the positive impact of the faith stance and spirituality as a protective factor, being prayer as the most significant practice. Knight et al. (2022) discussed the similarities between the Christian faith and social work because both frameworks address social justice. Vieten and Lukoff (2022) addressed that religious and spiritual practices are linked to better health and improved psychological functioning; Jerome et al. (2022) also discussed religious beliefs as coping strategies for people who have experienced trauma. Furthermore, the case study provided in-depth information about the faith stance in a residential program and the potential positive outcomes for survivors and personnel. Further research on the impact of spirituality in the context of trauma-informed practices will be beneficial to the organization and other faith-based organizations.

Another area to further explore is the workforce; employee turnover was the generator of the practice problem for this research; however, there is more to explore in terms of employee engagement, retention, and development. Burnout is an occupational phenomenon that requires further research, especially among healthcare providers exposed to trauma and complex trauma. Employee well-being is an area to further develop in the practice field and academic research. The interaction survivor-workforce

in the context of sex trafficking requires further attention to ensure their well-being and an organizational culture fostering inclusion, respect, and mental health.

I shared the research findings with the organization's leadership in a conference call presenting an executive summary on an accessible format to further reading. The organization might consider recommendations and promote meetings with personnel at the different levels to implement as needed. I will be available to consultation as requested by the organization's leadership.

Conclusion

I described findings based on the analysis of the data collected through interviews and secondary data, followed by recommendations for behavioral health leaders. The BHO in the case study focuses on providing a trauma-informed residential program for female sex trafficking survivors. The core principle of this approach is the understanding that every person has experienced trauma; therefore, the practices implemented in the residential program must consider the survivors and the personnel and their experience of trauma.

The entry-level is the most challenging because the survivors experience trauma symptoms and a sense of distrust, while employees are constantly exposed to distress and at risk of vicarious trauma. However, implementing trauma-informed principles within the organization has proven to be highly effective in addressing the unique needs of this population. Furthermore, focusing on humanizing the entry-level experience has increased treatment adherence and health outcomes.

The recommendations to behavioral health leaders include specific practices to enhance the program, increase employee retention, and foster compassion satisfaction. One crucial recommendation is to prioritize survivor inclusion at all levels. This can be achieved by actively increasing their presence, amplifying their voice, and involving them in decision-making. The principles of collaboration and empowerment will lead the way in the survivor inclusion process.

Considering the faith stance of the organization, spirituality can be recognized as a protective factor and a driving force in the organizational culture. The firm faith stance

might encourage other faith-based organizations to work against this form of social injustice. A balance based on the principle of choice allows the organization to stand firm on its mission and core values. While employees are encouraged to uphold these core beliefs and values, survivors are given a choice even before joining the program. The recommendations for the hiring process and the inclusion of other spiritual practices aim to strengthen the organization.

Finally, I recommend embracing continuous improvement and integrating data to propel the organizations forward regarding service quality. Becoming a data-driven organization will significantly enhance the ability to adapt and improve. Furthermore, leveraging the knowledge will enable the organization to contribute to other providers and advocates in the continuum of care. Through its advocacy and influence in the community, the organization can positively influence legislation and public policy, furthering the fight against this form of modern slavery.

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