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Trauma-Informed Continuity of Care: A Reintegration Model for Trafficking Survivors and Vulnerable Return Migrants

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ABSTRACT

Return does not equal recovery. Survivors of trafficking and vulnerable return migrants often face continuing psychological distress, debt, stigma, family conflict, unstable housing, unmet health needs, and weak livelihood opportunities long after a case file records a location. This paper reframes reintegration as a capability process, the practical freedom to achieve safety, psychosocial stability, social acceptance, service access, and economic participation, rather than a completed status, a disbursed grant, or an income threshold. Using a narrative synthesis of evidence spanning trauma psychology, migration studies, and program evaluation, the paper develops a trauma-informed continuity-of-care model built around six sequenced phases: stabilization, collaborative assessment, individualized planning, coordinated implementation, adaptive review, and supported transition. The model links these phases to measurable outcomes across safety, psychosocial well-being, social connection, service access, and economic functioning, and to governance and evaluation design capable of testing where it breaks down. The analysis identifies premature case closure and livelihood assistance sequenced ahead of protection analysis as two avoidable failure points, and specifies what disconfirming evidence would look like rather than treating positive indicators as sufficient proof of recovery. Consolidated tables translate operational risk and governance assurance domains into case-management tools. The model is offered as a testable, falsifiable basis for program design and evaluation, not a demonstrated solution, closing with a research agenda for comparative and longitudinal testing.

Keywords: reintegration; capability approach; human trafficking; return migration; trauma-informed care; psychosocial support; case management; continuity of care; narrative synthesis

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Introduction

Return migration is often recorded as a movement outcome: an individual arrives in a country or community of origin. Reintegration is different. It concerns whether the person develops sufficient safety, psychosocial stability, social acceptance, access to services, and economic participation to live without heightened pressure to re-enter unsafe migration or exploitation. For trafficking survivors, the distinction is essential because return may occur while threats, trauma symptoms, debt, stigma, or family conflict remain active.

Trauma-informed practice shifts the question from what is wrong with a person to what happened, what risks persist, what strengths exist, and what conditions support recovery [5]. It does not require every case manager to provide therapy. It requires organizations to design contact, choice, documentation, referral, and supervision in ways that recognize trauma and avoid further harm. Research on trafficking survivors emphasizes relational trust, multidisciplinary support, culturally responsive assessment, and long-term accompaniment [12], [13], [15], [16], [19], [21], [23], [25]. The health stakes of this recovery period are well established: conceptual work linking trafficking exposure to health has argued that post-trafficking health and psychosocial needs are inseparable from reintegration planning rather than a separate clinical track [36], and systematic evidence on the physical, mental, and sexual health burden associated with trafficking documents why unaddressed health needs can undermine reintegration efforts that otherwise appear well designed [37].

Many reintegration programs nevertheless remain time-limited and output-driven. They count grants, trainings, or completed plans, while outcomes such as emotional safety, family acceptance, stable housing, service continuity, and livelihood quality receive less

consistent attention. International guidance has increasingly framed reintegration as economic, social, and psychosocial dimensions that interact rather than as a single administrative milestone [3], [7]. This paper asks how protection programs should structure trauma-informed reintegration as a continuity-of-care process and how they should measure sustainability without reducing recovery to a single score.

The remainder of the paper proceeds as follows. Section 2 sets out the conceptual foundation and a narrative synthesis method for integrating evidence from trauma psychology, migration studies, and program evaluation that cannot be pooled through meta-analysis. Section 3 synthesizes findings on reintegration mechanisms, including the causal chain from safety to sustainable participation, competing explanations for observed change, and the boundary conditions that any continuity-of-care model must confront across different settings. Section 4 develops the trauma-informed continuity-of-care model itself: its six phases, multidomain outcomes, governance and workforce requirements, evaluation design, and consolidated tools for operational risk and assurance. Section 5 argues that reintegration should be understood as a capability process rather than a status or an income level, identifies where continuity-of-care models break down in practice, and specifies how sustainability should be measured and what would count as evidence against the model. Section 6 concludes.

This paper's contribution is threefold, each defined against a framework already cited. (1) Unlike the Palermo Protocol's victim-assistance provisions, which specify recovery measures tied to a person's status and case proceedings without addressing what happens once a case concludes [1], the model in Section 4 is explicitly non-linear: closure triggers a documented risk review and, where indicated, a return to stabilization (Figure 1) rather than an exit from the model. (2) Unlike direct-assistance guidance that delivers livelihood, medical, legal, and psychosocial

support as components of one package without a required order [3], this model sequences livelihood and individualized planning strictly after risk assessment, treating order, not only availability, as the protective mechanism. (3) Unlike IOM's integrated approach, which establishes conceptually that economic, social, and psychosocial dimensions interact but does not specify how they should be measured together [7], this paper operationalizes that interaction as five outcome domains reported as an interdependent profile (Figure 2), each read against the other four, so no single domain's result can substitute for the others.

2 Conceptual Foundation and Narrative Synthesis Method

2.1 A social-ecological model of trauma-informed reintegration

The analysis combines trauma-informed principles with a social ecological view of reintegration. Individual well-being depends on relationships, institutions, labour markets, community norms, and public systems. The framework therefore examines five levels: personal stabilization, household relations, community inclusion, service-system performance, and structural opportunity. This layered view follows the logic used in international reintegration guidance, which treats economic, social, and psychosocial dimensions as interacting rather than additive components of a single outcome [7]. A shift at one level tends to propagate to the others: a hostile labour market can strain household finances and intensify family conflict, an unresponsive service system can leave a psychologically stable survivor without livelihood support, and a well-run referral network can partly compensate for constrained state services. The model therefore treats these levels as connected pathways rather than independent domains, so an intervention aimed at one level is evaluated

for its effects on the others as well.

2.2 Narrative synthesis as the review method

This paper synthesizes evidence narratively rather than statistically because the underlying studies cannot be pooled into a single effect size. The evidence base spans experimental and observational trauma psychology, qualitative and ethnographic migration studies, and program evaluations and monitoring toolkits produced by protection agencies, and these bodies of work use incompatible outcome measures, sampling frames, and units of analysis. Narrative synthesis, as set out in the ESRC Methods Programme guidance developed by Popay and colleagues, addresses this heterogeneity through a structured sequence: developing a preliminary theory of how the intervention or mechanism is expected to work, organizing extracted findings into a common tabular format so that studies addressing the same mechanism can be compared side by side, exploring relationships within and between studies to identify where findings converge or conflict, and assessing the robustness of the resulting synthesis by weighing study quality and the risk that missing or unpublished evidence has shaped the pattern of results [30]. Applied here, this means the review first specified the mechanisms introduced in Section 2.1, tabulated findings from trauma psychology, migration studies, and program evaluation against those mechanisms rather than against a single outcome metric, and treated agreement across method types, not statistical pooling, as the strongest form of evidence available. Disagreement between sources was retained and reported as a boundary condition rather than resolved by discarding the outlying study, consistent with narrative synthesis guidance that treats conflicting findings as informative rather than as noise to be averaged away [30].

2.3 Search strategy, coding, and evidence appraisal

Sources included international guidance, conceptual work, qualitative studies, practice frameworks, and reintegration research published

mainly between 2000 and 2026, with search strategies combining database queries with citation tracking from recent systematic reviews of trafficking-survivor services [26], [27]. Evidence was coded against the mechanisms specified in Section 2.1: felt safety, dependable relationships, restored agency, service fit, economic control, social acceptance, and continuity across transitions, following the tabulation step described in Section 2.2. Greater weight was given to findings that described the sequence of support and the lived experience of survivors or frontline practitioners than to sources that reported activity counts alone, because activity counts cannot distinguish a mechanism that worked from one that merely occurred. Sources were retained only where they addressed trafficking survivors, unsafe labour migration, or closely related displacement and return populations; general refugee or asylum literature was excluded unless it addressed a mechanism directly transferable to trafficking-specific risk, such as trauma-coerced attachment or reintegration-linked stigma. Each source was appraised for population relevance, method transparency, and disclosed limitations before its findings were used to support a claim in Sections 3 and 4, and conflicting findings were retained rather than discarded so that boundary conditions could be specified explicitly, consistent with the narrative synthesis approach set out above [30].

2.4 Defining the reintegration pathway as the unit of analysis

The review's unit of analysis is not a single service contact but a longitudinal reintegration pathway spanning stabilization, collaborative planning, service coordination, livelihood recovery, social connection, and follow-up for trafficking survivors and vulnerable return migrants specifically, not protection populations in general. This choice matters because a pathway framing prevents a

common analytical error in this literature: attributing a survivor's outcome to one worker, one grant, or one organization when the outcome in fact emerged from an interdependent sequence of decisions. A person may receive a competent first response from a shelter or case manager and still experience harm because the next provider is unavailable, information about her history is transferred unsafely between agencies, or no one reviews the case again after initial assistance ends. The framework therefore evaluates the connections between stages, not only the quality of any single stage in isolation.

The relevant actors in this pathway include survivors, family members, peer workers, case managers, mental-health providers, livelihood partners, community leaders, and program funders, and their incentives, authority, knowledge, and exposure to risk differ in ways specific to trafficking and return-migration casework. Frontline personnel often see urgent facts, such as an unsafe household or a missed appointment, but lack formal authority to reallocate resources. Managers control resources but may see only aggregated reports that hide an individual case's deterioration. Survivors hold essential knowledge about what is safe and acceptable to them but may face unequal power in every interaction with the system meant to help them. Analysis must specify who decides, who bears the consequences, who receives information, and who is accountable when coordination fails at any point along this specific pathway, following guidance that treats reintegration's economic, social, and psychosocial dimensions as interacting components of a single process rather than as separable outputs assignable to a single actor [7].

2.5 Distinguishing constructs used across the review

This review treats quality in trauma-informed reintegration as the degree to which a system produces safe, timely, equitable, and person-centred action under real operating constraints, not as compliance with a checklist. A service may

complete every required form, disburse a grant on schedule, and log a completed training session while still failing to secure the response a survivor actually needed. Compliance still matters because minimum duties protect against arbitrary practice, but procedural completion is weak evidence of substantive success in a population where the central risks, re-exploitation, unsafe family return, or livelihood collapse, often surface only after a case appears closed.

The mechanisms this review tracks, felt safety, dependable relationships, restored agency, service fit, economic control, social acceptance, and continuity across transitions, are defined and measured separately from one another because trafficking-specific practice literature repeatedly shows that they are conflated in ways that inflate claims of success. Trust is not identical to satisfaction with a single interaction. Referral issuance is not the same as service receipt. Training attendance is not demonstrated staff competence. Data completeness is not data validity. A dedicated reintegration monitoring toolkit makes exactly this point operational for trafficking-survivor casework, requiring each indicator to carry a definition, numerator, denominator, source, and owner before it is treated as evidence of a specific construct rather than a convenient proxy for it [9]. Holding these constructs apart lets an

evaluator locate failure along the causal pathway specified in Section 2.4, rather than concluding only that a program did or did not work.

2.6 Scope, clinical boundary, and exclusions

The review addresses non-clinical program design for trauma-informed reintegration casework. Clinical diagnosis and treatment remain the responsibility of qualified professionals, and the measures proposed in Section 4 support case management and program evaluation; they do not replace clinical instruments or individualized clinical judgment. This boundary follows established guidance that separates trauma-informed program design from clinical diagnosis and treatment, which require licensed practitioners operating under separate professional standards [5]. The review also concentrates on adult and mixed-age service populations characteristic of trafficking-survivor and return-migrant casework; child-specific statutory protection systems are referenced only where they intersect directly with family engagement and reintegration planning, since a full child-protection framework raises distinct legal and developmental questions beyond this paper's scope. The review is further limited to sources available in English and to internationally published or indexed material, a boundary revisited in Section 5.4 because it may underrepresent locally documented practice in some of the settings the model is intended to serve. Table 1 summarizes the six phases of the

Table 1. Reintegration phases and decision points

Phase	Primary purpose	Exit question
Stabilization	Address urgent safety and practical needs	Is participation safe and feasible?
Assessment	Understand risks, strengths, and priorities	Does the plan reflect the survivor's goals?
Planning	Sequence services and responsibilities	Are roles, timing, and contingencies clear?
Implementation	Deliver and coordinate support	Are services received and useful?
Review	Adapt to change and monitor harm	What should continue, change, or stop?
Transition	Close responsibly and preserve re-entry	Is closure safe and understood?

proposed model and their associated decision points; Section 4 develops each phase with objectives, activities, and transition criteria.

3 Findings on Reintegration Mechanisms

3.1 Stabilization precedes demanding participation

Programs often ask survivors to complete detailed assessments, business plans, or training soon after return. When housing, food, safety, sleep, or acute health concerns remain unresolved, these demands may overwhelm rather than empower. Stabilization includes practical assistance, predictable communication, crisis referral, and clear information about available choices. Trauma-informed guidance treats this sequencing as a design principle rather than a matter of pacing preference: asking a person in acute crisis to make complex decisions or disclose sensitive history before basic safety is addressed risks retraumatization and disengagement, and can read to the survivor as further proof that the system's priorities do not match their own [5]. A stabilization phase that meets practical needs first, without demanding disclosure or commitment as a condition of help, builds the minimal trust that later assessment and planning depend on, and premature escalation to structured intervention should be treated as a program failure to investigate rather than a survivor failure to comply. Population-level evidence on trauma exposure among trafficked and sexually exploited women and girls found a dose-response relationship between exposure severity and mental-health morbidity, reinforcing why acute health and psychological needs cannot be deferred until later program phases [38], and studies of survivors' health-care access more broadly have found persistent disparities in engagement even where services exist on paper, further supporting a stabilization-first sequence [45]. Health-system frameworks

that integrate structured mental health screening directly into primary-care intake show that early psychosocial identification can occur without imposing a separate, demanding assessment step at first contact, reinforcing the case for stabilization-first sequencing [51].

3.2 Trust develops through reliability

Trust is not secured by a consent form. Survivors assess whether staff keep appointments, explain limits of confidentiality, respond to urgent needs, and avoid punishment for missed contact. Collaborative accompaniment models emphasize consistency and shared decision-making [15]. Trust-building is also complicated where a survivor has formed a trauma-coerced attachment to an exploiter; case managers should expect ambivalence, protective loyalty, and non-linear disclosure rather than interpreting them as non-cooperation [17]. Staff supervision also matters because secondary traumatic stress and high caseloads influence service quality. A worker who is exhausted, undersupervised, or carrying an unmanageable caseload is more likely to cancel appointments, respond slowly to messages, or misread ambivalence as disengagement, and each of these erodes the reliability that trust depends on. Programs that treat trust-building as a personal trait of individual staff, rather than an organizational output that depends on caseload limits, supervision quality, and continuity of assignment, will see trust vary unpredictably by worker instead of improving systematically across the caseload.

3.3 Livelihood support must follow protection analysis

Income generation supports autonomy, but poorly matched assistance can create debt, expose location, intensify household conflict, or return a survivor to exploitative work. Livelihood planning should assess skills, market demand, care responsibilities, disability, transport, safety, and access to documentation. Economic outcomes should include income stability, job quality, control over earnings, and exposure to harm. Evidence from returnee mentoring

programs in West Africa shows that unmentored grants without follow-up support are more likely to be depleted quickly or diverted to debt repayment, while structured mentoring relationships help sustain livelihood gains once initial assistance ends [20]. Livelihood planning should therefore be sequenced after, not instead of, a protection analysis: a plan that overlooks an abusive household relationship or an unsafe workplace can leave a survivor more visible or more dependent on a risky arrangement, even when the business itself succeeds financially. An early evaluation of an economic-empowerment program for returned survivors in Thailand and the Philippines similarly found psychosocial reintegration benefits alongside income effects, but only where vocational support was paired with continued follow-up rather than a one-time disbursement [49].

3.4 Community conditions shape outcomes

Stigma, blame, misinformation, and community surveillance may undermine an otherwise strong individual plan even when every service within it performs well. A survivor whose status becomes locally known may face reduced marriage prospects, exclusion from community associations, withdrawal of informal credit, or renewed contact from people connected to the original exploitation, and these pressures can force relocation regardless of how carefully a case plan was designed. Evidence from Indonesian reintegration experiences shows that stigma and continuing economic precarity, rather than an absence of services, were what survivors identified as the central threats to sustained recovery [21]. Recent qualitative evidence from Bangladesh reaches a closely related conclusion: socio-cultural norms around family honor, combined with structural economic exclusion, shape whether survivors can sustain reintegration once formal assistance ends, which reinforces that

community-level conditions operate as an independent determinant of outcome rather than a background factor a case plan can safely ignore [33]. Programs therefore need discreet engagement, service mapping conducted without naming individuals, family work only where it is assessed as safe, and community-level prevention messaging that addresses migration and exploitation risk in general terms rather than by identifying specific returnees. Reintegration should never depend on public disclosure of survivor status, and any monitoring or evaluation activity that would require a survivor to be identified within a community setting should be treated as a safeguarding risk in its own right, not as a routine data-collection step.

3.5 Case closure is a risk decision

Administrative completion differs from sustainable reintegration, and treating a completed checklist as equivalent to a safe closure is one of the more consequential errors a program can make. A case can be formally closed because a grant was disbursed, a training course was finished, or a fixed service period ended, while the underlying risks that brought the person into the program, such as unresolved debt, an unsafe household, or an unstable livelihood, remain active. Qualitative accounts of survivors' health and support experiences at a carceral touchpoint similarly find that a case can be closed from an institutional standpoint while the underlying risks that brought the person into contact with services in the first place remain fully active [48]. Closure decisions should instead weigh current risk, service continuity, the survivor's own preference, stability across the safety, psychosocial, and economic domains tracked throughout the case, and a documented re-entry pathway in case circumstances deteriorate after the case is closed. A monitoring toolkit developed for trafficking-survivor reintegration recommends recording not only that a case was closed but why closure was judged safe at that specific point and what support remains reachable afterward, since closure without that record leaves no basis for learning

when a case reopens or a later review finds harm that predated closure [9].

3.6 Reintegration as a capability process

A capability perspective, developed as a framework for evaluating well-being in terms of the practical freedoms a person actually has rather than the resources nominally made available to them, asks what a person is able to do and become, not only what assistance was delivered [2]. Two survivors receiving the same grant may have different freedom to use it because of family control, disability, childcare, insecurity, market access, or legal documentation. Reintegration assessment should therefore examine practical opportunities, personal control, and constraints. This perspective avoids equating formal service access with meaningful benefit. Reviews of aftercare service models for trafficking survivors identify a comparable range of program elements, shelter, medical care, legal assistance, vocational training, and family reintegration support, but caution that few evaluations track whether these elements combine into the kind of practical freedom a capability perspective asks about [39]. Systematic review evidence on aftercare specifically for child trafficking victims reaches a similar conclusion, finding that available evaluations describe service provision more often than they measure a child's actual functioning after program exit [50].

The capability approach also supports individualized goals within a common outcome framework. Programs may monitor safety, health, housing, social connection, learning, and economic participation for everyone while allowing each person to define priorities and acceptable pathways. Goal attainment should record partial progress and changing preferences rather than classify every plan as completed or failed. This individualized, multidomain framing is consistent with guidance that treats

reintegration's economic, social, and psychosocial dimensions as interacting rather than as separate outputs to be scored in isolation [7].

3.7 Gender, age, disability, and intersecting risk

Trafficking and unsafe migration do not affect a uniform population. Gender norms may shape stigma, care responsibilities, livelihood options, and exposure to violence. Age influences legal status, autonomy, education, and guardianship. Disability affects communication, mobility, service eligibility, and dependence on caregivers. Sexual orientation, ethnicity, religion, and migration status may compound exclusion.

Programs should build these dimensions into assessment and service design while avoiding fixed assumptions. Disaggregation identifies patterns, but small groups require privacy protection. Equity review should examine who waits longer, whose referrals fail, who leaves programs early, and whose economic outcomes appear weaker. The response should address barriers rather than lower expectations. A scoping review of resilience among trafficking survivors similarly cautions against treating any single demographic factor as determinative, since individual coping capacity interacts with structural exposure in ways that vary case by case [25]. Regional evidence from child and adolescent trafficking survivors in the Greater Mekong Subregion found that exploitation severity and post-trafficking conditions, including family rejection and ongoing violence, were independently associated with elevated suicide risk, underscoring why age- and gender-specific risk factors require dedicated assessment rather than being absorbed into a general vulnerability score [43].

3.8 Digital follow-up and safe contact

Mobile communication supports continuity across distance, yet ordinary messages may reveal status to family members, employers, traffickers, or community members. Contact plans should identify safe channels, names, times, language, message content, and procedures when a device

changes. Staff should confirm identity without asking dangerous questions and should avoid storing sensitive labels in contact names.

Remote support also changes professional boundaries. Organizations need rules for staff accounts, after-hours contact, emergency escalation, documentation, recording, and deletion. Digital participation should never become a condition for service where connectivity, literacy, disability, cost, or surveillance creates exclusion. These same safeguards apply to routine monitoring contact, not only crisis communication: a reintegration monitoring toolkit developed for trafficking survivors recommends that any follow-up contact plan specify consented channels, timing, and a safe way to end contact, treating an intrusive or unsafe check-in as a measurement harm in its own right rather than an acceptable cost of data collection [9].

3.9 The reintegration causal chain: from safety to sustainable participation

The proposed model treats reintegration as a chain of enabling conditions, mechanisms, and outcomes rather than a single intervention. Enabling conditions include leadership, workforce capacity, referral availability, accessible communication, secure information, and supervision. These conditions support felt safety, dependable relationships, restored agency, service fit, economic control, social acceptance, and continuity across transitions. Predictable and respectful engagement increases trust; trust improves disclosure and collaborative planning; better planning improves service fit and continuity; effective services strengthen safety, functioning, and agency; and improved capability supports sustainable social and economic participation [7], [26].

Context moderates every link in this chain, and the sequence is neither automatic nor linear. Service scarcity, discrimination, household conflict, and labour-market

weakness may interrupt progress even when case management is strong. Trust may improve disclosure, but disclosure has limited value when services are absent. Better data may identify inequity, but leadership must authorize corrective action. The model therefore includes feedback loops: outcomes and incidents return information to supervision, policy, resource allocation, and service design. This causal pathway directs evaluation toward mechanisms rather than a single success rate. If service uptake remains low despite timely referral, researchers should test trust, affordability, accessibility, and provider behavior; if livelihoods begin but collapse, evaluation should examine market fit, control over earnings, household demands, health, and mentoring.

3.10 Ruling out funding, policy, and reporting shifts as alternative explanations

Observed improvement may arise from factors outside the framework. New funding, staff recruitment, policy change, seasonal migration, local economic conditions, or expanded service supply may improve outcomes at the same time as implementation. Conversely, worsening indicators may reflect improved reporting rather than worsening practice. A rise in complaints or identified concerns may signal greater awareness and confidence in reporting.

Evaluation should pre-specify rival explanations and collect contextual data. Comparison sites, interrupted time-series models, staged rollout, and qualitative process tracing help distinguish implementation effects from background change. Researchers should test whether the proposed mechanisms changed before attributing outcomes to the framework. If timeliness improves without increased trust, for example, administrative redesign rather than relational practice may explain the result. This caution mirrors recent systematic-review evidence that many social-service evaluations for trafficking survivors report positive change without designs adequate to rule out concurrent policy or funding shifts as the true driver [27].

3.11 What predictable exceptions reveal about system design

Average performance conceals cases where the system fails despite apparent fidelity. Negative-case analysis should examine successful referrals followed by harm, complete assessments followed by inaction, positive experience scores alongside later disengagement, and favorable aggregate outcomes with persistent subgroup disparity. Such cases test the framework more rigorously than confirmation alone.

Exception review should focus on paternalism, retraumatization, stigma, unsafe family return, livelihood failure, digital surveillance, attrition, and re-exploitation. Each exception requires a reconstruction of decisions, information, workload, authority, and service constraints. The objective is not to excuse individual misconduct. It is to distinguish reckless or abusive conduct from predictable system weakness and to identify controls capable of preventing recurrence. Realist reviews of psychosocial support for trafficking survivors reach a similar conclusion: outcomes depend on the interaction between mechanism and context, so a negative case is often more informative about which contextual condition was missing than about whether the intervention itself is sound [26].

3.12 Why mechanisms travel differently across Ethiopia, Indonesia, Azerbaijan, Bangladesh, and Nigeria

The proposed framework applies across return communities, shelters, urban settlements, rural households, cross-border programs, and low-resource service systems, but implementation should differ by setting. Comparative evidence from Ethiopia, Indonesia, Azerbaijan, Bangladesh, and Nigeria illustrates this variation: female return migrants in Ethiopia relied heavily on household and market conditions that shelter-based models do not capture [19]; Indonesian

survivors described stigma and economic precarity as central threats to sustained recovery [21]; Azerbaijani survivors reported that reintegration support diminished sharply once formal assistance ended [22]; ethnographic work in a Bangladeshi shelter showed how institutional categories of victimhood could themselves become a barrier to reintegration [23]; and interviews with returnees in Nigeria found that reintegration support delivered without sustained follow-up left survivors managing debt, stigma, and renewed recruitment pressure largely on their own once a program's formal involvement ended [31]. Regional analysis across ASEAN countries similarly finds that identification, recovery, and reintegration systems for child trafficking victims remain unevenly developed across the region, with knowledge gaps concentrated precisely in the post-identification recovery phase this framework addresses [44]. High-volume sites need rapid triage and clear escalation. Rural settings need transport, communication redundancy, and broader worker roles. Specialized organizations may support deeper expertise, while general services need reliable consultation and referral. Low-connectivity environments require offline procedures and controlled synchronization.

Transferability should be judged through mechanism and context rather than surface similarity. A model developed in one country or sector may remain useful where authority, resources, and population needs differ, but only if the mechanism remains plausible. Adaptation records should identify which element changed, why change was needed, what risk was introduced, and how performance will be reviewed.

3.13 Assistance packages, sequenced case management, or continuity of care: choosing among models

Three broad alternatives are relevant: short-term assistance packages, sequenced case management, and adaptive continuity-of-care models with voluntary re-entry. The first often

preserves institutional familiarity but weakens coordination. The second offers standardization but may impose excessive uniformity, though sequenced case-management structures have shown comparable value in adjacent recovery domains, including a randomized trial of a systematically sequenced housing-and-treatment pathway for individuals recovering from substance use and mental illness while experiencing homelessness [34]. The third retains common rights and data requirements while permitting governed adaptation. No option dominates under every condition. Appraisal should compare safety, burden, interoperability, implementation cost, accountability, accessibility, and adaptability. A model that performs well on data completeness but poorly on trust should not rank as high quality. Likewise, a locally flexible model without version control may fragment over time. Decision-makers should publish the criteria and the trade-offs used to select an approach. International guidance on reintegration explicitly frames this appraisal as a governance choice rather than a technical default, recommending that programs

document why a given sequencing or coordination model was selected over the alternatives available in that context [7].

3.14 Equity as a determinant of exposure across the reintegration pathway

Equity is not a final disaggregation exercise. It shapes access, disclosure, decision thresholds, service availability, and exposure to intervention. Language, disability, age, gender, race or ethnicity, migration status, poverty, geography, family structure, digital access, and institutional mistrust may alter every stage of the pathway. Universal procedures may therefore generate unequal outcomes. Family-level dynamics compound these effects: research on trafficking survivors in the United States found that separation and reunification could themselves transmit trauma across generations when handled without structured support, even where the receiving family was safe and willing [24].

Equity analysis should examine who enters the system, who is screened out, who waits, who receives preferred options, who disengages, and who experiences coercive or adverse action. Small groups require disclosure control and careful interpretation. Quantitative differences should trigger investigation, not automatic claims

Table 2. Six phases of the trauma-informed continuity-of-care model

Phase	Core objective	Key activities	Transition criteria
Reception and stabilization	Address urgent safety, practical, and health needs	Crisis referral, predictable communication, orientation to rights and choices	Immediate risks addressed; participation is voluntary and feasible
Collaborative assessment	Understand risks, strengths, and priorities with the survivor	Trauma-informed interview, risk and capability assessment, goal setting	Assessment reflects the survivor's stated goals and constraints
Individualized planning	Sequence services and assign responsibility	Service mapping, livelihood and family planning, contingency planning	Roles, timing, and escalation triggers are documented and understood
Coordinated implementation	Deliver and coordinate support across providers	Referral, service delivery, safe contact, case conferencing	Services are received, verified, and experienced as useful
Adaptive review	Monitor change, harm, and shifting priorities	Multidomain review, missing-data follow-up, plan revision	Plan is updated or confirmed based on current evidence
Supported transition	Close responsibly while preserving re-entry	Closure risk review, re-entry pathway, referral confirmation	Closure is documented as safe, understood, and reversible

of discrimination or neutrality. Participatory interpretation helps distinguish measurement artifacts from lived barriers.

3.15 Choice, consent, and proportionality in trauma-informed casework

The framework rests on choice, pacing, privacy, non-discrimination, compensation for lived-experience expertise, child-sensitive practice, and protection from coercion. Ethical practice requires more than benevolent intent; it should follow established guidance on safety, confidentiality, and survivor-centred engagement in interviewing and clinical contexts [4], [6]. Every information request, referral, restriction, or disclosure should have a defined purpose, a lawful or policy basis, and a proportionate relationship to foreseeable harm. Less intrusive options deserve priority where they provide comparable protection.

Consent requires understandable information, realistic choice, and freedom from service penalty where refusal is permitted. When law authorizes action without consent, staff should explain the decision, limit disclosure, involve the person where safe, and document review. Children and adults with communication or decision-support needs require appropriate accommodation rather than exclusion from participation.

4 Trauma-Informed Continuity of Care Model

The model developed here operationalizes the mechanisms identified in Section 3 into six sequenced phases, a multidomain outcome set, and governance arrangements capable of sustaining both across a full case pathway, consistent with continuity-of-care frameworks that distinguish relational, informational, and management continuity as separate but interacting dimensions of a single care trajectory rather than a single handoff event [11]. It also specifies how economic and psychosocial support should be sequenced,

how families and communities should be engaged, and how programs should measure and interpret change without collapsing recovery into a single score. The section closes with consolidated tools, an assurance table and an operational risk and case-management table, that translate the model into instruments a program can use directly rather than a checklist read once and filed away. This structure follows international guidance that treats reintegration as an interacting set of economic, social, and psychosocial dimensions rather than a single administrative milestone, and it translates that guidance into instruments a case-management team can apply directly rather than a principle to reinterpret in each new case [7].

4.1 Six phases of the model

The model includes reception and stabilization, collaborative assessment, individualized planning, coordinated implementation, adaptive review, and supported transition. Movement is not strictly linear: a new threat, health crisis, family change, or livelihood loss may require returning to an earlier phase, consistent with trauma-informed system design that treats safety, trustworthiness, and collaboration as conditions to be continuously renegotiated across a case rather than secured once and assumed stable [10]. A comprehensive care model proposed specifically for sex-trafficking survivors likewise integrates medical, psychosocial, and reintegration components into a single coordinated pathway rather than separately managed services, supporting the phase structure adopted here [41]. Because such coordinated pathways often route survivors through partner hospitals for medical stabilization, multidimensional frameworks for strengthening infection-prevention-and-control compliance in tertiary facilities offer a relevant benchmark for the clinical-safety assurances a referral agreement with such a facility should specify [52]. For survivors who are pregnant, this same coordination should extend to antenatal care, where a conceptual framework for systematic

drug-interaction screening offers a practical basis for catching avoidable medication conflicts across providers during stabilization [56]. Table 2 sets out the core objective, key activities, and transition criteria for each phase, extending the decision points introduced in Table 1 with the operational detail a case-management team needs to apply the model in practice [7], [8], [9]. Figure 1 presents these six phases as a process flow and makes the model's non-linearity explicit: a closure risk review, or a new threat, health crisis, family change, or livelihood loss identified at any later phase, can return the case to stabilization rather than exiting the model.

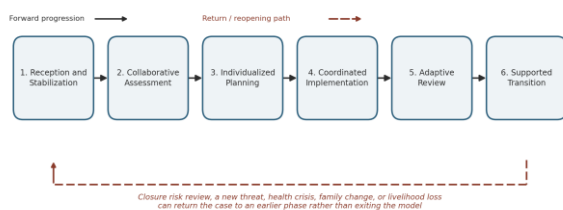


Figure 1. The six-phase trauma-informed continuity-of-care model. Solid arrows show forward progression from reception and stabilization through supported transition; the dashed return path shows that a closure risk review, or a new threat, health crisis, family change, or livelihood loss, can send a case back to an earlier phase rather than exiting the model.

4.2 Multidomain outcomes

The outcome framework covers safety, psychosocial well-being, physical health, documentation, housing, family and social connection, education or work, and access to justice. Programs should use a small core set of standardized indicators plus individualized goals, and survivor-reported outcomes should sit beside administrative data rather than substitute for it [9]. Table 3 condenses this framework into five priority domains with a core indicator, review frequency, and responsible actor for each, replacing a longer list of possible measures with the minimum set a program needs to track routinely. Figure 2 depicts these five domains as an interdependent set rather than five independently scored measures: safety, mental health, social connection, service access, and economic functioning are each read against the other four, so a favorable result in one domain cannot substitute for the others, a pattern consistent with evidence on forced-return migrants showing that economic, social, and psychological embeddedness operate as interacting rather than substitutable components of sustainable reintegration [18].

Table 3. Multidomain outcome indicators

Domain	Core indicator	Review frequency	Responsible actor
Safety	Current threats and safety-plan use, not physical return alone	At each contact and every phase transition	Case manager with supervisor review
Mental health	Standardized psychosocial functioning measure plus self-reported well-being, not absence of disclosure	Baseline, early follow-up, transition, post-closure	Case manager with clinical consultation
Social connection	Chosen supportive relationships and family-conflict indicators, not family contact alone	Quarterly and at phase transition	Case manager and family-engagement lead
Service access	Verified referral completion and continuity, not referral issuance alone	Monthly aggregate review	Program manager
Economic functioning	Net income, control over earnings, and workplace safety, not gross revenue alone	Quarterly and at livelihood milestones	Livelihood specialist with case manager

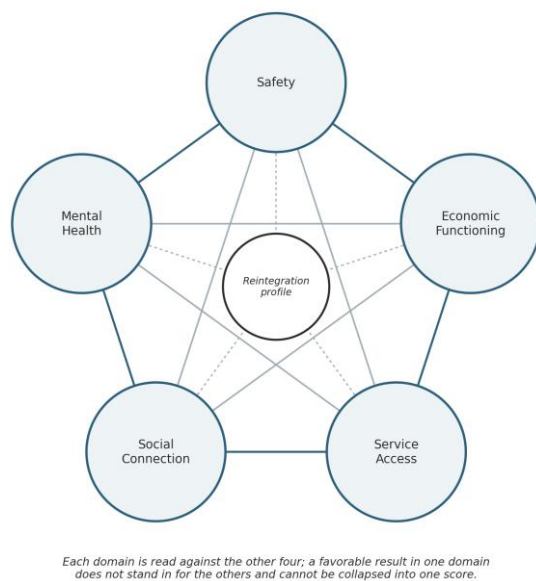


Figure 2. The multidomain outcomes model. Safety, mental health, social connection, service access, and economic functioning are shown as a fully interdependent set, each read against the other four, rather than as five independently scored measures that could be collapsed into a single reintegration index.

4.3 Governance, workforce, and referral infrastructure

Organizations need caseload standards, reflective supervision, emergency escalation, referral agreements, secure records, and staff well-being supports. Referral directories should include eligibility, cost, accessibility, language, location, waiting time, and safe-contact procedures. A referral is counted as completed only after receipt is confirmed or an exception is documented. Reviews of identification practice during service provision find that the indicators different disciplines rely on to flag a case are frequently inconsistent, complicating referral into the kind of coordinated aftercare this section describes [40], and local service-mapping studies have found persistent, specific gaps between the services survivors need and what a given referral network can actually provide,

even where a directory formally lists the service [46].

Readiness for these arrangements should be tested before launch rather than assumed from written policy. Quality-improvement strategies that pair routine data review with iterative process adjustment have measurably increased uptake of specific clinical services in comparable resource-constrained health systems, suggesting that referral readiness benefits from the same continuous, data-driven testing rather than a one-time launch audit [53]. Organizations should use scenarios to test how teams respond outside normal hours, across jurisdictional boundaries, during technology failure, and when a partner refuses a referral, and should identify minimum viable capacity across case-management time, clinical referral access, peer support, safe housing, market-responsive livelihood finance, childcare, transport, and long-term follow-up before accepting new cases. Mobile-application tools developed for adverse-event reporting in low-resource settings illustrate one practical way to keep referral and outcome data flowing when routine reporting channels are disrupted, a scenario this readiness testing should also cover [54]. Reviews of last-mile drug distribution to underserved communities identify transport, storage, and workforce barriers that referral networks in rural or hard-to-reach areas should plan around explicitly rather than assume away [57]. Where essential services are missing, the implementation plan should state how risk will be managed rather than assuming referral solves the problem. Funders should recognize supervision, coordination, accessibility, secure records, and follow-up as direct service costs rather than overhead. This framing follows established direct-assistance guidance, which treats case-management infrastructure, not only frontline contact hours, as a core component of protection service delivery that funders should resource explicitly [3].

4.4 Evaluation design

Evaluation should combine repeated quantitative

measures with qualitative accounts. Baseline, early follow-up, transition, and post-closure checkpoints show trajectories rather than snapshots, consistent with recent systematic evidence that trafficking-survivor interventions produce heterogeneous effects that a single endpoint measure would obscure [27]. Disaggregation helps identify inequities. Programs should interpret changes with caution because improved disclosure may initially increase recorded distress or protection concerns, and a systematic review of psychosocial interventions for trafficking survivors similarly found that intervention mechanisms varied enough across studies that no single intervention label reliably predicted whether support helped or harmed [26]. Survivors should influence research questions, outcome definitions, instruments, interpretation, and dissemination. Participation requires compensation, choice, confidentiality, and support. Programs should avoid inviting people to recount trauma merely to legitimize a study; advisory roles may focus on service design and interpretation without personal disclosure. Comparison groups require careful ethical design because withholding needed assistance is inappropriate. Alternatives include phased or stepped-wedge implementation, matched observational comparisons, and interrupted time-series analysis. Researchers should preregister primary outcomes where feasible and report attrition, missing data, adverse events, and implementation variation. Outcome evaluation without process evidence cannot explain success or failure. Process evaluation should assess reach, dose, fidelity, adaptation, acceptability, feasibility, and context, distinguishing core components from adaptable features. Core components include rights protections, minimum safety action, documented accountability, response to serious concern, and feedback after referral or incident; workflow sequence, local role titles,

review frequency, and supplementary indicators may adapt within defined limits. A defensible protocol should also specify, before analysis begins, the eligible population and how repeat episodes are handled, which components each participant or site actually received, the comparator against which change is judged, the hierarchy of primary, secondary, and balancing outcomes, the timing of measurement relative to plausible mechanism activation, how missing data and confounding will be examined, and how subgroup heterogeneity and adverse effects will be reported. A positive aggregate trend provides weak evidence if a study cannot show who encountered the intervention, what they received, and whether the underlying mechanism changed.

4.5 Sequencing economic and psychosocial support

Programs often separate economic assistance from psychosocial support even though each influences the other. Financial insecurity increases stress and dependence, while severe distress, unsafe relationships, or poor health may limit livelihood participation. Sequencing should remain individualized. Some people need rapid income support to stabilize housing and food. Others need health care, documentation, childcare, or safety planning before entering training or work. Case reviews should examine whether the chosen economic activity improves control and stability or creates new exposure. Livelihood assistance should include market assessment, realistic costing, mentorship, risk planning, and options beyond self-employment. A business grant is unsuitable where markets are saturated or where the person does not want entrepreneurship. Wage employment, apprenticeships, education, social protection, and cooperative models may fit better. Evidence from returnee mentoring programs in Senegal, Guinea, and Morocco indicates that structured mentoring relationships, not grants alone, help sustain livelihood gains after cash or in-kind assistance ends [20], and a multi-country study of economic-empowerment programming for trafficking-

vulnerable young women similarly finds that workplace safety and a supportive environment matter as much as wage level for sustained participation [29]. Programs should measure net benefit after costs, control over income, workplace safety, and continuity rather than gross revenue alone.

4.6 Family engagement

Families may provide care, belonging, childcare, housing, and economic support. They may also contribute to debt pressure, blame, violence, forced disclosure, or renewed exploitation. Family engagement therefore requires consent and risk assessment. Practitioners should not assume reunification is beneficial. Where engagement is safe, structured conversations may address expectations, confidentiality, support roles, conflict, and warning signs. Evidence on family separation and reunification after trafficking in the United States shows that reunification conducted without structured preparation can transmit trauma across generations even where the receiving family is safe and willing, reinforcing the case for structured rather than assumed reunification [24].

Children and young adults need special attention to caregiver authority and evolving autonomy. A family plan should state who will provide daily care, how education and health needs will be met, and how concerns will be reported. Where the family is unsafe, alternative care and statutory protection pathways take priority.

4.7 Cultural responsiveness without stereotyping

Cultural responsiveness requires curiosity, language access, and respect for local meaning. It does not justify harmful practices or treat communities as homogeneous. Programs should recruit diverse staff, work with trusted local actors, and ask participants how distress, recovery, work, family, and help-seeking are understood. In many low-

resource settings, informal health-seeking commonly includes reliance on locally available medicinal plants before or alongside formal care, a pattern documented in ethnobotanical studies of commonly used species, and programs should treat this as a contextual reality to engage with rather than a deficit to correct [55]. Country-specific accounts of reintegration in Ethiopia and Indonesia illustrate how family expectations and market norms shape which options survivors regard as acceptable even when formally available [19], [21]. Standardized measures may require careful translation and interpretation.

Community engagement should avoid identifying returnees or survivors. Broad messages about safe migration, violence prevention, mental health, and available services often reduce stigma more safely than targeted public events. Programs should assess whether publicity, photographs, testimonials, or donor visibility create risk.

4.8 Workforce quality and secondary stress

Case managers make complex decisions while hearing traumatic histories and confronting service scarcity. High caseloads and weak supervision increase error, emotional exhaustion, boundary problems, and premature closure. A study of secondary traumatic stress among social workers found that caseload size, supervision, and income jointly predicted secondary traumatic stress, with supervisory support the most modifiable factor [28]. Organizational climate specifically, rather than caseload alone, has also been identified as a key lever shaping secondary traumatic stress among practitioners serving survivors of family violence and sexual assault [35], and qualitative accounts of mental-health service provision to trafficking survivors document how limited training and unclear referral pathways compound this strain for frontline staff [42]. Workforce standards should include manageable caseloads, structured supervision, emergency consultation, debriefing after critical incidents, leave, and access to confidential staff support.

Supervision should examine reasoning, ethics,

Table 4. Governance assurance domains

Domain	Core assurance question	Primary evidence source
Leadership	Do senior leaders review risk, remove barriers, fund controls, and track unresolved actions?	Board minutes, funding decisions, corrective-action log
Workforce	Do staff have role-specific competence, supervision access, and manageable workload?	Supervision records, caseload data, training records
Partnerships	Do referral partners meet agreed standards and address repeated failure?	Partner agreements, referral outcome data
Information	Is collection minimized, access controlled, and breach response defined?	Data-protection audit, access logs
Participation	Do affected people influence design, interpretation, and complaints handling?	Advisory records, complaints log
Accessibility	Do language, disability, cost, and digital barriers receive practical response?	Accessibility audit, service-uptake data by need
Decision quality	Are thresholds understood, judgment documented, and overrides reviewed?	Case-file audit, supervision notes
Incident response	Is safety action timely, investigation fair, and remedy practical?	Incident register, effectiveness reviews
Measurement	Are indicators valid, denominators stable, and missingness visible?	Indicator registry, data-quality report
Equity	Are pathway and outcome differences examined and linked to action?	Disaggregated outcome data
Resources	Do staffing, services, and follow-up capacity match demand?	Budget and capacity review
Sustainability	Do core functions survive funding, leadership, and staff transitions?	Transition and continuity plan

relationship quality, documentation, and staff well-being. It should distinguish supportive reflection from disciplinary review while preserving accountability. Programs should monitor turnover, sickness absence, overtime, and supervision completion as quality signals.

4.9 Measurement interpretation and indicator design

Recovery trajectories vary. A person may report greater distress after trust improves and previously hidden concerns emerge. Economic progress may coincide with increased family conflict. A single composite score can conceal these patterns. Programs should display domain-level change and narrative context. Missing follow-up should

be analyzed because people lost to contact may have different outcomes from those retained.

Evaluation should include negative and unintended outcomes, such as debt, business failure, stigma, violence, unsafe work, or loss of housing. Learning from these outcomes supports safer adaptation. Long-term follow-up should use consented contact plans and avoid persistent outreach that threatens privacy. A monitoring toolkit developed specifically for trafficking-survivor reintegration recommends distinguishing structure, process, output, outcome, and balancing indicators for exactly this reason: an outcome measure read alone cannot show whether a program produced the result through appropriate means or through pressure,

and each indicator needs a definition, numerator, denominator, source, owner, and interpretation note before it is trusted [9].

4.10 Governance, accountability, and assurance

Governance should connect frontline decisions to executive and board oversight without exposing unnecessary personal detail. Operational teams need case-level information; managers need trends, exceptions, and resource constraints; boards need severity, recurrence, overdue corrective action, control effectiveness, and evidence of participant voice. Accountability requires independent reporting routes, protection from retaliation, documented response timelines, appeal or review, and closure communication. Partner organizations should enter written agreements covering roles, data, quality, escalation, and termination, consistent with established direct-assistance standards [3].

Assurance is the practice of testing whether these arrangements work rather than assuming they do because a policy exists. A credible assurance review combines document examination, record sampling, interviews, observation, and data analysis, because policy may describe a control that staff do not understand while administrative data show completion without quality. Findings should identify affected groups, duration, severity, and recurrence, and a finding should not be closed on evidence of activity alone; closure requires proof that the underlying risk changed and that the correction did not create a new access, privacy, workload, or equity problem. Table 4 consolidates the domains an assurance review should cover, replacing a domain-by-domain narrative with a single reference table.

4.11 Operational risk and case-management response

The scenarios most likely to disrupt a continuity-of-care pathway are not exotic; they are predictable stresses that recur across

programs: caseload surges, interruption of a referral partner's services, technology outages, privacy incidents, sudden workforce loss, disagreement between agencies over jurisdiction or thresholds, disagreement from a participant with a recommended course of action, community opposition to the program or its participants, funding contraction, distortion of performance indicators by targets, leadership transition, and a severe adverse event despite apparent compliance with the model. Systematic reviews of social-service interventions for trafficking survivors support treating each of these as a recurring, foreseeable stress rather than an exceptional failure: caseload pressure, service interruption, and inconsistent follow-up recur across very different program settings and delivery models [27]. Treating each of these as a separate governance exercise produces documentation that nobody consults under pressure. Table 5 instead condenses them into a single case-management reference: what typically triggers the scenario, how a case manager and supervisor should respond, and where the decision escalates when the standard response is insufficient.

Reviewers examining any of these scenarios, whether through a live incident or a planned exercise, should assess whether the response preserved choice, pacing, privacy, non-discrimination, compensation for lived-experience expertise, child-sensitive practice, and protection from coercion, and whether it avoided the predictable harms of paternalism, retraumatization, stigma, unsafe family return, livelihood failure, digital surveillance, attrition, and re-exploitation. The after-action report should separate preparation gaps, execution gaps, and external constraints, and corrective actions need measurable completion criteria and a second exercise to confirm that the control now works under pressure.

4.12 Scaling, sustainability, and economic evaluation

Economic evaluation should estimate implementation cost, recurrent cost, participant

Table 5. Operational risk scenarios and case-management response

Risk scenario	Typical trigger	Case-management response	Escalation pathway
Caseload surge	Demand doubles while staffing is unchanged	Activate priority protocol for core safety protections; reassign non-urgent tasks; communicate revised response times	Program manager authorizes a temporary caseload ceiling and additional coverage
Service interruption	A major referral partner closes or restricts eligibility without notice	Activate backup referral list; contact affected cases directly; document interim safety plan	Supervisor escalates to the commissioning body if no alternative exists within the safety timeframe
Technology outage	Case systems or secure communication become unavailable during urgent work	Switch to documented offline fallback procedure; prioritize contact for highest-risk cases	IT lead and program manager jointly authorize return to digital systems after a data-integrity check
Privacy incident	Sensitive information is accessed, exported, or disclosed without authorization	Contain exposure; notify affected individuals per policy; preserve evidence for review	Data-protection officer leads breach response; board notified for high-severity events
Workforce loss	Experienced supervisors or frontline staff leave within a short period	Reassign caseloads with supervisor sign-off; brief incoming staff on open safety concerns	Program manager reviews whether minimum viable capacity is still met
Interagency disagreement	Partners dispute authority, thresholds, or information-sharing rules	Apply documented threshold criteria; request a joint case conference within a set timeframe	Named senior authority issues a reasoned decision and records the rationale
Participant disagreement	The affected person rejects the recommended action or disputes recorded information	Revisit choice and information with the participant; document the alternative the participant prefers	Supervisor reviews for imminent-risk exceptions to standard consent rules
Community opposition	Local actors challenge the service model or participant group	Reduce visibility of individual participants; engage community leaders on general prevention messaging	Program manager and communications lead coordinate the public response
Funding contraction	The program must reduce expenditure while preserving essential functions	Protect core safety and supervision functions first; document what will not continue	Board approves the reduction plan with stated risk implications
Indicator distortion	Performance targets change staff behavior in ways that inflate results	Cross-check the indicator trend against an independent case-file sample	Measurement lead investigates and may suspend the target pending review
Severe adverse event	A participant experiences serious harm despite apparent compliance with the model	Secure immediate safety and continuity; preserve evidence; offer an independent contact point	Board-level learning review with named owners and deadlines for corrective action

burden, and the consequences of failure. Relevant costs include training time, supervision, coordination, secure technology, accommodation, interpretation, travel, audit, and complaint handling; programs often understate these costs by treating existing staff time as free. Cost-consequence analysis is suitable when outcomes span safety, access, well-being, and organizational risk; cost-effectiveness analysis requires a defensible common outcome and may miss distributional effects; and budget-impact analysis helps decision-makers judge affordability at scale. Equity-weighted analysis should identify who receives benefits and who bears time, travel, privacy, or compliance burdens.

Scale should follow demonstrated readiness and learning rather than a funding deadline. Rapid expansion may dilute supervision, overwhelm referral partners, and create inconsistent data; a staged strategy should define entry criteria, pause criteria, and minimum capacity for each new site, and early scale decisions should prioritize variation in context so the model is tested beyond favorable pilot locations. Analysis of how re/integration services for trafficking survivors are actually funded finds that short-term, project-based funding cycles are a structural obstacle to the kind of staged, multi-year scaling this section describes, independent of any single program's technical design [47]. Evidence from staged mentoring-based reintegration programs suggests that gains achieved through phased, well-supervised expansion are more likely to persist after funding ends than gains achieved through rapid rollout without matching supervisory capacity [20]. Sustainability depends on integration into budgets, job descriptions, supervision, procurement, technology maintenance, and governance calendars. Short grants often fund visible activities while leaving coordination and assurance unsupported; transition planning

should identify which institution owns each function after external funding ends and how participants will retain access during organizational change.

5 Discussion

5.1 Reintegration as a capability, not a status or an income level

Section 3.6 documented that survivors receiving the same grant, referral, or training can end up with very different reintegration outcomes because family control, disability, childcare responsibilities, insecurity, market access, or missing documentation shape what each person can actually do with what was provided. The theoretical implication is that reintegration should not be defined as a status a person occupies, returned, assisted, case closed, or as a level of income reached, but as a capability: the practical freedom to convert available resources into safety, psychosocial stability, social acceptance, service access, and economic participation. A status-based definition treats a completed grant disbursement or a closed case file as evidence of recovery; a capability-based definition asks whether that disbursement or closure actually expanded what the person is safely able to do and become, which is a different and harder question. This move formalizes, at the level of theory, a shift that international reintegration guidance had already begun to make in practice by treating economic, social, and psychosocial dimensions as interacting rather than additive components of a single outcome; the contribution here is to name that interaction explicitly as a capability relationship and to draw out what follows for measurement [7]. The reframing changes what counts as evidence of program success. A program can report high service-completion rates, on-time grant disbursement, and low case-reopening while still failing survivors whose capability to use those services was constrained by an unsafe household or a saturated local labour market, a pattern the review found repeatedly in Section 3.3 and Section 3.4. It also changes

measurement: indicators built around activity or income alone cannot distinguish a survivor who gained real control over her circumstances from one who received the same inputs without acquiring any corresponding freedom to act, which is the specific gap Section 5.3 addresses directly. The remainder of this discussion treats capability, not status or income, as the outcome the continuity-of-care model in Section 4 is ultimately designed to protect.

5.2 Where continuity-of-care models break down in practice

The evidence assembled in Section 3 points to two failure modes that recur across the mechanisms this review examined, and both are sequencing errors rather than failures of individual staff competence or goodwill. The first is premature case closure. Section 3.5 showed that administrative completion, a disbursed grant, a finished training course, a fixed service period ending, is routinely treated as equivalent to safe closure, even when the risks that brought a survivor into the program, unresolved debt, an unsafe household, an unstable livelihood, remain active. This failure mode is structural: it is produced by funding cycles and reporting deadlines that reward documented completion, not by case managers failing to care about outcomes. The second is livelihood assistance sequenced ahead of, rather than after, protection analysis. Section 3.3 showed that income generation intended to support autonomy can instead create debt, expose a survivor's location, intensify household conflict, or return her to exploitative work when it is not preceded by an assessment of household safety, market conditions, and documentation status. Both failure modes share a common structure: each substitutes a visible, fundable, and easily reported action, a disbursement, a closed file, a completed training, for the underlying capability change described in Section 5.1, and each is more

likely where funders and organizations lack the patience or the indicators to distinguish the two. Trauma-informed frameworks developed specifically for trafficking survivors identify the same underlying cause: individual clinical skill cannot substitute for a control environment that defines decision authority, supervision frequency, and escalation time before, not during, a crisis, and closure or livelihood decisions made outside such a control environment default to whichever action is easiest to document [12], [14]. Addressing both failure modes therefore requires the governance and workforce arrangements specified in Section 4.3 and Section 4.8, not additional training content alone.

5.3 Measuring sustainability without collapsing recovery into a single score

A single composite reintegration score, however well constructed, cannot do the work this paper's evidence requires of measurement, because the same aggregate result can be produced by genuinely improving safety and control or by a survivor's declining engagement with a system that no longer feels worth the effort of contact. Recent research on measuring trauma-treatment outcomes demonstrates a workable alternative: a validated instrument that tracks clinically significant change separately across distinct PTSD and complex-PTSD symptom domains, rather than a single endpoint, so that improvement in one domain and deterioration in another remain visible instead of averaging out [32]. Applied to the model in Section 4.2, this means the five outcome domains in Table 3, safety, mental health, social connection, service access, and economic functioning, should be reported and reviewed as a profile, not compressed into one number, and a monitoring toolkit built specifically for trafficking-survivor reintegration already requires exactly this kind of domain-level, defined-indicator reporting rather than a single index [9].

Sustainability claims also need a specified way to be wrong. This paper's model would be disconfirmed, in whole or in part, by findings

such as survivors whose composite indicators improve while independently collected interview data show rising fear, coercion, or dependence; livelihood or service-access gains that do not survive the months following case closure that the transition criteria in Table 2 anticipate; or improvement that tracks funding cycles and site staffing levels more closely than it tracks the mechanisms specified in Section 3.9. Treating these as disconfirming evidence, rather than as noise to be explained away, is what separates a testable model from a reassuring narrative, and it is the standard against which the propositions in Section 5.4 should be evaluated.

5.4 Implications for practice, policy, and future research

For practice, the capability framing in Section 5.1 and the failure modes in Section 5.2 together imply that programs should fund and staff the connective functions, supervision, referral follow-up, re-entry pathways, that make continuity possible, not only the visible frontline contact hours that are easiest to report. For policy, this means commissioners and donors should require the domain-level, disconfirmation-sensitive measurement described in Section 5.3 rather than volume targets, and should build course correction into contracts when evidence shows unintended harm, consistent with the duties set out in the Palermo Protocol and established direct-assistance guidance [1], [3]. For research, the priority is comparative implementation studies that test whether the specific mechanisms named in Section 3.9, felt safety, dependable relationships, restored agency, service fit, economic control, social acceptance, actually change before outcomes are attributed to the model, together with validated measurement of the core constructs specified in Section 2.5, economic evaluation of full delivery cost, and participatory research that gives survivors decision

authority over priorities and interpretation rather than only a consulted role.

These implications should be read against clear limits. The evidence base is strongest on mechanism and principle and weakest on comparative effectiveness: recent systematic and realist reviews confirm that social-service interventions for trafficking survivors show heterogeneous and often small effects across the few studies with adequate designs, and that psychosocial interventions work through relational and contextual mechanisms that a single intervention label cannot capture [26], [27]. The review itself concentrated on English-language and internationally indexed sources, which may underrepresent locally documented practice in exactly the low-resource settings the model is meant to serve, a boundary already flagged in Section 2.6. The paper therefore offers the model as a structured, falsifiable hypothesis and implementation guide, not as evidence that any specific service is safe, and decision-makers should not treat it as a substitute for independent outcome and incident data.

6 Conclusion

Sustainable reintegration requires more than return, a grant, or completion of training. Recast as a capability rather than a status or an income level, reintegration asks not what was delivered but what a survivor became safely able to do with it. It requires a coordinated process that protects choice, responds to trauma, strengthens relationships, expands access to services, and supports safe economic participation. The proposed continuity-of-care model provides a structure for sequencing assistance and measuring outcomes without treating recovery as linear, and the consolidated tables developed in Section 4 translate that structure into tools a program can apply directly to case management and governance. Programs should test the model through participatory pilots and assess safety, feasibility, staff workload, survivor experience, and longer-term stability, watching in particular

for the disconfirming patterns set out in Section 5.3. The quality of reintegration depends as much on reliable systems and respectful relationships as on the amount of assistance delivered, a conclusion consistent with international guidance that treats economic, social, and psychosocial support as interacting elements of a single reintegration process rather than as sequential add-ons to be completed and closed [7].

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