Supplemental Table 1. Facilitators to improve care for domestically sex trafficked persons: sub-themes, code categories, and supporting quotations.

Sub-Themes	Code Category	Supporting Quotations
Address needs in service provision	Collaborative, coordinated supports across social, health care, and community settings	Having [social service] partnerships with health agencies, so they [the health care provider] have a secure trusted agency they can make that call [...] to talk to, to consult with. [...] Just like we have with [name of social service organization], we have those different services where we can reach out and ask and inquire about or have partnerships with, then that would be helpful. (HCP 14) I think our health care system needs to expand also just from silos. (HCP 2) [I]t needs to be a holistic approach. You can't just try and rescue somebody [out] of the sex trafficking industry unless you address the underlying components and barriers to that. Like you said, home, food, security, if there's drug addiction, safety issues, the fact that they may lose their entire support system because their support system is within that network. It needs to be very holistic. There needs to be [...] a systematic effort. It can't just be different levels. It can't just be me. It can't just be the hospital. And it can't just be me and the hospital, because once they're discharged there needs to be other things in place. It is huge, but I think it's doable. (HCP 17) And warm up places. But […] I think it needs to be a community initiative because I might not catch this. But maybe the lady at [popular coffee shop], who's working, who sees that same girl every day at 6 am getting herself together or maybe she catches it and then calls me, right? So, it has to be a whole community piece because if all of our eyes are on it to say something's not right, then it's more likely to be caught, and there's more onus for it not to happen. Will [sex trafficking] ever stop, no, this is the oldest thing in human history. But will there be more eyes to catch it […] than just an emergency room? […] [T]hat's why when these things are coming forward and people in the community [are] getting involved […] it's important because you're not go[ing to] catch it necessarily at church, and but you might catch it, like I said, the lady of [popular coffee shop] who's sees the same girl every day. Or [...] the teacher might pick up on that or the apartment worker may pick [it] up, and this is [a] big thing, but it has to be a bigger conversation than just in health care. And needs to happen to health care and needs to get better, but it has to be a community conversation. (HCP 2)

		I think they need to be set up with some kind of psychologist or a counselor or some form of therapy after they leave. Because it's really hard to unpack that much trauma in under 2 weeks (HCP 8).
	Integrated, team-based, wrap-around, co-located services	I speak about [name of city] a lot because I had a lot of good experiences, they had things like a mobile bus going out there with [name of multidisciplinary clinic] but that was [to address] the need of sex workers while they're working. That is huge, right? Obviously not everyone is out working on certain areas of the road, right, but they had […] a bus that would go out to certain areas and people could just come and ask for their needs or whatnot and that was also an access point for people so now they know those people are safe people too. (HCP 2) Our health care system is built for physical care and is starting to broach more mental health care, and they've put money into that. [...] We need space for maybes [patients who fall into gray areas of whether they have been sex trafficked], and I think as a [specialized nurse] there needs to be a way for me to leverage that. When I see these people now, I contact the social worker. [W]e try to get a plan. Sometimes I contact the psychiatric unit because it's not really a psych admission, but they have psychiatric needs. Can we house them there until we can tease [them] apart, that's not the best either. (HCP 2) We don't have one spot that does everything and I think that's kind of the big missing piece. In essence community health centers do that but you have to get there right and if you can't get there and you don't have access to a phone, you're not someone who's in a place where you can check in every Tuesday at 9 am or whatever. That's the hard part [...], these people need that anchor, that one place that knows everything about them and can get to them, the social work, the money, the housing, the physical health needs, and the mental health needs that they need. (HCP 2) It needs to be an organization that holistically addresses everything all in one go. (HCP 17) If there was a specific place that offered resources, a one-stop shop type of thing. […] I would be able to help on some level. But I don't have that expertise to be able to help them with as much as what they would need. It would have to be a team that really knew how to deal with this. (HCP 5) They would obviously need a psychiatrist, but they also need a team that works around supporting them with their mental

		health, with their housing, with their finances. Helping them rebuild what they don't have or what they've lost. And I think that takes an interdisciplinary team and I think the government needs to invest more money into hospitals to be able to build that up. (HCP 8) I just don't feel like it's one area that needs to be addressed. I think it's complex, human trafficking, and I don't know if it just falls on one type of team member or it's definitely not, it's not an individual approach. I don't think working in silos would be helpful, either. [I] need a team to help this client and support them. That's what I mean by wrap-around, [a] multi-disciplinary approach to helping a client. [...] One person [...] can only [do so much]. Maybe let's just say that you went to talk to a doctor and they just provided you [with] a crisis list [of resources], right? But then, what if they [the sex trafficked person] don't follow through, or what if they didn't feel like that was really helpful? Then [...] I feel there would be a beginning and an end. Whereas I think if they had more support, it would be ongoing and in different areas, because it's not just the physical. Like I said it's [...] mental, emotional, spiritual. So, there's different areas that have to be addressed as well. (HCP 5) Developing the clinical services to support this population should be organizational, should be departmental, and so backing it with research, backing it with funding, and building the bridges with the other disciplines that we need to be effective. (HCP 28) We need spaces to meet these people where they are at and it does not work within a 9 to 5 job. We need emergency housing for these people. We need emergency case workers and there's places that are doing this well. If you look at [name of organization] in these places like they're doing it well, for people navigating HIV, because we recognize the gaps in that system, right? (HCP 2)
	Attainable specialized expertise	If there was a place for sex trafficking, I think that would be good, cause I feel sex trafficking [supports] would be beyond probably what I could offer in terms of helping. (HCP 5) But a piece we need is a much bigger piece that's dedicated [sex trafficking] therapy and long-term, right? You [sex trafficked person] don't get out of this stuff fast. (HCP 28) I want to see more [...] psychotherapy supports for people who are currently involved around the process of contemplating exiting sex trafficking or have exited sex trafficking. (HCP 26) In the future, the child therapy program might benefit from

		having a group specific to people who have been human trafficked or another program could exist in Ontario for that. Resources specific to that as well. (HCP 18) I think ideally it would be somebody whose role in the hospital, or maybe shared amongst several hospitals, knowing who to pick up the phone and call for that support to really discuss the case and receive the advice in real time would be helpful. [...] I think the role I would imagine that would be helpful or specific to this need [is similar to] when we see a patient in the emergency department who has come in with an acute intoxication. We would pick up the phone or the emergency doc[tor] that typically makes the first contact. But they call the Poison Control center and they're getting phone advice from a specialist at the Poison Control Center. [There is] always a MD [doctor] in the situation, but they're receiving advice on how to medically manage the intoxication overdose from somebody who is providing that advice to emergency departments all over the province,and is reminding people of kind of the more nuanced management of those presentations.So, if there was a phone resource, but again it's just so helpful that it's a live person answering, and you're summarizing the case for them, and they're giving you tailored advice on how to approach the issues that you're having particular difficulty with that, like the phone, the consultant who's available by phone. In this case it might not have to be an MD or probably wouldn't be an MD,but having that person available to provide co-management by phone would be really helpful. (HCP 23) Having the ability to call a central line that I can call if somebody is being trafficked, they're open to getting help, and they'd like to get help. If there's an expert group of providers that I can call and say, 'listen, this person has disclosed in real time.' [...] I could see it really corresponding very well to sexual assault centers because they are open 24/7. So, having a trafficking line that [...] I can just call and say, 'look, this person has disclosed. What do I do now?' That would be maybe a helpful thing. (HCP 31) Having allied health professionals who have [sex trafficking] expertise and paying for those allied health professionals to be designated for this kind of work, because in that moment, when someone discloses, I don't want to lose that opportunity if they're ready to talk about it. (HCP 31)
	Available, suitable shelters and housing	I think there needs to be more shelters, less co-ed shelters, more gender-orientated shelters. [...] [W]hen I had that one patient, the transgender patient, there [were no] women's shelters that are accepting of transgender females to make sure

		that they have a safe environment. [...] I think it is less safe for someone who's trying to escape from their traffickers to go into a shelter where they have to sleep next to a guy that they don't know; it's traumatizing to them. (HCP 8) [R]ight now shelters are filled with people who are homeless, people who are coming out of domestic violence, and there is no space for anybody right now, not even for people who are being trafficked. […] Right now, people are being put into hotels and sometimes it's not safe in there either, because I have clients who don't feel safe in a hotel. They want to be within a shelter where people cannot enter and access their rooms. (HCP 6) [W]e will get them a spot at the women's shelter whatever else. But then, think about this when you're in a rural community and there's one women's shelter [where] people know where you are. So there's the other thing, could we get them to [name of city]]? Yes, for sure, but [...] I don't know [if] other places are better. The city of [name of city] [some]one once told me you have to be a resident in [name of city] for three months to access the women's shelter, which I said, 'that's insane I'm going to talk to the manager.' But are there other parameters at other places, I don't know? But we usually can get them emergency housing. It's just, it's not in my perspective, it's not the safest, because if you're in a small place, people know where you are. People can easily find out where you are. (HCP 2)
	Curriculum, training, toolkits, and protocols	We want to do everything we can to help them [sex trafficked person]. But I think there's just a […] knowledge gap or maybe just we don't always know how to best help these people. I think just [...] having more education is […] important, because a lot of times people [who] are being trafficked are going to come through the ED [emergency department] at some point. [...] [T]here's gonna' be so many opportunities to intervene if you are astute enough to pick it up. (HCP 22) Even if it was just an e-module at work saying, if you suspect this is happening with your patient, this is your resource. This is your starting point. And then, if that starting point ended up being something that connected to something like [name of sex trafficking advocacy group] that would be great. Something while you still take care of that patient, something to support you, some evidence-based tools on how to care for these patients. (HCP 17) Sort of [how] hotel workers, for example, are being educated on the signs of human trafficking. And I think that should be the case with all health care workers as well. Because we see it in

		all parts of our population, not just poverty stricken. (HCP 13) Bringing someone in to do training, maybe learning more about what modalities work best with people who have that experience [sex trafficking]. The practical pieces around housing employment that may be specific to that population. What are their needs? (HCP 18) The other thing that can be done is provide an in-house training, where instead of getting staff to go out to get training, to bring someone in and provide that training in the units. That has happened with some initiatives in the past [to] make sure that more people attend the session. Because right now if I was to go do any kind of session, I have to get coverage from a nurse in the unit. And those basically double the patients that person has while I'm gone. (HCP 8) Patients who have been sex trafficked […] need their health care workers, both the medical staff, the social workers, direct therapists, all the medical staff, not medical health care workers that they interact with, to be educated and trained. (HCP 8) Again, in terms of the hospital level, I think staff, like myself, need to be trained more. We have to be given proper tool sets and formulated questions, so we can ask it [sex trafficking]. It should be part of orientation where we get this education, because right now, there's a set of orientations that we get, like how to respond to a code blue, or [...] how to de-escalate someone who's either violent [or] having mental health distress, like how do you de-escalate that person? There has to be a specialized [tool]kit for how you interact with someone who is being trafficked? (HCP 8) [A] toolkit, resources, more providers who do this work, so that we can ask these questions, teaching it [sex trafficking] in medical school so it becomes part of our vocabulary and what we're asking patients. We've come a far way in some ways in that now we include gender and questions around that in our sexual health history. But we don't include trafficking and sex work and consent as part of our discussion. So, those sorts of things, I think the more we do that, then maybe patients would be more open to talking about it, too, because it's just part of what we do. (HCP 31) If we had [sex trafficking training] modules where we could kind of combine the generalities of a lot of the different cases, like here's what tipped this person off to the fact that this person may have been trafficked. We just don't see enough of the cases for each person to develop that list of red flags. If we were able to share the information and compile a module of what we've

		noticed at all these different sites, that may be more helpful. (HCP 25) People have no idea that the majority of sex trafficking that happens in Canada is high school students and college students who are taken up the road to [name of city] on the weekend, sex trafficked all weekend, and then brought back and they just spend the rest of their week, like a normal person. […] [T]hat's often what your typical human trafficking victim looks like right now and people have absolutely no idea. So, I think, having more education about that not only would keep people safe, but it would also make it easier for victims of human trafficking to talk about their experiences, because there will will hopefully be able to get rid of this idea [that] it only happens to this certain kind of person so they're embarrassed to talk about it because they're not that kind of person. (HCP 25) I think education for health care providers would be really, really important. Because again, we know that there is a lack of resources, as long as I have worked, there always has been. What can we do in that time with them in our office? What are the best ways to be asking about this [sex trafficking] or supporting the people? I think, having really practical training on what to say [and] what not. (HCP 21) I think it's important to teach, not just the medicine, but also what we call the art of medicine, right? There's the science in the art and the art might be asking that one extra question or making sure you interview someone alone, whereas that's not necessarily something you're going to learn in a textbook. (HCP 22) Having a clear protocol of how to support and having training as an agency of how to deal with that [sex trafficking], I think that'd be really good. I think that would give staff confidence. (HCP 14) I don't think we have a set of questions. If I had a set of questions, I might feel more comfortable asking myself [...] or even a crash course of what to identify [...] I think it's when you're shoved into a realm of something you've never done before, there's uncomfortableness. (HCP 5) Public health should have a mandatory module [...], now we haven't. You have to know how to, how to do this, how to do that, whatever [...]. We have all this stuff [other training], we should be having that, [it] should be mandatory. HCP 20 The best [time] to do that education [is] as early as possible in medical school [...] because teaching one class of 250 medical students all of these resources in first year, [...] even if only a

		100 of them are listening, and only 50 of them absorb it, that's 50 people ongoing who will become teachers, you know what I mean? (HCP 29) I guess aside from paying people better and hiring and keeping our staff and all that stuff. I guess education and [...] having policies in place already that people can refer to. […] You could add a short, I don't think it has to be long, but even a little 10 minute video is probably better than what exists now, which is just nothing. (HCP 7) Education opportunities, because I know there's a lot of physicians that would be very interested in it and just as a CME [continuing medical education] or a learning because I'm sure it would break a lot of myths that a lot of us are holding in our heads and that's framing how we provide care. I think there's a lot of myth busting that probably needs to happen. (HCP 24) Absolutely not only a resource, guide, a real guide to what it [sex trafficking] is, how it is, how it happens, all of this stuff because you can have a guide, but if you can't have a sense of identifying what you need in terms of resources, you could have all the pamphlets sit[ting] there [all] you want. But it's who you give them to is really important as well, right to be able to because people who work in this sex trafficking, I'm sure you guys have much clearer ideas, much more, not defined in the sense that it's so straightforward, but certainly to help us be able to identify sex trafficked people and things that will be helpful to to us. I think that it [education] should be mandatory. (HCP 20) [W]e do grand rounds and every week we have a lecture hour that's on any sort of topic, but I think more training on gender-based violence [and] sex trafficking in particular [is needed]. I think specifically to get [...] formalized training that would apply to all EDs [emergency departments], I think would be really important and [learn] how to approach patients, that you're suspicious of [and] how to approach confirmed patients [who have been sex trafficked], [and] other things to screen [and] look for. (HCP 22) I think it's really important that there's some kind of [sex trafficking] education for all health care workers, doctors, and nurses, does not matter what, anybody who works in a health care situation for any reason whatsoever. (HCP 20) I'd like to know [how] to pick up on it a lot quicker. More specifically, just like my emergency room. [...] I would like to be able to like, learn the little nuances that could help me be like 'Hey something's a little bit off here.' [...] So, like it's really hard to like, identify that. (HCP 10)

		I think for me [...] [I would like to know how to] approach [...] health care encounters [to make] safe space[s] where people could disclose, and how to specifically phrase that because I [don't] know […] if [I] should be doing a little spiel to all of [my] patients [saying] like, 'Hey, this is human trafficking and if you see [these] things that are happening, you can come to the hospital, and we [can] take a care of you like, I promise you it's safe.' […] I don't expect disclosure when I'm giving my like, 'Hey, if you're not safe, you can come back here.' I just want them to know that they can do that when they're ready but I want to know how to say it better. (HCP 15)
	Funds for survivors, services, and supports	We may need to change the way we fund health care or at least a piece of it. When you have 15 minutes to see a patient as a family doctor, you're not going to see this [sex trafficking], you're not going to spot this. And they're our gatekeepers. They see the vast number of, when I say, family doctors, let's say primary care, right, see the vast number of our patients. (HCP 28) Our funding just got cut at our center, it boggles my mind […] at a time when people are just absolutely struggling. So, that would be a huge one, if there's any way to get more funding for more help. And maybe that would mean there'd be more individual counseling, groups as well, group therapy where people can feel connected. (HCP 4) Well, we cannot help people with our money. [...] Money is necessary; sometimes it takes a while to get somebody on [social assistance] or get them any kind of support. Sometimes you need money just to get people to a safe place [...], [but] most of the time people don't have access to money and without money you can have all the information in the world, but [that doesn't matter if] you don't have access to funding. [...] I'm not talking [about] funding for the organization. I'm talking […] help to people directly. (HCP 6) [B]ecause the needs keep growing and everyone keeps cutting back and health care right now is just at a breaking point. (HCP 2)
Center unique needs of survivors	Survivor-led and informed approaches	I think we need to make it more visible, so there should be programs geared where people are trained. And I always say somebody, a person that will provide a one-on-one set of this could be somebody who has gone through the experience himself. So, he understands the language, but it should be specific to the population and we need shelters that are specific too. (HCP 6)

		And we also need representation of survivors. If hospitals are going to design programs, they need to have survivors be the leaders, be the voice, provide their input before staff are trained on materials. (HCP 8) Having people who have experienced that be part of the training, be the ones to teach, because they've had the experience, too. Whether it's a keynote speaker or whether or not it's more peer support. (HCP 18) It would be nice to know what are some of the factors that we need to be on the lookout for and go from there, but also how to support people from the client perspective. Like, what are things they want from their health care provider, because sometimes we have our approach of what we think they need to know. But maybe they're not ready to hear that or maybe that's not what their priority is. (HCP 24) I want training and some of that training has to come through the women themselves. (HCP 6) I mean, they have not personally lived through it, but they work with people right. So, just anyone who has that experience. It's always nice to hear from that person as well, who has gone through and has gone through the other side of it and they have survived. But it might be better to see from both perspectives so from that person, who's help[ing] them, and then the person who has received that. (HCP 5) I think it'd be helpful for us to know from a client perspective or from a patient perspective, what are their needs as well, and what we can do best to support [them]. (HCP 24) A lot of it is trust […] and I have to work towards that [...] [by] making them a part of the plan. So [asking the patient] […], 'Would you be open to going to a women's shelter?' [T]hen you get their reason why [they] don't, and [then asking], ' What other ideas do you have?' So, one came up with go[ing] to [her] sister's for the weekend. [I agreed] that [was] a good idea. (HCP 16) [I want to know from] people with lived experience how they would want it [discussion around sex trafficking] to be phrased to them. (HCP 15)
	Primacy of trust, rapport, and safety	We don't have time, which sounds really bad and I feel like it's really hard to build a trusting relationship with somebody that is like this [sex trafficked]. Nobody's going to come out and tell you, 'Oh, yes, I have been sex trafficked.'[...] So, it would be really

		interesting to see if there's a way you [can] build a good trusting relationship and not essentially mess it up. (HCP 10) Having a resource to be reminded of the best way to practice safely and protect the patient's confidentiality, while not alerting the person trafficking them that we're aware of the situation. (HCP 23) [It's] [h]ard to identify [sex trafficking] because of the limited time people [doctors] have with their clients or patients, the rush in the waiting room, and [patients] feeling uncomfortable talking to someone who they don't feel safe with. There used to be posters on walls, [...] in sexual health clinics and stuff like that […] [saying] this is a safe place. Maybe all doctors' offices need to have that. [...] Maybe [saying] something [to the patient] about, 'If you have anything that you need to talk about as well, whatever, this is a safe place to do it. We will not do harm [...] and if you need help in any way, [we are here].' Something that [lets] people know that they can [disclose]. Because it's scary to go into a doctor's office for people and young women. (HCP 20) If I had a safe space to talk to them more, I think that would help, there's not, there's never enough room in the emerge [emergency department], there's never a safe spot for that. (HCP 2) But how do you keep that person overnight and leverage that [person being in the hospital]? Especially if they're maybe mentally suffering, right? They're in a place where they're mental health isn't good, they can't sleep, they're going through withdrawal, like what are the med[ication]s that are kind of pre-arranged that you could order and support them with. So, we have those, that's organized. I mean ideally, I would love for these people to [...] not have to be in the emergency part of the main area where you're next to someone with a chest tube, but more of just kind of a safe room, or there's a locked door on the other side, but it's also just a normal bed that you can just kind of sleep in and feel safe in for the night until someone comes and talks to you. That would be lovely. We don't really have that. (HCP 2) They need care. They need somebody that is compassionate with them and they need somebody that is going to [...] be like, 'Okay, we need to figure out something safe for you.' (HCP 10)