Journal of Applied Research on Children: Informing Policy for Children at Risk

Volume 6 | Issue 1 Article 7

2015

Implementing a Coordinated Care Model for Sex Trafficked Minors in Smaller Cities

Mary Burke
Carlow University, mcburke@carlow.edu

Heather L. McCauley
Division of Adolescent Medicine, Department of Pediatrics, University of Pittsburgh, Children's Hospital of Pittsburgh of UPMC, heather.mccauley@chp.edu

Anne Rackow
National Center for Juvenile Justice, amrackow@gmail.com

Bradley Orsini
Federal Bureau of Investigation, Pittsburgh Division, bradley.orsini@ic.fbi.gov

Bridget Simunovic
Federal Bureau of Investigation, Pittsburgh Division, Bridget.Simunovic@ic.fbi.gov

See next page for additional authors

Implementing a Coordinated Care Model for Sex Trafficked Minors in Smaller Cities

Authors
Mary Burke, Heather L. McCauley, Anne Rackow, Bradley Orsini, Bridget Simunovic, and Elizabeth Miller

Background
Addressing the social and clinical service needs of minors who have been sexually exploited remains a challenge across the United States. While larger metropolitan centers have established shelters and service provision specific for trafficked persons, in smaller cities and more rural settings, survivors of trafficking (especially minors) are usually served by multiple, disparate social service and health providers working across different systems. Sexually exploited minors present an even greater challenge due to intersections with child welfare and juvenile justice systems, histories of abuse by family that limit placement options, and limited services that address the complex medical, mental health, and psychosocial needs of these youth. Major health organizations have recommended a coordinated care model that integrates the therapeutic and social service needs of trafficked persons including housing and education; implementation of such service provision requires intensive, multi-sectoral collaboration.

Methods
We present two case studies from an anti-trafficking coalition established in a smaller urban area.

Findings/Conclusions
Multi-sector collaboration requires the development of policies and protocols for addressing the diverse needs (acute and ongoing) of trafficked minors who are often “dual jurisdiction,” involved in both the juvenile justice and child welfare systems. Principles of care including autonomy, empowerment, protection, and safety may be at odds as systems may approach these youth differently. A clearly identified care coordinator can help navigate across these systems and facilitate communication among service providers while protecting client privacy, confidentiality, and autonomy. Assessing the quality of services provided and accountability among service providers remain significant challenges, especially in resource limited settings.

INTRODUCTION

While human trafficking has increasingly been recognized as a prevalent and pernicious human rights problem globally, much of the attention in the United States has focused on the trafficking of migrants from international settings into the US[1] The Trafficking Victims Protection Act, expanded the definition of sex trafficking in this country to include any person under the age of consent (18 years) involved in a commercial sex act.[2] This has increased the number of US citizen sex trafficking victims. As children and adolescents are considered too young to give consent, there is no expectation that coercion be demonstrated.[3]

In 2013, the Institute of Medicine and National Research Council published a report on commercial sexual exploitation and sex trafficking of minors in the US.[4] The report combines both commercial sexual exploitation and sex trafficking of minors as a range of crimes committed against children and adolescents: recruiting, enticing, harboring, transporting, providing, obtaining, and/or maintaining (all acts that constitute trafficking) a minor for the purpose of sexual exploitation; exploiting a minor through prostitution or having her/him perform in sexual venues (e.g., strip clubs); exploiting a minor through survival sex (exchanging sex for money or something of value, such as shelter, food, or drugs); using a minor in pornography; exploiting a minor through sex tourism, mail order bride trade, and early marriage.[4,5]

Studies of females in the United States trafficked into commercial sex consistently find the average age of entry to be 13 to 16 years old.[6-9] Transgender youth also are at increased risk for trafficking victimization in comparison to other children.[10] Other factors that are associated with vulnerability to trafficking among youth include the lack of a protective, stable family structure[7-9,11] and being forced to leave home or running away,[11-13] in part because traffickers often target female runaways for sexual exploitation.[14] Adverse childhood experiences including abuse, neglect, or emotional abandonment are particularly strong indicators for risk of sex trafficking of girls.[12,15] Moreover, adolescents with a sexual abuse or assault history, especially those sexually abused by a parent or trusted adult, are at heightened risk for unhealthy interpersonal relationships and for revictimization.[16] While the research is unclear regarding definitive mechanisms for this, one theory is that these youth desire connection and attachment rather than isolation and traffickers manipulate this to their advantage.

In addition to highlighting the prevalence of such exploitation across multiple cities in the US, the Institute of Medicine report underscored the

need to recognize such exploitation of minors as a form of child abuse (rather than prosecuting minors for prostitution), the lack of awareness among those working with youth (such as teachers, health care providers, child welfare workers, and those staff in youth-serving agencies) around how to identify and address sex trafficking in their communities, and the critical gap in coordinated services to support the care of these children and adolescents. A supplementary guide for care providers drew particular attention to the concentration of specialized services in large metropolitan areas, with most smaller cities and rural areas having limited services to meet these needs and varied capacity to provide essential care.[4] The report concluded that greater collaboration across different sectors including housing, education, and health care is needed. The American Academy of Pediatrics, the largest national organization of health professionals serving children, also recently released a policy report emphasizing the role of pediatricians in helping to develop collaborations among medical and non-medical sectors to serve sexually exploited children.[17]

Within the US health care delivery system, collaborative care models have generally focused on the integration of medical, behavioral, and subspecialty medical care within primary care.[18] For sexually exploited minors, case identification and care coordination rarely occurs in a primary care setting, and more often within child welfare or the juvenile justice systems. Additionally, as noted, the needs for trafficked minors are myriad extending far beyond medical needs to food, shelter, clothing, housing, education, and financial stability. Thus, a coordinated, multidisciplinary community response has emerged as an approach to serving trafficked persons, including minors, in towns and cities around the country. In fact, much of the responsibility for meeting survivor needs has been initiated at the grassroots level and has been undertaken by concerned citizens, non-governmental organizations (NGOs) and social service agencies (e.g., domestic violence agencies, homeless centers and shelters, refugee support and resettlement agencies, child advocacy centers). In these instances, many of these organizations are stretching their already limited resources to include support for this marginalized population. In many regions, these groups have come together to form coalitions, which often include law enforcement, local FBI, states attorneys' offices, housing, health care professionals, child welfare workers, domestic and sexual violence victim service advocates, school administrators, and other youth-serving agency staff. These coalitions have played a critical role in not only meeting survivor needs, but also in increasing awareness about sex trafficking by educating citizens, which in

turn has led to victim identification and arrests and prosecution of traffickers. Coalitions allow for collaboration in meeting survivor needs, which can mean identifying and drawing upon the unique skill and knowledge sets among members and sharing in the work itself. The value of these coalitions should not be underestimated; for example, Farrell et al. (2012) found that law enforcement officers may be reluctant to expend resources in investigating potential trafficking cases if there are no community resources available for the survivor.[19] To our knowledge, while coordination of services across sectors has been emphasized in the care of sexually exploited minors, the role of anti-trafficking coalitions in serving minors has not been addressed. This paper uses two case studies to illustrate the critical importance of care coordination and the benefits of a coalition organized and prepared to provide collaborative care for sexually exploited minors.

Coalition Overview

In 2005, an anti-trafficking organization in Pittsburgh, Pennsylvania, the Project to End Human Trafficking formed the Western Pennsylvania Trafficking Coalition. This coalition is comprised of many of the types of groups and organizations mentioned previously and over the years this group has refined its functioning and expanded membership significantly. This coalition has a team of individuals trained as “first responders” who meet trafficking survivors to first and foremost assess their safety and immediate needs. Other responsibilities of the coalition include providing housing, food, clothing, access to health and mental health care and legal consultation. In smaller cities, addressing both the acute and longer-term service needs of children and adolescents remains a distinct challenge due to intersections with child welfare and juvenile justice systems, histories of abuse by family that limit placement options, and limited services that address the complex medical, mental health, and psychosocial needs of these youth.

Collaboration among the many members of the Western Pennsylvania Trafficking Coalition has led to the opening of numerous human trafficking cases. Many of these cases, some of which involved sex trafficking of minors, resulted in successful prosecution under federal statutes with perpetrators receiving lengthy prison sentences and survivors taking steps toward living a safe and fulfilling life. Members of the Coalition work not only to support victims, but to assist each other in ensuring the best interest and protection of victims. The Coalition is currently comprised of approximately 75 members, most of whom represent agencies for which they work and others of whom are

independently involved. In part because membership is sizeable, Coalition structure includes a Steering Committee, Co-facilitators and three sub-committees, each of which are assigned different responsibilities related to survivor care. Sub-committees include 1) Public Affairs and Fundraising, 2) Resources and Services and 3) Law Enforcement. Each of these is co-facilitated in an effort to ease the workload of volunteers. Members join committees based on their expertise and interest. The Steering Committee includes representatives from the founding agency, the Project to End Human Trafficking the FBI's Pittsburgh Office, a representative from a rape crisis center, a local mental health agency (with a focus on serving lesbian, gay, bisexual and transgender individuals), and one to two representatives from the local police. The Steering Committee meets monthly or bi-monthly, depending on need and is responsible for general oversight of the Coalition. Sub-committees determine their own schedule for convening with most meeting bi-monthly while the Coalition meets as a whole group four times yearly.

Ethical Considerations: Cultural Sensitivity and Confidentiality

Coalition members, especially those interacting directly with trafficking survivors, adhere to strict guidelines regarding confidentiality. Identifying information about survivors is shared on a limited basis in an effort to protect the privacy and sometimes the physical safety of the survivor. Culturally relevant care is also a core guiding principle, and sensitivity training related to individual and cultural differences is provided at regular intervals for members.

The role of law enforcement and the Victim Specialist

The Coalition has numerous law enforcement members from many participating agencies. The law enforcement component is centrally housed at the Pittsburgh Office of the Federal Bureau of Investigation (FBI). The Coalition has taken a team approach in the investigation of these cases while marshalling all available resources to provide direct and indirect services to survivors. A unique aspect of the connection between the investigation and service provision is that the FBI is able to provide services through the FBI Victim Specialist (VS), a position that was implemented in all 56 field offices in the early 2000s. The role of the VS in supporting trafficking survivors may vary to some extent by city, depending on whether there is a local coalition or task force. The primary mission of the Victim Specialist Program in the FBI is to ensure that victims of federal crimes investigated by the FBI have access to the rights and assistance to which they are entitled under the law and the Attorney

General Guidelines. The FBI VS in Pittsburgh is a trained therapist who is the primary care coordinator for the survivors of sex trafficking. Since the inception of the position, the collaboration of the VS and the investigating law enforcement entities have paid significant dividends for victims, allowing victims to obtain comprehensive care and coverage while aiding in the prosecution of traffickers.

Role of the FBI Victim Specialist and Coalition Response to Child Sex Trafficking Survivors

The Coalition takes a collaborative, team-based approach with the Steering Committee playing an active role in all cases. Survivors are referred to the Coalition through any number of in and out of state sources including the National Hotline, social service agencies, law enforcement, church groups, health care facilities, and citizens. Members of the Steering Committee are often the first responders and as such are heavily involved in initial assessment of the survivor which is followed by a harnessing of all available resources to provide direct and indirect services as needed. For adults, the nature of the initial response to the survivor depends in part on the stated goals of the survivor (for example, does s/he want to involve law enforcement immediately and proceed with developing a prosecutable case or does s/he prefer to stabilize with regard to securing housing, health and mental health care etc.). Within the Western Pennsylvania Coalition, service coordination for child sex trafficking survivors is managed by the FBI VS. This includes organization of all care provision and leveraging of the resources of the entire Coalition while maintaining confidentiality, respecting youth autonomy and privacy, and promoting shared decision making.

Methods

The following describes two case studies from 2013 in which the FBI VS and the Coalition were involved to illustrate the critical importance of care coordination (specifically the role of the VS) and the benefits of a Coalition primed to provide assistance. While the case studies also include details about identification, the focus for this paper is on care coordination and providing collaborative care through the Coalition. Identifying details have been changed or left out to protect the privacy of participants. These two contrasting cases were selected to illustrate the unique challenges of serving minors who have been trafficked, including the complex social context and incessant pull back to the streets.

Case Studies

Case Study #1

A 15 year old female, who was a local runaway with no stable housing, was arrested for prostitution and sent to a local juvenile detention center. As a child, she experienced neglect by her biological parents, who struggled with addiction. She was placed in foster care and eventually adopted, where she endured sexual abuse by her adoptive father and emotional abuse by her adoptive mother. She ran away from her foster parents, became homeless, and shortly thereafter met the trafficker. In her case, the arresting officer was an active member of the Coalition and notified the FBI of the arrest scenario. The FBI assigned a Victim Specialist and Special Agent to interview this youth, who was deemed a victim of sex trafficking given her age.

While the initial intent for the VS was to provide crisis intervention, little information was forthcoming at first. Like many trafficked persons, this young person was reluctant and scared to share information about her history, including her history of trauma, or current needs. The VS conducted numerous and extensive follow up interviews which assisted in building trust as well as revealing a highly complex history of familial abuse and no social supports. She identified more with her “pimp” than any family member. Slowly, as trust continued to develop, she shared more details of the prostitution and abuse she endured. In an effort to ensure continuity of care and support and to maintain the therapeutic relationship with the survivor (as called for in best practices following trauma), the VS served as her primary service coordinator. In that role, the VS had significant one-on-one contact with the survivor, including accompanying her to court to provide victim advocacy, assisting her to create the victim impact statement, explaining the criminal justice system, and providing support during the interview process. Additionally, the VS accompanied the victim to various service provider appointments such as medical services (including care for sexually transmitted infections), counseling, school, life skills training, employment, food assistance, housing and shelter, including providing and arranging for transportation. The VS was available through frequent follow up contacts, in person, by phone, text and email, with frequent crisis intervention and need to address safety concerns. The VS also provided information about the nature of human trafficking and sexual exploitation to help this young person better comprehend her experiences.

Through the Resources and Services Subcommittee, the Coalition aided the VS in the provision of clothing and food for the young person. Furthermore, members of the Coalition donated and purchased household goods on her behalf, helped with transportation needs, and facilitated

employment. Thus, collaboration among Coalition members was integral to her recovery. All communication with the Coalition about her needs was initiated by the VS to maintain confidentiality and privacy.

The survivor was eventually placed in independent living housing, and received support and intensive case management to continue her education and earn her general education diploma. She applied for and received a driver's license and is currently in college and employed. In Pennsylvania, she is allowed to stay in the independent living facility until she reaches 23 years of age. She has assimilated to day to day life and moved toward her goal of independent living. She continues to contact and maintain a relationship with the VS.

Case Study #2

A male-to-female transgender youth was first identified at the age of 16 (when still identifying as male), when she was arrested and charged with prostitution. This young person already had an extensive juvenile record, including arrests for prostitution, theft, and trespassing. As with the case above, the extent of abuse history was not immediately apparent. The young person's mother was physically abusive with longstanding substance abuse, and the young person was the oldest of six children, often serving as the primary care giver for the younger siblings. The biological father was not involved.

The VS was assigned as the primary service provider and care coordinator once the victim was identified; members of the Law Enforcement Subcommittee of the Coalition (local and FBI) went to the juvenile detention center to conduct the interviews. Once the young person began to receive consistent medical care, numerous health concerns were identified including chronic infections, needing specialized care. The young person also revealed that she identified herself as female, and wished to transition from her natal male sex to have her body more congruent with her gender identity, requiring care coordination with her infectious disease specialist and the adolescent medicine health professionals who were able to provide transgender care. The adolescent medicine specialists served as the primary coordinator for her medical and behavioral health needs, following the collaborative care model within the health care delivery system. Assistance to obtain the general education diploma, counseling, transportation, and numerous other services were provided by the VS.

Further complicating her care was that this young person had been engaging in sex work for a number of years and had learned that selling sex as a transgender individual was more lucrative than selling sex in the

role of her natal male sex. The young person perceived pressure to return to the streets, and when released on monitored status from the detention center, immediately ran away and reconnected with traffickers.

DISCUSSION

These two cases highlight critical challenges associated with serving and supporting minors who have been sex trafficked as well as the important role of collaboration in service provision. With the growing recognition of the vulnerabilities of youth to sex trafficking, the number of trafficked persons who are minors being identified is increasing. Most of the youth have extensive histories of familial abuse, childhood sexual abuse, and experiences of intimate partner violence and sexual violence. Likely related to their histories of abuse, both youth had previous or current involvement in the child welfare and juvenile justice systems ("dual jurisdiction" or "cross over" youth), which is characteristic of many cases identified in Western PA and elsewhere. As recommended by numerous national legal advocacy organizations for youth, training for child welfare and juvenile justice system employees and judges is needed on the complex dynamics of sexually exploited minors and trafficking to ensure that decisions around placement and services are made that take these histories of trauma into account.

The health consequences of trauma, including their experiences of trafficking, are profound and require specialized care as highlighted in both cases.[20-23] All the young people served by the Coalition in Pittsburgh to date have required trauma-focused counseling and extensive medical care for poor dentition, sexually transmitted infections, disordered eating, and chronic pain. Need for specialty medical and mental health services, such as trauma-focused mental health interventions, transgender care, and HIV care is not uncommon. Now, a decade later, the Coalition has identified a network of clinical and mental health providers to provide these specialty services and other need areas, but coordinating the care provision with where youth are being placed (such as shelter, residential homes, and independent living) remains difficult.

Most youth identified through the Coalition are not aware of the extent to which the behaviors they have been subjected to are against the law. Despite the efforts of the Coalition to emphasize the need for victim-centered approaches, youth are still being arrested for prostitution as in both of the cases above. While this does allow for identification and while law enforcement and judges are increasingly recognizing that youth who have been engaging in commercial sex work are victims, youth are caught within several complex systems -- the juvenile justice system, child

protective services, and law enforcement. The Victim Specialist thus serves a critical role in this process as the primary coordinator of service provision for youth (compared to adult victims, for whom the Coalition members lead response and care coordination) and as the main point of contact for trafficked youth. In cities that do not have an FBI VS, this role may be filled by a child welfare case worker or a juvenile probation officer, although questions remain as to how successful this model would be with a less experienced VS or community-based care coordinator. As illustrated in the case studies above, the VS is positioned to navigate across these systems, accompany youth to hearings as their advocate, and ensure that service provision happens expeditiously. In communities without an FBI VS, a probation officer or case worker may have greater difficulty in working across systems; community-based anti-trafficking coalitions can assist with policies and protocols for the care of trafficked youth including creating and educating on appropriate practices for sharing of information.

In many jurisdictions, it is common practice to detain or adjudicate victims of sex trafficking as a way of connecting them with services. A community based anti-trafficking coalition combined with a victim services coordinator can provide an alternative approach to connecting these youth with the necessary services without having to immerse them into the juvenile justice system. A Coalition comprised of a wide range of professionals is critical to the care provided to these young people as no single agency or individual can provide all the services needed. In instances of child sex trafficking, for the role of the VS to be effective, there needs to be an efficient system for communication across the coalition and the ability of the VS to pull in needed services expeditiously as these arise. As the youth's privacy and confidentiality are critical, the VS must also be able to tap into coalition services and resources while not divulging personal information. Memorandums of understanding as well as clear systems for sharing information (that involve the young person in determining what information gets shared to whom) are critical for protecting youth confidentiality. Jurisdictions face similar issues regarding information sharing and complex case management across systems when working with youth who are simultaneously adjudicated delinquent and dependent. There are many initiatives in place across the country to address these challenges that can inform practices for serving victims of minor sex trafficking.

In addition to identifying services needed and calling on members of the Coalition to assist in specific cases as described in the cases above, the VS must work to establish rapport and trust with the young

person. The VS helps to reduce the fears associated with being arrested; for many youth in these circumstances, pimps' ability to find, threaten, and control them limits the willingness of young people to fully connect with the VS, much less law enforcement. To date, while outcomes for several young people have been positive, many (as in the second case study) have also run away and been lost to follow up for many months. The position of the VS within the FBI is thus both a strength and a limitation. Inevitably, youth initially see the VS as part of law enforcement, and creating the sense of safety and trust requires extensive visits and time.

Another challenge is monitoring the quality of service provision as the agency charged with providing oversight and accountability for services can vary from case to case depending on adjudication status of the youth. In the community setting in Western Pennsylvania, funding for the Coalition is limited, so ensuring accountability and continuity with services can be difficult. As these cases are unique and involve many different agencies, instances arise where it is unclear what the roles and responsibilities are of each agency and staff member. Additionally, communication expectations as well as restrictions around sharing of information (such as personal health information) may contribute to confusion around roles and responsibilities. The treatment needs for survivors of sex trafficking are highly individualized and success would be defined and measured differently for each person. Monitoring the quality of the services offered is an important step to increasing the likelihood of success. All interventions implemented should be based on research and have some level of evidence of their effectiveness from rigorous evaluations. As the role of the Coalition has evolved over time and with the oversight of the FBI VS, a network of service providers who share a commitment to ongoing support for these identified youth is emerging.

In summary, multi-sector collaboration requires the development of policies and protocols for addressing the diverse needs (acute and ongoing) of trafficked minors who are often "dual jurisdiction," involved in both the juvenile justice and child welfare systems. A clearly identified care coordinator who can navigate across these systems and a network of services organized through a coalition such as described here appear to be key elements of a community-based response to supporting child sex trafficking survivors. Strategies to facilitate communication while protecting client privacy, confidentiality, and autonomy are crucial. Assessing the quality of services provided and accountability among service providers remain significant challenges, especially in settings with limited resources.

References

1. Logan TK, Walker R, Hunt G. Understanding Human Trafficking in the United States. *Trauma Violence Abuse.* 2009;10:3-30.
2. Office on Violence Against Women. *Victims of Trafficking and Violence Prevention Act of 2000.* Washington, D.C.: United States Department of Justice;2000.
3. Schauer EJ, Wheaton EM. Sex Trafficking into the United States: A Literature Review. *Criminal Justice Review.* 2006;31:146-169.
4. Institute of Medicine & National Research Council. *Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States.* Washington, D.C.: The National Academies Press; 2013.
5. APA Task Force on Trafficking of Women and Girls. *Report of the Task Force on Trafficking of Women and Girls.* Washington, D.C.: American Psychological Association; 2013.
6. Boyer D. Who pays the price? Assessment of youth involvement in prostitution in Seattle. Seattle Human Services Department, Domestic Violence & Sexual Assault Prevention Division; 2008.
7. Pierce A. Shattered hearts: The commercial sexual exploitation of American Indian women and girls in Minnesota. 2011; http://www.miwrc.org/shattered_hearts_full_report-web_version.pdf.
8. Priebe A, Suhr C. Hidden in plain view: the commercial sexual exploitation of girls in Atlanta. *Atlanta Women's Agenda.* 2005.
9. Raphael J, Ashley J. Domestic sex trafficking of Chicago women and girls. 2008; http://www.law.depaul.edu/centers_institutes/family_law/pdf/sex_trafficking.pdf.
10. *Trafficking in Persons Report.* Washington, D.C.: U.S. Department of State;2014.
11. Lloyd R. *Girls Like Us.* New York, NY: Harper Collins; 2011.
12. Reid JA. Doors wide shut: Barriers to the successful delivery of victim services for domestically trafficked minors in a southern US metropolitan area. *Women & Criminal Justice.* 2010;20(1-2):147-166.
13. Williams LM, Frederick ME. Pathways into and out of commercial sexual victimization of children: Understanding and responding to sexually exploited teens. 2009; http://faculty.uml.edu/lwilliams/Williams%20Pathways%20Final%20Report%202006-MU-FX-0060%2010-31-09L.pdf.
14. Albanese J. *Commercial Sexual Exploitation of Children: What Do We Know and What Do We Do About It? .* Washington, D.C.: U.S. Department of Justice; 2007.

15. Rabinovitch J. PEERS: The Prostitutes' Empowerment, Education and Resource Society. *Journal of Trauma Practice.* 2004;2(3-4):239-253.
16. Gobin RL, Freyd JJ. Betrayal and Revictimization: Preliminary Findings. *Psychological Trauma: Theory, Research, Practice, and Policy.* 2009;1(3):242-257.
17. Greenbaum J, Crawford-Jakubiak JE, Committee on Child Abuse and Neglect. Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims. *Pediatrics.* 2015;135(3):566-574.
18. Unützer J, Harbin H, Schoenbaum M, Druss B. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.* Washington, D.C.: Centers for Medicare & Medicaid Services 2013.
19. Farrell A, McDevitt J, Pfeffer R, et al. *Identifying Challenges to Improve the Investigation and Prosecution of State and Local Human Trafficking Cases.* Washington, D.C.: Urban Institute & Northeastern University; 2012.
20. Hardy VL, Compton KD, McPhatter VS. Domestic Minor Sex Trafficking: Practice Implications for Mental Health Professionals. *Affilia.* 2013.
21. Hossain M, Zimmerman C, Abas M, Light M, Watts C. The Relationship of Trauma to Mental Disorders Among Trafficked and Sexually Exploited Girls and Women. *American Journal of Public Health.* 2010;100(12):2442-2449.
22. Hussey JM, Chang JJ, Kotch JB. Child Maltreatment in the United States: Prevalence, Risk Factors, and Adolescent Health Consequences. *Pediatrics.* September 1, 2006 2006;118(3):933-942.
23. Miller E, Decker MR, Silverman JG, Raj A. Migration, Sexual Exploitation, and Women's Health: A Case Report From a Community Health Center. *Violence Against Women.* 2007;13(5):486-497.