

SEX TRAFFICKING OF DOMESTIC MINORS IN PHOENIX, ARIZONA: A RESEARCH PROJECT

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INTRODUCTION

In 2011, The Child Sex Trafficking Think Tank was convened in Phoenix to address the local problem of domestic minor sex trafficking (DMST). Initial research, for this think tank, identified a significant gap in the continuum of services for this population of children: the lack of services for those youth not yet able or ready to leave “the life”. Theoretically, this range of services could be offered at a resource rich drop-in center. This paper represents the summation of a research project, which was intended to assess the feasibility of establishing such a drop-in center to serve the Phoenix metropolitan area. Upon conclusion of this further research, however, somewhat different conclusions and recommendations were reached. This analysis included a literature review, interviews with local Arizona stakeholders, and discussions with representatives of best practices in the nation. This paper will review these findings and the subsequent research-based recommendations.

BACKGROUND

Commercial sexual exploitation of children (CSEC) has been defined as encompassing several forms of exploitation, including pornography, prostitution, child sex tourism, and child marriage (1). The term domestic minor sex trafficking (DMST) is the most clearly identifiable form of CSEC. DMST specifically refers to the exchange of sex with a child under the age of 18, who is a United States (US) citizen or permanent resident, for a gain of cash, goods, or anything of value (2-4).

The Trafficking Victims Protection Act of 2000 (TVPA) clarified previous inconsistencies in the definition of human trafficking by establishing a legal definition of severe trafficking to include:

“Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age” (5).

Specifically, no force, fraud, or coercion need be proven in children younger than 18 years. Ironically, the TVPA of 2000 specifically addressed international trafficked victims, and as a result, to date, the services available to international victims significantly outweigh those available to domestic victims (6). The TVPA has been subsequently reauthorized in 2003, 2005, and 2008, the latter two finally including provisions for US victims (4).

The Phoenix-Mesa-Glendale Statistical Metropolitan Area, one of the nation’s fastest growing areas, is a large, sprawling, urban expanse of 4.2 million people (7). It is in close geographic proximity to known centers of sex trafficking on the west coast and in Las Vegas, Nevada. In fact, it is often considered an integral component of the hub of sex trafficking in the Western US (8). The Phoenix area is also a destination itself, home to a large tourism industry, including sporting events and conventions, and a thoroughfare for two major interstate highways. Finally, as a large urban area, one of the hardest hit by the current recession, it has a significant homeless population, including runaway and throwaway children. Each of these facets of Phoenix’s

demographics is a contributing factor to a thriving child sex trafficking industry.

LITERATURE REVIEW

DATA

A review of the literature reveals a conspicuous lack of reliable, accurate data regarding the prevalence and characterization of DMST in the US. A myriad of factors contributes to this dearth of information including: the failure of society to recognize the problem; the stigmatization and marginalization of victims; the absence of uniform reporting registries; and, the underreporting by all levels of stakeholders including law enforcement and human service providers such as medical professionals and social workers (8). The most commonly quoted, and often-misquoted prevalence data include:

- The work by Estes and Weiner (8), although the authors themselves note the limitations of their estimates. Based on the use of 17 “at risk” categories, the authors concluded that in 2000, there were 244,000 youth “at risk” for commercial sexual exploitation in the US.
- The obsolete General Accounting Office estimate of 1982, which estimated that at that time there were between “tens of thousands to 2.4 million” children involved in juvenile prostitution (9).

Unfortunately, those who have permutated these estimates have done so without data-based verification (9).

Despite the lack of reliable data, there is consensus that the incidence is severely underreported, and that DMST represents a significant public health and societal problem. Shared Hope International has found:

“misidentification of the victims to be the primary barrier to the rescue and response to domestic minor sex trafficking victims.” (10)

Underreporting occurs secondary to factors such as: the frequent movement of victims in order to remain under the radar; the various and dynamic changes of the sex industry such as the recent surge in internet use; the failure to recognize and identify victims; and the lack of consistent reporting mechanisms at the local, state, and national levels.

Recently, however, innovative ideas have been used in an attempt to obtain more accurate estimates. For example, in Georgia, the governor’s office has commissioned the preparation of quarterly estimates of commercially exploited girls in the state. Trafficking activity encountered through street activity, internet ads, and escort services is monitored (11). Figure 1 shows such data from 2007-2009. The total number of trafficked adolescent girls estimated by these methods was between 225-492 per month, with a significant upward trend noted in Internet based encounters.

In addition, indirect methods of assessing prevalence have been offered, using extrapolation of related data to obtain estimates.

- The Add Health in-school questionnaire was used to survey representative adolescents in the US. Notwithstanding limitations, this survey reported that out of 13,294 adolescents surveyed, 3.5% reported ever exchanging sex for money or drugs (12).
- Extrapolation of data regarding runaway and homeless youth also suggests a significant problem. In 2007, the Family and Youth Services Bureau of Health and Human Services (HHS) reported that 50,718 youth received homeless services and an additional 770,223 outreach

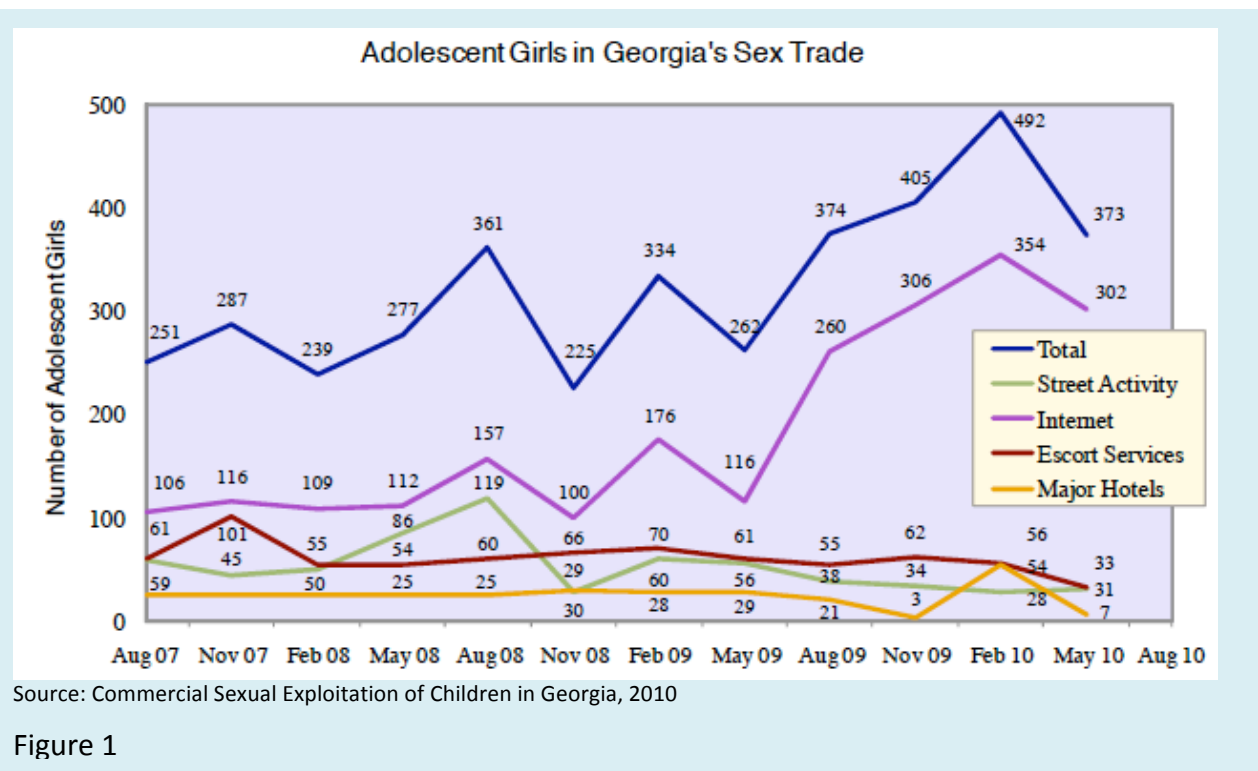


Figure 1

contacts were made to this population (13). Estes and Weiner estimate that 71% of these youth are “at-risk” for sex trafficking (8).

Finally, despite the lack of adequate scientific data, experts in the field agree on several key points, which follow.

PREVALENCE OF DOMESTIC VICTIMS

In a recent US Department of Justice (DOJ) review from the Human Trafficking Reporting System (HTRS), 83% of confirmed sex trafficking incidents between January, 2008 and June, 2010, were identified as US citizens (14). This underscores the significance of domestic victims relative to international victims, who have historically received more attention and resources. Despite this data, a recent survey of direct service providers in the US showed that very few recognized US citizens as victims of human trafficking (15).

AGE OF ENTRY

A significant number of adult victims of sex trafficking enter “the life” under the age of 18

years (4, 16). Nationally, the average age at which girls are first exploited is 12-14 years (13). In Arizona, interviews of adult victims confirm this; 21% of 396 adult victims arrested for sex trafficking reported that they had entered prior to age 18, with the average age of entry being 14.74 years (17).

In the aforementioned US DOJ report from 2008-2010, 54% of confirmed sex trafficking incidents involved minors under the age of 18 years (14). This data, accumulated from several US sex trafficking task forces, demonstrates the prevalence of minor sex trafficking in relation to the overall incidence.

GENDER

Domestic sex trafficking victims, including minors are overwhelmingly female (14). However, male and transgender victims, although not as visible, do exist and may reflect different demographics from females (18).

DIVERSITY OF RACE/ETHNICITY

Although there is great variation in prevalence of races and ethnicities in various studies, this may reflect a diversity of local

demographics. Clearly, all races and ethnicities are represented in the population of domestic sex trafficked minors (14).

STEREOTYPES

Historically, the general US population and culture, as well as law enforcement, juvenile justice, and the full range of relevant service providers, have subscribed to a stereotypical view of child victims of sex trafficking. Similarly, the focus of the majority of medical and public health literature, regarding this population, has been, for the most part, limited to the transmission of sexually transmitted infections (STI), particularly HIV/AIDS, particularly from victim to john (16). The intrinsic sexual violence and physical, and psychological abuse associated with child sex trafficking have often been misunderstood or ignored. Elements of victim psychological dependence and survival sex are little appreciated. Rather, the pervasive stereotype purports that these children are delinquents, exercising their choice in participating in prostitution. Added to this are the common experiences, of law enforcement and various service providers, of apparently hostile, ungrateful, rebellious youth. As a result, few, including the youth themselves, view these children as the victims they are. Many recent studies, however, offer that these characteristics are often the result of chronic, lifelong psychological and often sexual traumas which precede entry into “the life” (16). Thus, a major paradigm shift is critical to understanding these minors as victims rather than as prostitutes and criminals (2).

It is also essential to appreciate that the full spectrum of victims of DMST represents a diversity of children, affected by: different determinants; complex interactions of many determinants; and, an array of resultant behaviors. Survival sex (to fulfill subsistence needs), gang related trafficking, and “boyfriend” and “Daddy” pimps are all

examples of various victim situations along this spectrum.

DETERMINANTS

Several key determinants have been associated with an increased likelihood of becoming a victim of minor sex trafficking. Many of these factors are interdependent, and it is not uncommon that victims have co-occurring risk elements which interact cumulatively (2). Reid suggests that repetitive forms of child maltreatment often trigger an adolescent’s dysfunctional coping methods and result in a motivation to “escape” into risk taking behaviors, such as running away and substance abuse (2). These triggers and resulting behaviors, in turn increase the possibility of being victimized.

HOMELESSNESS

Although estimates vary, studies have consistently found that greater than 50% of the victims of DMST have been homeless at some time, particularly as runaways and throwaways (13). Furthermore, recent years have seen an increase in the homeless population, as well as a significant underestimation of the number of homeless youth (2, 19). Between 2008 and 2009, Arizona was one of the states showing the largest increase (17.88%) in the homeless population. In addition, as a state, it exceeds the national average on four of the five indicators believed to be important risk factors for homelessness (19). Once on the streets, lack of both funds, as well as life skills maturity, contribute to the increased risk of becoming victimized (20, 21). An often quoted, by unverifiable, statistic is that significant numbers of youth are approached by a trafficker within 48 hours of entering the street life (22).

POVERTY

It has been frequently noted that low-income children are at increased risk of becoming victims of sex trafficking (13). Estes and

Weiner have observed, however, that often poverty alone does not account for DMST; their study reported a significant number of trafficked minors in the US actually came from middle-class families (8).

RACE/ETHNICITY

Conflicting reports exist regarding the contribution of race and ethnicity to the risk of DMST. Some suggest that minority children are at substantially higher risk, while others do not (8, 10). This discrepancy may be a reflection of the diversity within the larger population of sex trafficked minors. This underscores the importance of obtaining and understanding local data and using it to inform programs appropriate for each specific community.

CHILDHOOD SEXUAL ABUSE/FAMILIAL DISRUPTION

“Child maltreatment remains a major public-health and social-welfare problem in high-income countries...For a few children, maltreatment is a chronic condition, not an event.” (23)

Innumerable studies document the strong association between childhood sexual abuse, often chronic in nature, and prostitution (16). Estes and Warner noted that of the minor trafficked victims they interviewed, 20-40% of girls and 0-30% of boys reported having experienced sexual or physical abuse at home prior to entering “the life” (8). Furthermore, it has been noted that familial disruption, secondary to, for instance, the death of a parent, divorce, or abandonment, also puts youth at significant increased risk of being victimized (13).

SUBSTANCE ABUSE

Studies consistently show a correlation between substance abuse and risk of sex trafficking. A study in Chicago noted that 83% of 222 trafficked women had one or both parents affected by alcohol or drug addiction (18). Similar findings were noted in the parents

of a cohort of juvenile victims in Arizona (17). More importantly, estimates of personal substance abuse by victims are high (20, 21, 24). It is unclear whether this abuse is more often antecedent or subsequent to the initiation of sex trafficking, although both scenarios are most likely important.

Despite the critical influence of these determinants, it would be presumptuous to assume that other children are immune from being trafficked. For example, none of the following characteristics of youth should be considered “safe”: middle socioeconomic class, living at home, non-minority ethnicity (4).

Appreciation of these determinants leads to a more sophisticated understanding of minor victims of sex trafficking. The chronic, repetitive psychological methods (e.g. verbal and physical abuse, isolation from family and friends) used by pimps on vulnerable youth (e.g. age, emotional immaturity, socioeconomic background), create emotional and financial dependencies that are extremely difficult to break, despite numerous “opportunities” (25). This more accurate perspective allows for a better comprehension of the skeptical, and often violent, behavior towards law enforcement and other service providers, as well as a more insightful understanding of the repetitive recidivism that often occurs.

CONSEQUENCES

“Child prostitution is a gross violation of children’s rights and dignity.” (26)

In addition to the egregious violations of human rights, as enumerated in the United Nations (UN) Convention of the Rights of the Child, minor sex trafficking causes significant morbidity and mortality in victimized children.

Short and long term ramifications of STIs can be devastating, including HIV/AIDS, hepatitis, and cervical cancer. Physical and dental injuries from violence; complications of teen pregnancy and abortion; and chronic

neurological, gastrointestinal, and respiratory complaints, are not uncommon (16). Alcohol and drug abuse and malnutrition have also been noted to be appreciably increased in trafficked children (26, 27).

Mental health problems such as depression, anxiety, and self-destructive behaviors are frequent (26). Severe psychological trauma, including posttraumatic stress disorder (PTSD), may result. These victims may manifest symptoms of changed perceptions of the perpetrator (Stockholm syndrome) including emotional bonding with their pimps; anger at those trying to assist in escape; reluctance to self-identify as victims; and difficulty in leaving the situation (16, 20). Social ostracism and marginalization also contribute to the extreme low self-esteem and self worth often seen in these children (2, 25, 28).

Furthermore, Potterat et al. studied a cohort of prostituted women in Colorado Springs over a 30-year period. They noted a significantly higher mortality rate (attributable largely to violence and drug use) in these women when compared to women matched for other demographic factors (29). In fact, they noted that these victimized women had an average lifespan of 34 years, and thus were engaged in the most dangerous “occupation” in the US.

Hence, as a recent HHS paper by Clawson and Grace noted, these are compelling reasons to view these children as victims rather than as criminals or delinquents (2). Victims of DMST have a variety of unique needs and circumstances, when compared to other child victims, for example, of domestic violence.

“Their level of trauma is much greater and their level of damage, severe.” (2)

ARIZONA STAKEHOLDERS

In early 2012, individual stakeholders in metropolitan Phoenix (figure 2) were interviewed in an attempt to better understand two things: 1) the local resources already

working on DMST, as well as those that may come into contact with victims and/or at risk youth, and 2) these providers’ sense of what services are most needed for this unique group of youth victims. Although constraints did not allow for certain critical groups to be included in these initial interviews, it is essential to obtain input from other stakeholders representing, for example, male victims, the LGBT community, people of color, faith based communities, child protective services, and the juvenile justice system. Inclusion of marginalized groups helps preclude the unintended consequence of increasing already unacceptable disparities.

“Many of the services needed already exist. What are missing are awareness, connection, coordination, and communication.”

(Marilyn Seymann, Bruce T. Halle Family Foundation)

The stakeholder interviews made it immediately clear that Phoenix currently has many diverse public and community groups, which are doing excellent work. Unfortunately, however, they are often isolated, disaggregated centers of excellence in their own niches, in need of a collaborative commitment to victims of DMST. Examples of the exceptional work being done include: street outreach and drop in centers for homeless youth at Tumbleweed; outreach, diversion, and residential programs for adults victims at DIGNITY; domestic violence and homeless programs at A New Leaf; the collaborative work of Project Rose (Arizona State University and the Phoenix police department); the Esuba group’s trauma intervention program; care dedicated to pregnant teens at the New Hope Teen Pregnancy Program; STI testing and treatment at Planned Parenthood Arizona; emergency case management for international victims at the International Rescue Committee; domestic violence resources at the Center of Healthcare Against Family Violence; a

ARIZONA STAKEHOLDERS

Arizona Foundation for Women Jodi Liggett, CEO
Arizona Sexual Assault Network (AZSAN) Peggy Bilsteen, Executive Director
Arizona State University School of Social Work Dominique Roe-Sepowitz, MSW, PhD
Bruce T. Halle Family Foundation Marilyn Seymann, PhD, CEO
Carstens Family Funds Deborah Carstens, Philanthropist and Community Leader
The Center of Healthcare Against Family Violence, Maricopa Medical Center Dean Coonrod, MD, MPH, Co-Founder Dena Saltar, MBA, Program Coordinator
City of Phoenix Chris Bray, Sergeant, Police Department, Vice Unit Jim Gallagher, Lieutenant, Police Department, Vice Unit Greg Stanton, Mayor Bethany Samaddar
The Diane Halle Center for Family Justice Sarah Buel, JD, Faculty Director
DIGNITY, Catholic Charities Community Services Cathy Bauer, Diversion Program Coordinator Kathleen Mitchell, Founder
Girl Scouts Arizona Cactus-Pine Council Barb Strachan, MEd, Just Us Program Manager
Hickey Family Foundation Nancy Baldwin, Executive Director
International Rescue Committee Reem Constantine, Case Manager
Maricopa County Juvenile Probation Department, Superior Court of Arizona Debra Hall, Deputy Chief, Detention Services Bureau
Natalie's House, Arizonans for the Protection of Exploited Children and Adults (APECA) Janet Olson, RN, MN, Executive Director
New Hope Teen Pregnancy Program, Maricopa Integrated Health System Tammalynn Bambulas, MSN, RN, CNM, Program Director
A New Leaf Dana Martinez, Program Manager
O'Connor House Lucia Howard, JD, Co-Chair Avon Program for Women and Justice
Planned Parenthood Arizona Christy Moore, MSW, Director of Organizational Effectiveness
Refugee Women's Health Clinic, Maricopa Integrated Health System Christa Johnson, MD, MSc, Director Jeanne Nizigiyimana, MA, MSW, Program Director
Streetlight Phoenix Lea Benson, CEO
Tumbleweed Center for Youth Development Paula Adkins, Volunteer Coordinator Richard Geasland, Executive Director Steven Serrano, Director Phoenix Youth Resource Center Jana Smith, Director Tempe Youth Resource Center

Figure 2

dedicated vice squad at the Phoenix police department; the compassionate work with

minors at the Maricopa County Juvenile Probation Department; long term shelters for

trafficked minors at Streetlight and Natalie's House; the Just Us Social Justice Program at the Girl Scouts Arizona Cactus-Pine Council; the legal services of the Halle Center for Family Justice; the advocacy work of the O'Connor House and the Arizona Sexual Assault Network; and the dedicated passion and funding of the Arizona Foundation for Women, the Bruce T. Halle Family Foundation, the Carstens Family Funds, and the Hickey Family Foundation.

In addition, local resources are involved in innovative programs. For example, at risk youth can connect with safety and emergency aid at Tumbleweed, through the Safe Place program at Quick Trip (QT) locations throughout the Valley. The Refugee Women's Clinic at Maricopa Medical Center is participating in the development of a multilingual universal screening program for mental health conditions such as depression and PTSD. Similar use of innovation to address DMST should be a next logical step.

The Arizona stakeholders emphasized key collective comments regarding the possibility of establishing a drop-in center:

- Start small and start smart, with realistic objectives. Only scale up when you are better informed by better data.

*"Ready, aim, fire; not ready, fire, aim."
(Sergeant Chris Bray, Phoenix police department)*

- The community needs to build an accurate database regarding DMST, using multiple resources, including victim interviews regarding their lives and their needs.
- The profile of minor trafficking is constantly changing in the Phoenix metro area, with an increase in gang related, hotel and Internet based trafficking. This will require innovative approaches to interacting with victims, pimps, and johns.

- Age restrictions on who to serve should not be too constraining. Many 18-25 year olds, who are in "the life", are emotionally living as 13-18 year olds.

- *"There needs to be an alternative to the present cycle of arrest, criminalization, and release back into the same environment"*

(Barb Strachan, Girl Scouts Arizona Cactus-Pine)

In order to begin to break this cycle there need to be safe places for law enforcement to take minor victims. Similarly, there need to be safe havens with relevant services for self-referred victims and at risk youth.

- Essential services/referral resources for victims and at risk youth should include: (figure 3)

Essential Services

- A dedicated triage program staffed by survivors
- Safety, short and long term shelters
- Needs of daily living, e.g. food, shower, clothes
- Medical/dental services
- Mental health, including trauma based therapy
- Legal services
- Education, life skills, job training
- Deprogramming, rebuilding, diversion, group therapy
- Mentoring, preferably by survivors
- A transportation and advocate system that can actually get youth to these resources

Figure 3

- The Phoenix metropolitan area consists of contiguous cities, many of which have not yet dedicated significant attention to DMST. Leadership will be required to develop a collaborative effort and a united front.
- Advocacy is required to push for legislative changes, reduction of demand, and more effective and severe prosecution of pimps.

NATIONAL BEST PRACTICES

Interviews were conducted with the following representative best practices. Unfortunately, two best practices specific to youth trafficking, Girls Educational and Mentoring Services: (<http://www.gems-girls.org>) and Standing Against Global Exploitation (SAGE): (<http://www.sagesf.org>) were not available to be interviewed. A comprehensive review of national best practices (30) is also discussed below.

NORTHSIDE WOMEN'S SPACE, MINNEAPOLIS, MN



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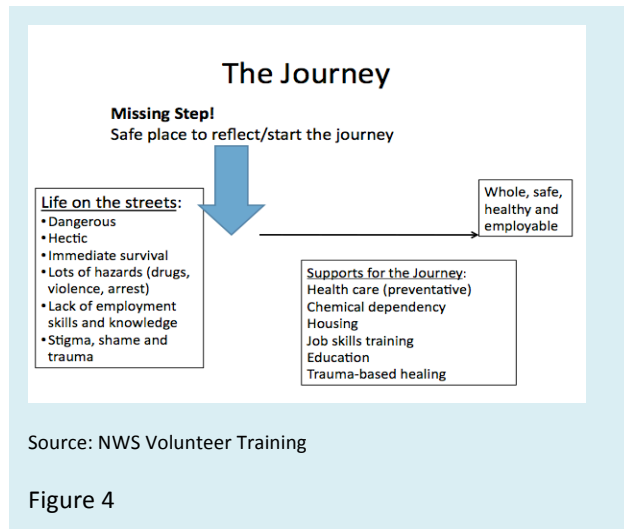
REVEREND ALIKA GALLOWAY

- Co-Pastor, Kwanzaa Community Church
- HIV/AIDS and Women's Health Expert

Northside Women's Space is a drop-in center "providing teens and women, who trade sex, with a safe and holistic space, short-term intervention, and long-term recovery support". Dr. Martin conceived the vision through extensive community-based participatory research, in 2006-2007, in a northern Minneapolis community. This research incorporated perspectives from trafficked women (in-person interviews and written surveys), service providers, law enforcement, and community advocates and members. It informed the foundation of the center's design.

"These women indicated that they responded best to services and people who treated them with respect, understanding, and dignity – what is often called an empowerment approach. Women also derived strength and support from prostitution-specific programming built around undoing internalized stigma and shame using a trauma-informed perspective." (31)

A partnership developed between Dr. Martin and a passionate community advocate, Pastor Alika Galloway, of the Kwanzaa Community Church, located within the community and the home of Northside Women's Space. With Dr. Martin's research providing the foundation for this space, the basic tenet is to provide "a missing step" between life on the streets and a safe, healthy life (figure 4).



Dr. Martin's research informed the design with several key best practice concepts: 1) a harm reduction strategy, 2) a nonjudgmental perspective with sincere engagement of staff and volunteers, rather than the traditional "help" perspective, 3) a trauma informed model acknowledging and addressing the trauma bonds involved, 4) a survivor based model, using peer mentors and providers, and 5) a design specifically informed by local data and input.

Finally, Northside demonstrates a fundamental paradigm shift which recognizes that victims are survivors and "untapped sources of community strength" (31).

POLARIS PROJECT, WASHINGTON, DC



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CEO

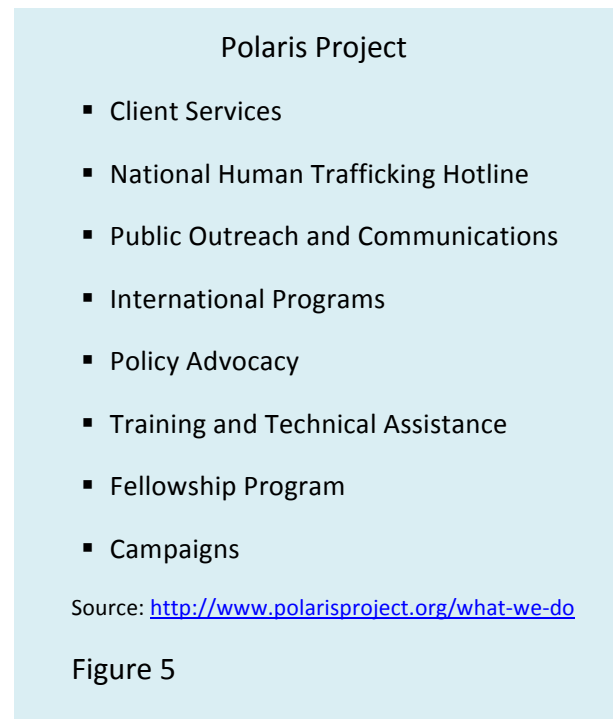
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The Polaris Project, which is committed to battling human trafficking and modern-day slavery, has many facets (figure 5). Particularly relevant to this research study are the national human trafficking toll-free 24-hour hotline; client services including two drop-in centers; the training and technical assistance program, which provides in-depth expertise to stakeholders; and the philosophy of using survivors to guide creation of programs and solutions. Bradley Myles, CEO, feels that victim identification is of key importance. The National Human Trafficking Resource Center (NHTRC) hotline (1-888-3737-888), in addition to providing victim resources, allows the collection of local and regional data. The Polaris Project also incorporates innovative ideas such as digital street outreach, use of cell phones to communicate with victims, and



infiltration of Internet sources. Another important Polaris Project approach to

identifying and connecting with victims is by the massive training of professionals who often come in contact with these youth, such as clinic and emergency room personnel and child welfare/foster care providers. Many of their training tools and webinars are available through their website.

As with all non-profits working in DMST sustainability is a constant concern. Polaris Project emphasizes not only private and corporate donors, but also their expertise in training, and the use of an array of volunteers and volunteer services.

The challenge of finding meaningful methods of measuring performance and success is also being addressed at Polaris. They are attempting to concentrate on behaviors such as those indicating self-esteem (e.g. as measured by talking with staff, conversations), self-sufficiency (e.g. frequency of office visits and staff contact) and emotional health.

CHILDREN AT RISK



<http://www.childrenatrisk.org>

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Another critical component of changing the landscape of DMST is policy advocacy. An example of best practices in this arena is Children at Risk, which addresses several child advocacy issues including trafficking. Its Public Policy and Law Center has been instrumental in drafting and facilitating passage of critical legislation in the Texas legislature regarding human trafficking. It engages in public awareness campaigns and training programs for law enforcement and legal

professionals. It is also publishes the peer-reviewed Journal of Applied Research on Children, which has dedicated an issue to topics surrounding child sex trafficking (<http://digitalcommons.library.tmc.edu/childrenatrisk/vol2/iss1/>).

NATIONAL SCAN OF BEST PRACTICES

In 2009, on behalf of the Georgia Governor's Office for Children and Families, the Shapiro Group performed a national survey of CSEC victim service providers and created a "nation scan" of best practices (30). Although this study did not involve independent evaluations of the practices and their outcomes, it represents a summary of the diversity of services offered throughout the US. Thirteen program types were reviewed, and emerging best practices in the creation and delivery of services were noted (figure 6).

CSEC Service Typologies

- Prevention Programming
- Referral Services
- Hotlines
- Direct Outreach
- Case Management and Advocacy
- Therapeutic Treatment Intensive
- Therapeutic Treatment Less Intensive
- Health Services
- Life and Vocational Training
- Short-Term Sheltering
- Long-Term Sheltering
- Niche Services
- Comprehensive Services

Source: The Shapiro Group
Figure 6

Several conclusions are particularly relevant to the consideration of design of a DMST program in the Phoenix metropolitan area:

- The comprehensive victim service approach is the gold standard for victims of DMST, and collaborative networking of multiple providers is essential.
- The trauma experienced by commercially trafficked youth is unique, unlike other types of trauma, and requires specifically designed programs.
- As there are well established and effective hotlines currently operating, it makes best sense to partner with an existing provider, and it is critical to provide a means to directly connect victims with services.
- A variety of channels (e.g. online, media, training programs,) should be used to educate the general population and to promote prevention and detection at all levels of the community including victims, families, non-profits, law enforcement, and social and judicial services.

RECOMMENDATIONS

The initial intent of this research project was to “investigate models, explore partnerships, and establish practical implementation steps to establishing a drop-in center for child sex trafficking victims in Phoenix”. Informed by the preceding research, the following alternative recommendations are offered.

First and foremost, the importance of addressing the more global and structural issues of poverty; racial, gender, and socioeconomic disparities; fundamental human rights; and the role of women and children in our society as sex objects, cannot be overstated. Secondly, while there are yet few studies evaluating the effectiveness of any specific programs, various

components are felt, based on observations and experiences of experts, to be critically important. Although these proposed strategies are described separately, realistically they are overlapping and intertwined; to have the greatest impact, they must be considered elements of a multifaceted approach. Many of the recommendations may be simultaneously effectuated, and the sequence of implementation should be fluid, informed continuously by need and reevaluation. Lastly, as will hopefully become evident, the first recommendation is paramount and may then become the vehicle through which the collaborative design and implementation of many of the others can occur. The collective expertise of such a coalition will not only improves success, but will also lead to an effort owned by the community as a whole.

DEDICATED DMST COALITION

“Because trafficking victims’ needs are complex and extensive, it is impossible for a single agency to respond effectively to this population.” (13)

“The importance of collaboration in meeting the needs of victims of human trafficking cannot be overstated.” (15)

Multidisciplinary, collaborative work is critical given the many complex and unique immediate needs (e.g. physical and emotional safety, transportation, medical) as well as longer term needs (e.g. housing, job training, mental health, substance abuse) that occur in the continuum of care for minor victims. In fact, a recent review of best practices deems this integrative approach absolutely essential in providing effective care (30).

The alignment of the currently disaggregated centers of excellence throughout the metropolitan Phoenix area would result in more than the simple sum of the individual elements. A coordinated coalition of experts would create a forum in which stakeholders could share their knowledge as well as

brainstorm challenging issues. It would also allow the various cities which comprise the larger metropolitan area to collaborate across boundaries.

Furthermore, such a consortium would become a highly credible resource from which the community as well as other communities could access a wide range of expertise on issues surrounding DMST. This coalition could be the central comprehensive repository of data where all stakeholders can contribute, minimizing duplication.

As such an entity, it could have a regional and national presence contributing to national data and expertise. It could ensure that Phoenix is an active participant in collaborations such as the Human Trafficking Reporting System data collection, as well as various task forces, such as the Innocence Lost Task Forces established by the Department of Justice, and composed of federal, state, and local entities (14).

Also, as a credible body representing multiple private, public, and non-profit stakeholders, it would have the clout necessary to launch successful advocacy campaigns. An example would be an effort to encourage hotels and motels to adopt and practice the End Child Prostitution Child Pornography & Trafficking of Children for Sexual Purposes (EPCAT) tourism Code of Conduct, which is respected as the tourism industry's most effective tool to combat child sex trafficking (32). Other campaigns to decrease demand and increase the prosecution of pimps and enablers would benefit from a unified coalition taking the lead.

VIRTUAL DROP-IN CENTER/HOTLINE-PLUS

In researching the feasibility of a physical drop-in center, numerous challenges became evident, including:

- How to reach those victims or at risk youth who are not on the street (e.g. those living at home or foster care, those sold on the Internet, those housed

in hotels, and those constantly on the run)

- How to be accessible to all contiguous cities (if you build it, will/can they come?)
- How to be accessible to all genders
- How to avoid being too restrictive on age, knowing that emotional age may not be equal to biological age, and that youth will often “age out” of programs
- How to provide safety to victims and staff
- How to avoid having pimps using the center as a recruiting site

In considering these challenges, many of which are particularly relevant to the metro Phoenix community, an alternative strategy emerged, that of a virtual drop-in center. By aligning with an existing best practices hotline such as the National Human Trafficking Hotline (Polaris Project), local victims can be connected with local resources. This model would alleviate many of these challenges and has the potential for “reaching” many others beyond the reach of a traditional physical center. Furthermore, while providing referrals and resources to victims, critically important data on the demographics, characteristics, and needs of victims can be collected and used to inform the next steps, which may include a physical center, but one that is based on accurate local data.

Resources abound on best practices of working with victims of sex trafficking, including youth. The World Health Organization (WHO) Ethical and Safety Recommendations for Interviewing Trafficked Women provides basic guiding principles in working with sex trafficked women (33) (figure 7). Organizations such as Northside and Polaris

TEN GUIDING PRINCIPLES

TO THE ETHICAL AND SAFE

CONDUCT OF INTERVIEWS WITH WOMEN WHO HAVE BEEN TRAFFICKED.

1. DO NO HARM

Treat each woman and the situation as if the potential for harm is extreme until there is evidence to the contrary. Do not undertake any interview that will make a woman's situation worse in the short term or longer term.

2. KNOW YOUR SUBJECT AND ASSESS THE RISKS

Learn the risks associated with trafficking and each woman's case before undertaking an interview.

3. PREPARE REFERRAL INFORMATION - DO NOT MAKE PROMISES THAT YOU CANNOT FULFILL

Be prepared to provide information in a woman's native language and the local language (if different) about appropriate legal, health, shelter, social support and security services, and to help with referral, if requested.

4. ADEQUATELY SELECT AND PREPARE INTERPRETERS, AND CO-WORKERS

Weigh the risks and benefits associated with employing interpreters, co-workers or others, and develop adequate methods for screening and training.

5. ENSURE ANONYMITY AND CONFIDENTIALITY

Protect a respondent's identity and confidentiality throughout the entire interview process – from the moment she is contacted through the time that details of her case are made public.

6. GET INFORMED CONSENT

Make certain that each respondent clearly understands the content and purpose of the interview, the intended use of the information, her right not to answer questions, her right to terminate the interview at any time, and her right to put restrictions on how the information is used.

7. LISTEN TO AND RESPECT EACH WOMAN'S ASSESSMENT OF HER SITUATION AND RISKS TO HER SAFETY

Recognize that each woman will have different concerns, and that the way she views her concerns may be different from how others might assess them.

8. DO NOT RE-TRAUMATIZE A WOMAN

Do not ask questions intended to provoke an emotionally charged response. Be prepared to respond to a woman's distress and highlight her strengths.

9. BE PREPARED FOR EMERGENCY INTERVENTION

Be prepared to respond if a woman says she is in imminent danger.

10. PUT INFORMATION COLLECTED TO GOOD USE

Use information in a way that benefits an individual woman or that advances the development of good policies and interventions for trafficked women generally.

Source: WHO, 2003

Figure 7

have in depth training materials on collecting data, designing intake questionnaires, and preparing staff and volunteers for this work.

Heeding the advice of starting small and starting smart, a brief summary of two potential phases of implementation of such a virtual drop-in center/hotline might appear as follows.

PHASE 1 RESOURCES

Acute resources including safety, short-term shelter, basic medical needs, legal, emergency

psychological and, health, food, clothing (there are currently community stakeholders available who could provide each of these services)(28). As an example, the IRC locally provides a 24-hour hotline model that has worked well for international victims in Phoenix, providing immediate support and referrals.

PHASE 2 RESOURCES

More intensive case management is often viewed as the cornerstone of long-term victim services (15) and will require collaboration of

stakeholders which offer longer term programs, such as life skills training; permanent housing; education/job training; long term psychological care including trauma therapy; substance abuse treatment, and youth development curricula.

VICTIM IDENTIFICATION

The critical answers to questions such as who are the victims; where are they; how are they trafficked; and what are their needs, can begin to be answered by data collected from the virtual drop-in center. Additional data sources will be strengthened by the implementation of many of the recommendations discussed in the next sections. Strong consideration should be given to the use of a sophisticated Geographic Information System (GIS) to aid in the visualization, analysis, and interpretation of this data as it is used to inform further programs.

TRAINING AND TECHNICAL ASSISTANCE

It has become clear that a major obstacle to victim identification is the lack of awareness by the array of providers with whom victims and at risk youth come into contact on a daily basis (15). The Shared Hope International study of DMST in ten US cities showed that it was rare for both governmental and non-governmental agencies who worked with at risk youth, to include questions about DMST in their intake assessments (10). One study found that 28% of trafficked victims sought care from a health care provider while in captivity (27). Recently, with proper training of providers, a cross-sectional survey of women aged 16-29 years presenting to family-planning clinics in Northern California, showed that 8% of those surveyed indicated a lifetime history of trading sex, and 37% of these females reported that their first experience occurred before the age of 18 years (34). When the Dallas police department adopted a victim identification training program, it found that 63% of high risk youth were involved in sex trafficking (4). In a final example, after training in victim identification was implemented at a runaway

youth shelter in Louisiana, 57% of their clients were identified as victims of DMST (10).

Several screening toolkits are now available, such as HHS's Administration for Children and Families Campaign to Rescue and Restore Victims of Human Trafficking (<http://www.acf.hhs.gov/trafficking/>) and EPCAT's program (http://www.ecpat.net/EI/Trafficking_Publications.asp).

Other organizations such as GEMS, SAGE, Polaris, and Shared Hope also have successful training programs. After choosing an appropriate program for the Phoenix community, it should be systematically adopted by child welfare agencies such as child protective services, foster care homes, emergency room personnel, health clinic workers, homeless shelters, law enforcement, juvenile detention facilities, and any other groups that may come in contact with at risk youth and trafficked minors.

Regarding the difficult challenge of prevention, similar programs, can reach potential victims by targeting high-risk populations at, for instance, homeless facilities and drug rehabilitation centers, and "non-high" risk groups in such as in schools, faith based and ethnic-based communities, and families.

SOCIAL MEDIA

Understanding and using social media is of paramount importance for two reasons. Firstly, it is the methods of communication for the youth of today. Effective connection to services requires the innovative use of social media to disseminate information to youth, particularly in a way that is of minimal risk to them.

Secondly, the Internet has increasingly become the vehicle of selling sex in many locations. In a recent study performed by Shared Hope International and funded by the US DOJ, 10 representative US locations were assessed regarding DMST. In all ten, the internet was substantially used by pimps/traffickers, facilitators (e.g. taxi drivers and hotel personnel), and johns for the business of sex trafficking (10). As Lieutenant Jim

Gallagher of the Phoenix police department states, innovative “intelligence led policing” is a requirement in this day and age.

PUBLIC AWARENESS

Increasing public awareness of DMST using strong community leadership has limitless potential. As an example, in 2008, Atlanta’s Mayor Shirley Franklin lent her public support to the “Dear John” campaign (<http://humantraffickingatlanta.wikidot.com/mayor-franklins-dear-john-program>). This collaborative media approach, included not only the mayor, but also other local officials, law enforcement, and a variety of women and child advocacy groups; the results included adoption of legislation, and significant increases in arrests and prosecutions of johns (35). Currently, in the metropolitan Phoenix area, there are dedicated public officials willing to take this leadership role.

DEMAND

It is all too rarely recognized that minor sex trafficking is demand driven (10). As such, advocacy to address the “demand” side of the issue can no longer be ignored. In 1999, a study by SAGE was one of the first to address this by requiring that first time offenders for sexual solicitation attend a “John School”. Since then, several such schools, including one in Phoenix, are providing more information about “who” the “demanders” are. Demographics of the SAGE group of 229 men showed a wide range of ages, 47.6% with at least a college degree, 54.7% with an annual income of at least \$30,000/year, 33.4% married, and 39% as first time solicitors. Over a two month period in 2009, the Shapiro group in Georgia, studied the demographics of men who responded to internet ads for sex with adolescent girls (36). Of the 218 men studied, 44% were between the ages of 30-39 years; the men came from urban and suburban locations; 9% gave their location as near the airport; and 42% either specifically requested young

females or were willing to ignore warnings that the females were adolescents (36).

METRICS AND EVALUATION

“Allow victims to define success for themselves. Women can move from where they are now to where they want to be. This is true empowerment”

(Pastor Alika, Northside Women’s Space)

Although the importance of metrics to evaluate “success” cannot be ignored, less traditional tools must be explored, keeping at the forefront the paradigm shift required to better understand trafficked youth. Measuring the extent of the knowledge that services exist, the number of initial and subsequent contacts (“she called again”), and narrative evaluations (allowing victims to tell their stories) are more realistic metrics than, for example, the actual number of victims who are “helped” to leave “the life”. It is essential that all stakeholders, including staff, volunteers, and funders commit to this perspective of evaluation. Finally, it must be emphasized that additionally, systems need to change, so the victims can change.

SUSTAINABILITY

Building a viable sustainability plan is an ever-present challenge for all. Pastor Alika of Northside Women’s Space emphasizes the importance of a diversity of funding streams, including private funders and foundations, partnerships with academic institutions, faith based communities, and innovative programs that provide an economic engine. More such opportunities exist for a collaborative coalition with its diversity of stakeholders.

SUMMARY

ESSENTIAL CROSSCUTTING TENETS

Evident throughout the discussion of these complex, intertwined components of a coordinated community approach are several

crosscutting tenets. In the form of a summary, they are briefly reiterated here.

CULTURALLY GENERATED

The development and implementation of culturally informed and appropriate programs is essential (13), given the diversity of ethnicity, race, gender, and culture in the metro Phoenix area.

SURVIVOR DRIVEN

Programs, from inception, must be survivor driven and informed. In most of the more successful programs, survivors are an integral part of the design of the services as well as the implementation (e.g. as peer-to-peer counselors and mentors) (13, 28). For example, SAGE, in San Francisco, works from the “survivor-centered” perspective in which youth and adult programs are designed and delivered by survivors (37). The Catholic Charities DIGNITY Program for adults in Phoenix is another example. The credibility and insight of the survivor is difficult to replicate; the validation of the survivor’s success in leaving “the life” is invaluable to both the victim and the survivor.

HARM REDUCTION

Many DMST experts believe the principle of harm reduction should be at the core of the spectrum of victim services. Harm reduction was originally designed to respond to risks of HIV in injection drug users. Cusick describes these principles as:

“pragmatic, value neutral, and focused on prioritizing achievable goals.” (38).

From the harm reduction perspective, relevant services for minor victims should be non-judgmental, accessible, and age, gender, and culturally appropriate. Moreover, it must be understood that a continuum of services is needed, including for those not ready to leave “the life”, and valuing the importance of

reducing their risk of physical and emotional harm.

MEANINGFUL METRICS

Services for minor sex trafficking victims must be considered, as a continuum of care, with different victim needs along that spectrum. Innovative, realistic, appropriate, and victim informed metrics must be developed which reflect a victim’s progress along that continuum rather than just the traditional end point measurements of successful reintegration into society (13).

TRAUMA-INFORMED

Programs must be trauma-informed, and as such, must be based on the understanding that 1) trauma is a defining event(s) for victims; 2) victims’ behavior and symptoms are often coping mechanisms; 3) goals of services are empowerment and recovery, and 4) the relationship between the provider and the victim is collaborative rather than hierarchical (13).

“The test we must set for ourselves is not to march alone but to march in such a way that others will wish to join us.”

- Hubert Humphrey, U.S. vice president, senator

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