Literature Review: Safe Housing for Sex Trafficked Youth

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Definitions: The Trafficking Victims Protection Act of 2000 defines *Domestic Minor Sex Trafficking (DMST)* as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act where the person is a U.S. citizen or lawful permanent resident under age 18." *Commercial Sexual Exploitation of Children (CSEC)* refers to a range of crimes and activities involving the sexual abuse or exploitation of a child for the financial benefit of any person, or in exchange for anything of value (including monetary and non-monetary benefits). *Survival sex* is the exchange or acceptance of sex acts as a means of meeting basic needs, such as food and shelter. A *safe house* is a secure transitional residential facility that typically provides housing and services.

Target Population: Victims or survivors of DMST in Bernalillo County; sex trafficked youth aged 18-24. However, there are no reliable estimates of the incidence or prevalence of commercial sexual exploitation and sex trafficking of minors in the US. (IOM, 2013), New Mexico or Bernalillo County. This is due, in part, to the difficulties associated with identifying victims, social stigma, and general underreporting of the crime. The Safe House Project estimates that 300,000 American children are sex trafficked domestically each year (Safe House Project, n.d.). Based on youth arrests for prostitution in 2019, Swaner et al., created a population estimate range with a lower limit of 4,457 and an upper limit of 20,994 youth "engaged in the sex trade" nationwide (2016).

Estimates of the number of sex trafficked youth in New Mexico and Bernalillo County suffer the same limitations as national estimates, resulting in an inability to determine the potential demand for safe housing and related services. For 2017, the National Human Trafficking Hotline (NHTH) reported 21 cases of human trafficking in New Mexico, based on phone calls, emails, and on-line reporting. Of the 21 cases, 15 were for sex trafficking, and eight cases involved minors (2018). In a 2018 interview, the Bernalillo County Sheriff's Office Ghost Unit reported approximately 75 new DMST victims a year in Bernalillo County, a number that did not take into account APD cases (Hartsock, 2018).

Although there are no reliable estimates of the number of sex trafficked youth, the literature does give some insight into the characteristics and vulnerabilities of those who are sex trafficked. The most common ages when a child enters sex trafficking are from 14-16 years old (Clawson & Grace, 2007). Sex trafficking can affect minors of any socio-economic background; they tend to share certain vulnerabilities that traffickers seek to exploit. Youth homelessness is a contributing factor in teens being recruited, forced, or defrauded into sex trafficking. Covenant House sponsored two multi-city studies to determine the prevalence of human trafficking among homeless young people. A total of 911 homeless youth were interviewed for the two projects. Between the two studies, 14% -- 17% of youth reported they had been sex trafficked. Sex trafficked homeless youth in tended to be female, identify as a racial or ethnic minority, and had less than a high school education (Murphy, 2016; Wolfe, 2018).

Other vulnerability factors that contribute to the recruitment of youth into sex trafficking include abuse and neglect by family members, poverty, history of running away, delinquent activities such as drug use or gang activity, being in the foster care system, and/or identifying as LGBTQ. These vulnerable populations are at an elevated risk because of their lack of stable social connections, their living situations, and their need for financial resources (Clawson & Grace, 2007).

Description: During her study of residential facilities for minor victims of sex trafficking, Clawson noted that sex trafficked girls were not being identified as victims but were being placed in typical system-involved facilities and programs. Only four residential facilities specific to this population existed in the US in 2007 (Clawson, 2007). A few years later, Kotrla also noted that sex trafficked youth were either held in juvenile detention centers, returned to the homes from which they fled, or placed in non-secure facilities, choices that could mean increased risk of a repeat episodes of running away, re-victimization of the

minor, or interference with a law enforcement investigation (Kotrla, 2010). By 2013, there were 14 residential care facilities for sex trafficking victims, an unknown proportion of which were for minors or youth (Reichert & Sylwestrzak, 2013).

Victims of trafficking often suffer from serious physical and psychological problems. The impacts of the trauma of sexual exploitation manifest as health-issues (e.g., broken bones, wounds), reproductive issues (e.g., STDs, pregnancies), mental issues (especially PTSD and trauma-bonding), malnutrition, and alcohol and drug use and addictions (Clawson, 2018). According to the U.S. Department of Justice, trafficking victims require specialized recovery programs that offer shelter, nutrition, and appropriate medical treatment, as well as psychological evaluation, counseling, alcohol and drug treatment programs, education programs, and life skills training (U.S. Department of Justice, 2010).

Once DMST victims either are rescued or have escaped, they are in need of appropriate housing, physical and mental health care, legal services, and other necessities such as food and clothing (Kotrla, 2010). To date, there have been a limited number of shelters and services available for sex trafficked youth and fewer still with the capacity to treat the severity of their problems (Reichert & Sylwestrzak, 2013). The current lack of services aimed specifically at this population means they often end up being lumped with other groups who may need similar care, such as those with substance abuse problems, mental health disorders, or victims of domestic violence or slavery, and this creates gaps in the services they receive. In order to identify victims of DMST and provide services specific to their needs, the literature reviewed suggests the development of screening tools and protocols in agencies where DMST victims are likely to be encountered such as social service agencies, health care, and law enforcement (Kotrla, 2010; Basson et al., 2018).

Effective interventions for sex trafficked youth rely on a comprehensive approach with collaboration across the legal, education, commercial, health and healthcare, and victim support services. Well-designed safe houses and programs specifically addressing the needs of sex trafficked youth can play an important role in the recovery of sexually exploited youth. New Mexico has no specialized facilities or beds for DMST victims. The Bernalillo County Behavioral Health Business Plan (CPI, 2015) includes a recommendation for Youth Transitional Living Services to address substance use in female minors but does not include safe housing for sex trafficked youth.

Research Summary: Studies examining the effect of safe houses and non-therapeutic services on outcomes for sex-trafficked youth did not appear in the literature search. According to the National Academy of Sciences' report on child sexual exploitation and sex trafficking in the United States, "very few evaluations of specific victim and support services have been conducted, and there are few published reports and even fewer peer-reviewed studies on these services. As a result, victim and support service professionals and programs lack a critically reviewed evidence base for practice" (Wright Clayton, 2013). Evidence-based practices for housing and treating sex trafficked youth are very limited and tend to address the efficacy of a few therapeutic treatments. This research summary focuses on *promising and best practices for safe housing and services* for sex trafficked youth.

Clawson's seminal *Finding a Path to Recovery: Residential Facilities for Minor Victims of Domestic Sex Trafficking* (2007) provides a framework for this summary. The best practices that form the basis for most of the discussion below are from her work. They are derived from the collected knowledge and experiences the of law enforcement, case workers, residential facility staff, community-based program provider, councilors, advocates, victims/survivors, and others who provided information for her study of sex trafficked minors. Citations are included where subsequent research has expanded the original topics.

Residential Facility Design and Operation for Sex Trafficked Youth

Promising practices for residential facilities take into account the effects of trauma on designing living arrangements for sex trafficked youth and the need for safety for residents and staff. S*afety considerations* include physical and psychological components. Recommendations include: an undisclosed facility location, security cameras and alarm systems, 24-hour staffing and security guards, unannounced room searches and drug screens, and locked doors with staff and residents buzzed in and out of the facility at all time. Exposure to the 'outside' is a potential safety concern as well: limited phone use, pre-approved/screened contact lists, and supervised or no internet access can be beneficial to residents. Close relationships with law enforcement and ongoing safety training for staff and residents increase safety and the capacity to respond to internal and

external threats. There is some debate about *program location*: an urban program might allow residents to develop and maintain natural supports (e.g., job, family, school) or it might be a source of triggers for PTSD. A more remote location could mitigate the increased flight risk that results from trying to respond to the intense trauma-bond that sexual abuse victims sometimes form with their abusers. The development of a *safety plan* for each resident can help when the compulsion to run overwhelms and it serves as an important post-program guide.

Staffing is a critical element of a residential facility for sex trafficked youth. It is paramount that, at a minimum, "staff are well trained in understanding sexual exploitation, the realities of prostitution and sex trafficking, the methods of recruitment, the physical/psychological/spiritual impact of the trauma, potential methods for exit, an overview of youth development programming, and appropriate boundaries and healthy working relationships" (Clawson, 2007, p. 6). Providers suggest that staff members have an authentic understanding of DMST and they strongly advocate for peers whose experience 'in The Life' accelerates the establishment of trust with residents.

Although sexually exploited youth are a heterogeneous group, residential facilities should serve *homogeneous populations* with separate facilities for males, females, and transgendered victims. Regardless of population, facilities should be *congregate care settings,* with 24-hour supervision and highly structured programing. Providers believe DMST victims have difficulty navigating relationships and are therefore more likely to benefit from *smaller facilities* of 6-10 beds, including a requirement of no more than two people per room. Providers and survivors advocate for a *minimum stay* of at least 18 months. The 18-month stay is believed to be sufficient to build trust with the victims, provide necessary therapy, and allow victims to begin rebuilding their lives. Providers and survivors also advocate for *voluntary residential programs* where victims could opt in once they were ready and willing to work on their recovery. Success rates are higher amongst residents who voluntarily enroll compared to court-mandated placements.

Services

Intensive case management. Case managers work with residents to build self-worth, self-respect and self-efficacy in the context of "understanding the developmental hindrances of having been under the control of someone [her trafficker] for so long" (Clawson, 2007, p. 6). An evaluation conducted by Gibbs et al., (2015) on three programs serving domestic minor victims of human trafficking found that the majority of clients needed crisis intervention, safety planning, education support, mental health services, and employment services. Case management was a core component in the delivery these programs and included assessing the needs of each survivor, setting goals and tracking progress, planning for safety, locating resources, and navigating systems. In these programs case managers also served as counselors, mentors, and advocates, and put time and effort into building relationships with survivors.

Interpersonal relationships. In a study of interpersonal relationships in the lives of DMST survivors, O'Brien (2018) found that they often cited interpersonal relationships as a necessary a support system that helped them persevere in the struggles of their new life and kept them from returning to trafficking. These interpersonal relationships were fostered with safe house staff, advocates, and mental health providers. Survivor-to-survivor peer mentorship was also mentioned as a key type of interpersonal relationship that fostered resiliency.

Mental health[1]. The mental health needs of DMST survivors are unique and complex. The trauma experienced by survivors occurs during critical stages of development and involves ruptures or insecurity in a child's primary caregiving system. It also involves a variety of physical, sexual, and psychological trauma (Basson, et al., 2018). Trauma-coerced bonding is a variant of the Stockholm syndrome and refers to the powerful emotional attachments between victims and their abusers as a result of a complex interaction of abusive control dynamics, exploitation of power imbalances, and intermittent positive and negative behavior. This bonding causes a shift in the victim's internal reality, leading the victim to lose a sense of self, adopt the worldview of the abuser, and take responsibility for the abuse (Raghavan & Doychak, 2015).

[1] This brief discussion highlights some key consideration in the provision of mental health services to victims of DMST; a full review of the mental health interventions for DMST victims is beyond the scope of this document. Please see Basson, et al., 2018 for a more thorough overview.

Trauma-informed care is called for in all interactions with DMST victims. Psychotherapy (specifically trauma-focused cognitive behavioral therapy, dialectical behavioral therapy and eye movement desensitization and reprocessing) can be effective in breaking the trauma bond the victim has with their abuser (Clawson, 2007). General treatment principles for DMST-involved youth are: focus on safety, work on healing relationships, help youth regulate emotions, recognize states of change, combat stigma; comprehensive case management, and focus on youth development/survivor leadership (Sapiro, 2015).

Medical screening/routine care. Providers recommend delivery of medical services by providers who are knowledgeable about and sensitive to DMST. Training Sexual Assault Nurse Examiners (SANEs) and Sexual Assault Forensic Examiners (SAFEs) in DMST is one way to meet this need.

Life skills, job training, and education. Programs serving DMST victims should consider integrating life skills, job training, and career development as part of residents' individualized treatment plans. Clawson & Grace (2007) found that providers agreed on the importance of deconstructing the relationship victims have with money by training youth on things such as bank account management, bill payment, and other types of financial literacy. When they reach the stage where they feel they are ready, residents can become involved in pre-employment and employment programs. Researchers found that the educational programming offered by existing residential facilities varied, with some programs referring victims to mainstream schools, GED programs, or vocational schools, and other programs offering educational programming through a collaborative arrangement with a local day-treatment provider. Having multiple education options for residents is optimal. Youth development programming that is strength-base, created, and led by youth can provide important creative outlets for DMST survivors (Clawson, 2007).

Culturally competent programs. In *Human Trafficking in Youth-Serving Program,* the Family & Youth Services Bureau recommends developing culturally competent programs. Social and cultural factors can further complicate relationship dynamics in DMST situations. Understanding their potential impacts on the nature of the trauma bond and as part of recovery and treatment can improve engagement and retention of youth (Matthew, n.d.).

Conclusion: There are no reliable estimates for the incidence and prevalence of DMST in Bernalillo County, New Mexico, or the US. Likewise, there are no evidence-based practices for the development of safe housing and services to improve survivor well-being or the likelihood of long-term escape and recovery from sexual exploitation. However, there appears to be consensus among subject matter experts and DMST survivors about the best practices for residential facilities and services that are more likely to lead to positive outcomes for sex trafficked youth. Earlier identification of DMST involved youth can lead to timely and appropriate system response. Small residential facilities with homogenous populations who have experienced DMST are part of that response. Safety and trauma-informed care should be at the basis of all aspects of a residential facility, from site location to staffing. The full continuum of care -- crisis intervention, assessment and treatment, housing, case management, and aftercare – needs to be developed with the specific needs of sex trafficked youth in mind.

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