

# The Medical Response to Sex Trafficking of Minors in Wisconsin

Angela Rabbitt, DO, FAAP

## ABSTRACT

Medical professionals are in a unique position to identify and assist pediatric victims of sex trafficking, who experience a high prevalence of physical, mental, and sexual health problems. However, providers report a need for education and guidelines for medical care of this population. A literature review was conducted on the nature and scope of pediatric sex trafficking in Wisconsin, the medical and mental health needs of victims, and existing guidelines for medical management. Few existing medical guidelines for the care of trafficking victims are specific to pediatrics or include specific recommendations for the forensic medical evaluation. Because of legislation and resources specific to Wisconsin, national guidelines may not apply locally. Based on the literature review, as well as input from community partners and medical professionals who frequently provide services to victims, guidelines for the medical care of pediatric sex trafficking victims in Wisconsin were developed. Additional community barriers that may prevent an effective medical response also are discussed.

## INTRODUCTION

Recent improvements in community awareness of sex trafficking have sparked awareness of this issue among medical professionals. However, providers in Wisconsin report a poor understanding of sex trafficking, have little confidence in their ability to identify and assist trafficking victims, and often underestimate the scope of the problem locally. A lack of awareness and access to medical guidelines is reported as a barrier to identification and an effective response.<sup>1</sup>

### Definition of Pediatric Sex Trafficking

Wisconsin state law defines sex trafficking of a child as knowingly recruiting, enticing, providing, obtaining, or harboring a child

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**Author Affiliations:** Assistant Professor Pediatrics, Medical College of Wisconsin, Milwaukee; Child Advocacy and Protection Services, Children's Hospital of Wisconsin, Milwaukee.

**Corresponding Author:** Angela Rabbitt, DO, FAAP, Children's Hospital of Wisconsin, Child Advocacy-C615, PO Box 1997, Milwaukee, WI 53201; phone 414.266.2090; fax 414.266.3157; e-mail arabbitt@chw.org.

for the purpose of a commercial sex act, or sexually explicit performance.<sup>2</sup> A child is defined<sup>3</sup> as any person under the age of 18, and a commercial sex act is sexual contact for which anything of value is given to, promised, or received, directly or indirectly, by any person.<sup>4</sup> This broad definition also includes pornography, stripping, and other sexually explicit performance. Additionally, those who procure children for the purpose of selling sexual contact, as well as buyers of sexual contacts with children (including those who pay with food, shelter, and other survival needs) can be considered traffickers

under Wisconsin statutes.<sup>5</sup> Children lack the maturity and experience to make informed choices about sex and are vulnerable to exploitation. For this reason, proof of force, fraud, or coercion is not required in the legal definition of sex trafficking for victims under 18 years of age.<sup>5</sup> Sex trafficking does not necessarily involve transportation of the child into the United States from another country, or even movement across state or county lines.<sup>6</sup> In fact, 83% of victims identified by the federal government between 2008 and 2010 were US citizens.<sup>7</sup> In Wisconsin, the majority of victims are recruited locally.<sup>8</sup>

Traffickers may be family members, acquaintances, or strangers to the victim. In Wisconsin, the most common forms of trafficking were parents or other caregivers selling children for money or drugs, and runaway minors trading sex for a place to stay or to meet basic needs.<sup>9</sup> Youth are particularly vulnerable to recruitment. Among adolescents victimized in the sex trade, the average age of entry was 12 to 15 years.<sup>10-12</sup> Traffickers preferentially prey on children and youth with low self-esteem and minimal social support.<sup>13</sup> Not surprisingly, many victims have a history of physical abuse, sexual abuse, or neglect.<sup>8,14</sup>

### The Role of Medical Providers

In its 5-year strategic plan, the US Department of Justice reports the need for enhanced coordination between service providers to improve victim identification and referral to necessary services.<sup>15</sup> Individuals who enter the sex trade prior to the age of 18 frequently

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CME available. See page 60 for more information.

report severe physical and sexual violence.<sup>16,17</sup> They often experience inadequate diet and hygiene, substance abuse, neglect, pregnancy, and poor access to health care.<sup>18</sup> Psychological abuse associated with removal from their families, isolation, ongoing threats, and witnessing the abuse of others can cause profound and lasting effects on their health and well-being. As a result, this population experiences high rates of depression, post-traumatic stress disorder, anxiety, and somatic complaints.<sup>19</sup> Because of victims' complex medical and mental health needs, medical professionals are in a unique position to identify and assist them.

Once victims are identified, the role of health care professionals is to identify and treat unmet medical needs, assist with evidence collection for legal purposes when appropriate, and provide resources for ongoing physical and mental health needs. In addition, medical providers can help educate community providers about the unique medical and mental health needs of this population. In a 2013 assessment of human trafficking in Wisconsin, community providers (law enforcement, prosecutors, victim advocates, and social service providers) reported that only 5% of trafficking victims identified by their agencies were referred for health care.<sup>20</sup>

### **The Scope of the Problem in Wisconsin**

Because victims are difficult to identify and no comprehensive centralized database of victims exists, the number of children involved in the sex trade is unknown.<sup>6</sup> According to the US Department of State, approximately 2 million children are being exploited globally.<sup>21</sup> In a recent representative sample of US adolescents, 3.5% disclosed they had exchanged sex for drugs or money in their lifetime.<sup>22</sup> Additional research is needed to explore the incidence and demographics of trafficked youth in Wisconsin. As of 2007, trafficking victims had been identified in over half of Wisconsin's 72 counties. These victims were from both urban and rural locations.<sup>6</sup> In the most comprehensive local study to date, 77 child victims were identified by law enforcement in Milwaukee County between 2010 and 2012. Approximately 20% of these victims were not from Milwaukee, but were trafficked into the city from more rural areas throughout Wisconsin.<sup>8</sup> The total number represents only those youth in contact with the Milwaukee Police Department. Given the problems in identifying these youth, it is likely a gross underestimate of the actual number of children affected by trafficking. Medical and mental health professionals at the Children's Hospital of Wisconsin and Milwaukee County Juvenile Detention Center began tracking victims in January 2014. This research is ongoing, but suggests that the number of victims is significantly higher than indicated in previous studies. (T. Medley, APNP, W. Ehrman, MD, written communication, January 2015).

### **Identification of Children at Risk**

Victims have varied demographic characteristics. They come from broken and intact families, urban and rural areas, wealthy com-

munities and high poverty areas. They may live at home, on the street, or alternate between the two.<sup>20</sup> Decisions to screen should not be based on any single characteristic. However, some populations (especially runaway youth, youth with a history of exposure to violence and abuse, lesbian, gay, bisexual, transgender, questioning [LGBTQ] youth) do possess vulnerabilities that place them at higher risk.<sup>23</sup> In Milwaukee County, the majority of victims identified by law enforcement were African American (78%) and female (92%), and 70% of victims had been reported missing at least once in their lifetime.<sup>8</sup> While most victims were female, trafficking of men and boys may be under-identified and is likely significantly higher than reported.<sup>24</sup> Boxes 1 and 2 are a summary of psychosocial risk factors and medical conditions that are common in victims of sex trafficking. Providers should consider screening for sex trafficking when children present with these risk factors and indicators.

### **Screening Potential Victims of Trafficking**

Unfortunately, identification of victims is often difficult. Victims may not identify themselves to providers because of threats and coercion by their trafficker, self-blame, and the stigma of "prostitution." They may have a history of negative interactions with law enforcement or child protective services, or may believe that they are criminals and will be incarcerated or punished for prostitution. They may demonstrate self-protective behaviors such as hostility and distrust toward providers. Some victims lack insight about the true nature of their relationship with the trafficker and don't identify as victims. Despite the abuse victims often experience at the hands of their trafficker, victims who have experienced physical or sexual abuse at home may feel they are better cared for by the trafficker than by their family. Medical professionals should attempt to gather information needed to make medical and safety decisions, but realize that a full disclosure may not occur at the time of the initial interview.

Interactions with potential victims should be honest and non-judgmental, with the goal of creating a safe environment for disclosure when the patient is ready to seek help. In order to facilitate trust, consider discussing the limits of confidentiality prior to taking the medical history or proceeding with screening questions. Whenever maltreatment is a concern in an adolescent patient, including trafficking, the history from the child should be taken separately from the caregiver. If a child who does not speak English presents with an English speaking caregiver, an independent translator should be called to assist in communication with the child. Ask open ended questions without the use of technical terms that the child will not understand such as "trafficking." Because they imply culpability on the part of the child, use of terms like "prostitution" also is discouraged.

There are currently no evidence-based screening tools for the identification of sex trafficking in minors.<sup>24</sup> The screening questions in Box 3 are modified from other published guidelines<sup>25,26</sup> and sug-

**Box 1. Risk Factors and Indicators of Sex Trafficking in Minors<sup>6,7,12,23,24,25,26</sup>**

Recurrent AWOL (absent without leave/runaway) behaviors.  
Youth in shelters or group homes.  
Homeless youth.  
Youth from other areas (international or within the United States) who recently relocated or have been removed from a supportive social network.  
Pregnant adolescents, adolescents concerned about being pregnant or who have had multiple abortions.  
Adolescents with sexually transmitted infections or with concern for sexually transmitted infections.  
Adolescents with unexplained injuries.  
Patients brought for medical care by unrelated caretaker who may seem controlling or “talk for the patient.”  
Adolescents who appear to have money, gifts, or clothing (especially sexual dress) with no prosocial source or that was provided by an older individual.  
Youth who report they “dance” for money.  
Youth familiar with language commonly used in the sex trade (examples include “bottom,” “stable,” “the game,” “daddy”).<sup>25</sup>  
Youth whose identification or cell phone has been taken from them.  
Prior history of sexual abuse or assault, neglect, or physical abuse; Child Protective Services involvement.  
Branding/tattoos.  
Youth with an anxious or fearful presentation, flat affect, or submissive demeanor; information appears to be recited.  
Youth with peers or family members involved in the sex trade.  
Youth who provide false or changing demographic information.

**Box 2. Medical Conditions that May Affect Trafficked Youth<sup>19,24,25</sup>**

Reproductive health problems, including exposure to HIV and other sexually transmitted infections, fertility issues, and other gynecological diagnoses associated with sexual violence and rape.  
Pregnancy.  
Physical health problems associated with beatings and rapes—evidence of cigarette burns, untreated fractures, sexual abuse, bruises, lacerations, skin injuries may be hidden by clothing.  
Self-injurious behavior such as cutting.  
Blood-borne infections from tattoos or brandings.  
Untreated chronic medical conditions.  
Mental health issues—depression, post-traumatic stress disorder, anxiety disorders, oppositional behaviors, attachment disorder, aggression, attention deficit and hyperactivity disorder, and somatic complaints (headaches, chronic pain) associated with chronic stress and trauma.  
Malnutrition (may be thin or obese).  
Substance abuse—this may be forced by the trafficker or used as a coping mechanism to deal with trauma and abuse.

gestions by community partners who work closely with trafficked youth. Youth are screened routinely for high-risk situations through use of the HEADSS (home, education, activities/employment, drugs, suicidality, and sex) tool. Many of the questions about possible trafficking also can be incorporated into these standard screening questions.

**Mandated Reporting and Confidentiality**

Unlike cases of sex trafficking of adults, mandated reporters are required under Wisconsin law to report to child protective services and/or law enforcement if the provider has a reasonable suspicion that a child seen in the course of professional duties may be or will be a victim of sexual abuse, including sex trafficking.<sup>27</sup> Dual report-

ing to both child protective services and law enforcement is best practice in suspected trafficking situations, even when the potential perpetrator is not a parent or guardian. Victims are at high risk for other forms of maltreatment such as supervisory neglect, physical, and sexual abuse. Child protective services may be a resource to the child and family.

Providers should report to the law enforcement jurisdiction where the trafficking occurred, if this can be determined. If the location of the trafficking event is unclear, or if it occurred in multiple locations, report to law enforcement in the jurisdiction of the clinic or hospital. The report to child protective services should be to the county in which the child resides. Reproductive health information in adolescents is generally confidential and cannot be disclosed by providers without the child’s consent. However, any form of sexual exploitation is considered an exception to adolescent confidentiality laws.<sup>27</sup> Health care providers are allowed to share protected health information with law enforcement and child protective services when reporting suspected abuse and when the information is pursuant and relevant to an active child maltreatment investigation.<sup>28</sup> Box 4 lists tips to guide communication with investigators in suspected child trafficking cases.

Under most circumstances, parents/guardians have a right to obtain medical information about their children. However, health care providers are allowed to withhold medical information under certain circumstances:<sup>29</sup> (1) when the minor has the legal right to consent to care (eg, reproductive health care services, diagnosis and treatment of sexually transmitted infections [STI], emancipated minor); (2) when the minor obtains judicial approval for medical care; (3) when the parent/guardian agrees to allow the minor to receive confidential medical care; and (4) if disclosure of information to a parent/guardian may endanger the minor.

**Care of At-risk Youth Without Clear Concerns for Trafficking**

Many youth are not prepared to disclose their victimization. The decision to report to law enforcement and child protective services when an at-risk child has not disclosed trafficking is based on case-specific details. Often, other history discovered during screening for

trafficking will mandate a report to investigators. Child abuse pediatricians and providers at child advocacy centers throughout Wisconsin specialize in the medical care of victims of physical abuse, sexual abuse, and neglect. Child advocacy centers are multidisciplinary programs with services that include forensic interviewing, victim advocacy and support, and often medical and mental health services. These providers can assist with reporting decisions in difficult cases.

Regardless of whether the case is reported, consider providing a list of local resources for runaway or trafficked youth. Inform the child that exploitation of youth is common and these resources are for friends or for the child should he/she ever need them. Some victims may fear retaliation from the trafficker if the resource list is found. Providers can verbally give patients the number for the National Human Trafficking Hotline: 1.888.373.7888, which will direct the youth to local resources, or provide contact information on a small, foldable piece of paper.

### Medical Management for Suspected or Confirmed Victims

Trafficking victims often do not present for medical care until it is urgently necessary. The initial evaluation should assess for any acute medical needs and screen for medical conditions common in trafficked youth (Box 2). Follow-up often cannot be assured in this population and victims may not be compliant with medical treatment because of control by traffickers, frequent relocation, or other reasons. Consider hospital admission for potentially serious illnesses that require close follow-up. Assess for any immediate safety concerns. Protocols for security during potentially violent situations involving trafficking victims should be clarified in advance. In order to monitor for violence or threats to the patient, ensure the child is not left alone. If a social worker is available, place a social work consult to perform a psychosocial assessment, assist with referrals, and assess resource needs.

When trafficking is disclosed and after addressing urgent medical and safety needs, perform a forensic medical evaluation or refer the victim for a forensic evaluation. Medical treatment and forensic evidence collection should be performed only with the victim's consent/assent. If the patient refuses a medical evaluation, provide information about the time frame for forensic evidence collection and prophylactic treatment for STIs and pregnancy as described

below in case he/she should desire this evaluation in the future. In some cases, a forensic medical evaluation should occur urgently to maximize the likelihood of recovering forensic evidence or documenting injuries that may heal quickly. See Box 5 for general guidelines for triage decisions and the Figure for a flow chart summarizing medical guidelines for at-risk youth. Child abuse pediatricians and child advocacy center staff also can provide additional assistance about locations and timing of referrals and follow-up.

### The Forensic Medical Evaluation

The forensic medical evaluation includes a medical screening for physical and sexual assault, as well as unmet medical and mental health needs. It also may include collection of forensic evidence from the victim's body, documentation of injuries, and prophylaxis for STIs and pregnancy. Medical professionals also can address victim's concerns about reproductive health and educate youth about

**Box 3.** Modified HEADSS (Home, Education [ie, School], Activities/Employment, Drugs, Suicidality, and Sex): Screening Questions for At-risk Youth

Home
Who do you live with? Who can you talk to about things? What are the people you live with like? Do you get along with your family? What would you change about them?
Can you come and go as you please? Have you ever been kicked out, run away, or not had a place to stay?
Education/Employment
What grade are you in? What are your grades like? Do you ever skip school? What do you want to do when you are done with school?
Do you have a job? How do you make your money?
Activities
Help me understand what a day in your life is like. What kinds of activities do you do throughout the day? What do you do on weekends?
Do you have a boyfriend/girlfriend? How old is this person? How did you meet?
Drugs
Do you smoke cigarettes, weed? Have you ever tried drugs? Do you drink alcohol? How much? How did you get it? Do you ever get sick, pass out or have a hangover? Do you ever use drugs or alcohol to escape from reality?
Did you ever do anything you didn't want to do when you were high, drunk, or passed out?
Suicide/Safety
Do you ever feel sad or lonely? Have you ever had thoughts of suicide?
Do you ever get in fights with friends or with your boyfriend/girlfriend? What is it like when you fight? Ask about violence or abuse history (physical abuse, bullying).
Sex/Sexual Exploitation
<b>How many people have you had sex with in your life? When was the last time you had sex? Have you ever been pregnant or had an STD? Do you use protection?</b>
<b>Have you ever done sexual things even though you didn't want to?</b>
<b>Over the years, we've heard about more and more young people turning to the streets to make money for themselves or for other people. Sometimes they tell us they trade sex or sexual type activities for money, clothes, a place to stay, drugs, or survival. Do you know anyone like that?<sup>26</sup></b>
<b>Has anyone ever asked you to do sexual things for money or suggested it would be a good way to make money or get the things you want?</b>
<b>Sometimes people feel like they don't have any other options but to trade sex for money or survival or someone else has made them do it. Has that ever happened to you?</b>
Screening questions specific to trafficking are in bold. In order to develop rapport, HEADSS questions are ordered so more sensitive questions are asked last.

#### Box 4. Tips for Medical Documentation and Communication with Investigators

Thoroughly document any disclosures by the child/adolescent using quotes when possible.

Clearly identify concerns for sex trafficking when reporting to law enforcement and child protective services. In many locations, early identification of trafficking concerns will trigger protocols within investigative agencies that can improve the initial response to victims.

Investigators need to clearly understand the medical information. Avoid medical jargon in documentation and oral communications.

Advocate for trauma-focused mental health therapy for trafficking victims as well as any other medical follow-up.

Document what steps were taken to ensure the child's safety and any resources provided.

Avoid making distinctions between youth who state they are "pimped" and those who state they are independent. Further investigation often reveals involvement of a trafficker.

Emphasize that the child is a victim in need of services, rather than a juvenile offender. Avoid the term "prostitute" to describe victims verbally and in documentation. The level of understanding about the dynamics of sex trafficking and the culpability of child/adolescent victims will vary among investigators, other providers, and the general community.

#### Box 5. Triage Decisions for the Sexual Assault Medical Exam

##### Situations Requiring an Urgent Sexual Assault Medical Evaluation

###### An Urgent Evaluation is Indicated in Any of the Following Circumstances. The Victim:

1. Has a history of acute sexual assault fulfilling criteria for an evidence collection kit or prophylaxis for pregnancy and sexually transmitted infections (generally less than 120 hours after the last sexual contact).
2. Complains of medically urgent symptoms (eg: symptoms of a possible sexually transmitted infection).
3. Has a possible genital injury or suspicious injuries that require documentation and may heal (eg: minor vaginal bleeding, complaints of anogenital pain, suspicious skin injuries).
  - a. Genital injuries must be photo-documented by colposcopy or digital camera. This can be done in the Emergency Department by a trained provider, by a Sexual Assault Nurse Examiner, or at a Child Advocacy Center (CAC).
  - b. Cutaneous injuries should be photographed at a CAC or by law enforcement.
4. There are prominent mental health or safety issues and the provider feels it is not safe to release the child without further evaluation or investigation.

###### The Urgent Evaluation Should Occur in the Emergency Department if the Victim Has Any of the Following:

1. Severe anogenital bleeding.
2. An injury that may require surgical intervention.
3. Other unrelated medical problems requiring emergent attention.

##### Situations Appropriate for a Non-Urgent (Scheduled) Sexual Assault Medical Evaluation at a Child Advocacy Center

1. The last episode of sexual assault is remote (> 120 hours).
2. The victim is asymptomatic.
3. There are no urgent mental health or safety concerns.
4. Follow-up can be assured.

collection up to 120 hours and may consider collection up to 2 weeks after reported sexual contact. Sperm has been reported in cervical specimens for up to 2 weeks after sexual contact in adolescents and adults.<sup>30,31</sup>

Guidelines for postexposure prophylaxis for STIs in sexual assault victims are outlined by the Centers for Disease Control and Prevention.<sup>32</sup> Due to transient living conditions and control by traffickers, follow-up for positive testing cannot be assured in this population. Therefore, it is generally advisable to provide postexposure prophylaxis for pregnancy and common infections (chlamydia, gonorrhea, and trichomoniasis) to all adolescent victims when they first present for medical care after a sexual assault.<sup>23,25</sup> Consider HIV postexposure prophylaxis as well if the assault occurred within 72 hours of the exam. The risks and benefits of medications should be discussed with the patient.

Testing for HIV, hepatitis B and C, syphilis, and pregnancy should be performed in this high-risk population, and pregnancy prophylaxis can be given up to 120 hours after sexual assault. In adolescents, testing for common STIs (gonorrhea, chlamydia, and trichomoniasis) should be performed if the victim is not given prophylaxis; however, a positive test can result from either a pre-existing infection unrelated to the assault, or to inoculum (semen) from the assault. If prophylaxis is given, testing for these common STIs at the initial evaluation is at the discretion of the provider, but may not be forensically valuable in the adolescent population when some prior sexual

STIs, pregnancy prevention, and safety. The evaluation should be performed in an emergency department by a physician, physician assistant, or nurse trained to collect forensic evidence, by a sexual assault nurse examiner, or at a local child advocacy center.

In postmenarchal victims, a speculum exam with evidence collection from the cervix should be performed if the child can tolerate the procedure. In prepubertal children, a speculum exam is not appropriate due to the low yield of evidence from the cervix in young children and discomfort to the child. Evidence collection is appropriate in all cases with sexual contact reported to have occurred within 72 hours of the medical exam. In pubertal victims receiving a speculum exam, providers should strongly consider evidence

contact may have been consensual. However, consider that the abuser and other sexual partners may need treatment, and testing in this population may be valuable from a public health perspective. Urine and vaginal nucleic acid amplification testing (NAAT) has higher sensitivity than culture for the detection of gonorrhea and chlamydia and has FDA approval for use in adolescents and adults. However, if the positive NAAT has legal implications, it must be confirmed by culture or by a second NAAT using a different DNA sequence.<sup>32,33</sup>

The medical history in cases of identified sex trafficking should include screening questions to identify a history of drug facilitated sexual assault. If there are current symptoms of altered mental sta-

tus or amnesia associated with sexual assault, or there is a history of symptoms within 4 days of presentation, obtain a urine drug investigation screen and specific tests for gamma hydroxybutyrate, ketamine, and flunitrazepam. Alcohol is also commonly used in drug-facilitated sexual assault. Consider obtaining a blood alcohol level if the child presents with current or recent symptoms of intoxication. Drug screening should include legal confirmation of any positive results.

Victims who have been acutely sexually assaulted should routinely receive a follow-up medical evaluation, usually 2 weeks after the initial medical visit. During this visit, providers should consider repeat pregnancy testing, a reevaluation for STIs, and reassessment of suspected or confirmed genital injury if indicated. It is also an opportunity to assess for additional advocacy resource needs and to establish primary care. It is particularly important in this-high risk population to address the need for contraception and ongoing reproductive health care. Because they offer specialized services for children and adolescents, follow-up at a child advocacy center is preferred.

### **Community Barriers: Next Steps for Wisconsin**

In addition to the reported need for guidelines in identification and medical response to victims, health care providers report concern that once victims are identified, community referrals will not result in adequate services for victims. Like medical providers, community service providers in Wisconsin also self-report a lack of awareness and understanding of sex trafficking.<sup>34</sup> In addition, there are currently very few organizations capable of providing an early assessment for resource needs, safe shelter, and ongoing case management for victims.<sup>20</sup> Some states mandate that child protective services fill this role. In Wisconsin, child protective services currently provides services for victims of abuse and neglect, but individual counties have discretion in investigating reports of abuse when the suspected perpetrator is not a caregiver.<sup>35</sup> As a result, suspected victims of sex trafficking reported to child protective services in some areas of Wisconsin may not receive services through this organization.

When cases are investigated, the child welfare system is generally set up to address the parents' behavior rather than to provide targeted services to victims of trafficking.<sup>14,35</sup> Victims of trafficking have unique medical, legal, and therapeutic needs which are different from the needs of child abuse victims.<sup>36</sup> Unlike the circumstances of child sexual abuse, where the wider community is usually supportive and sympathetic to victims, victims of trafficking more often receive inconsistent support as well as blame, and experience multiple levels of trauma throughout their victimization. Mental health resources that focus on the needs of child sexual abuse victims may not address the unique needs of trafficking victims. Residential facilities and group homes available to victims of physical and sexual abuse may not provide the security needed

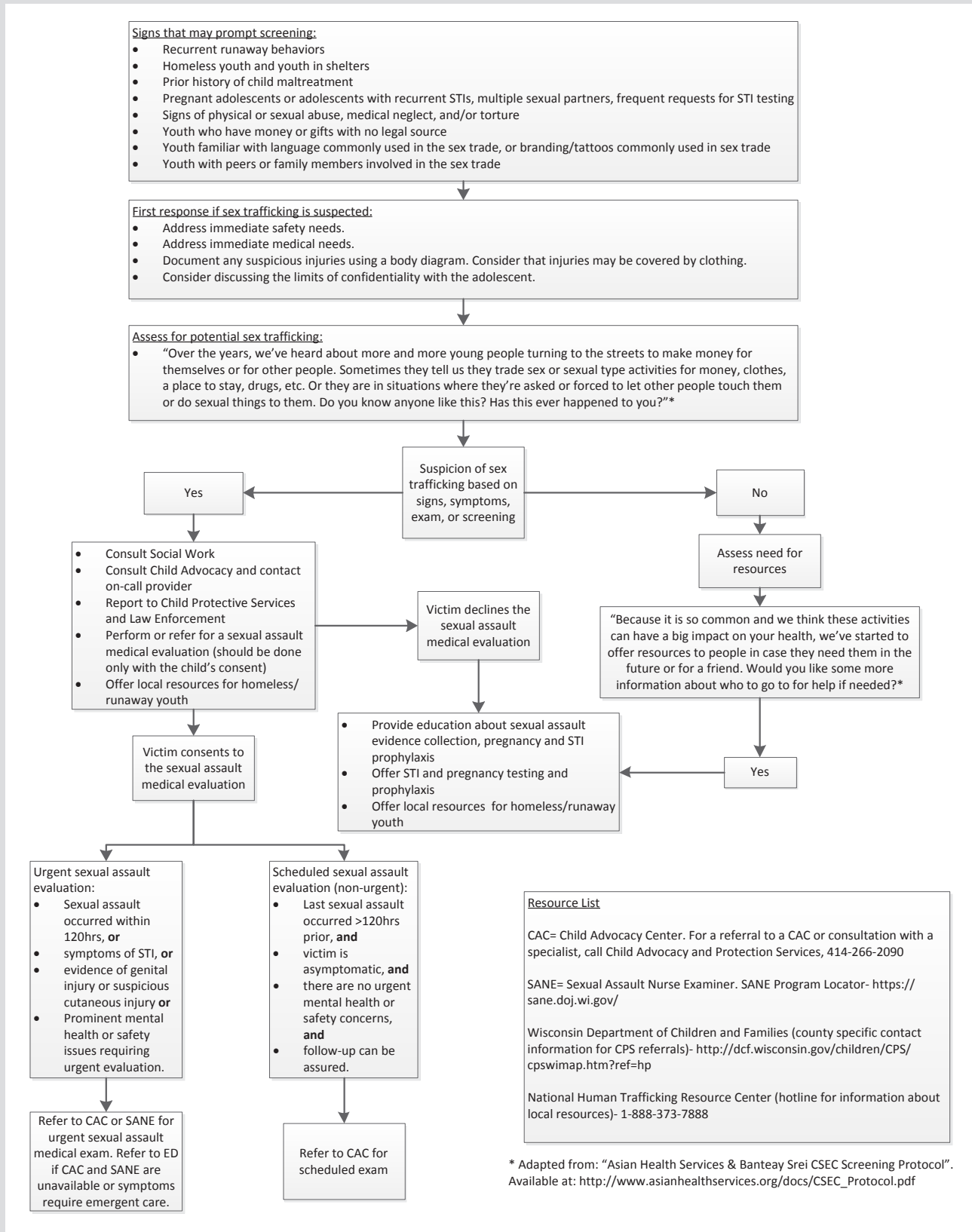
by trafficking victims, who are at risk for ongoing coercion and threats by traffickers. In addition to the psychological abuse and self-blame often imposed by traffickers, this lack of specific mental health and safety resources hinders the child's recognition of the situation and desire to seek help.<sup>18</sup> Unfortunately, the increased needs of this population present a challenge to community organizations with limited funding and staffing, including child protective services.<sup>9,34</sup>

Some victims may not disclose their exploitation for fear of prosecution, and some may be discouraged from seeking medical care because the medical evaluation may lead to proof of their involvement in the sex trade. Currently in Wisconsin, minor victims can be arrested and prosecuted for prostitution and other related charges. Prosecution increases distrust of law enforcement and other authority figures by victims and focuses too heavily on the culpability of the child rather than the exploitative nature of traffickers and buyers of sex.<sup>14</sup> Prosecution of minors for prostitution also contradicts statutory rape laws, which assert that minors are not legally capable of consenting to sex with an adult.<sup>37</sup> Some states prohibit prosecution of juvenile victims, or require courts to divert victims who are arrested for prostitution to specialized services (deferred prosecution).<sup>38</sup> New legislation in Wisconsin does limit the ability to prosecute minors and encourages deferred prosecutions.<sup>39</sup> However, with few options for secure shelter, juvenile detention centers may be the only option for victims during the early investigation and safety assessment.<sup>14</sup> Additional funds and efforts toward safe housing and effective victim-centered, trauma-informed services are needed.

Providers who work with at-risk youth in Wisconsin can attest to the widespread problem of trafficking, but those who do not regularly screen may not be aware of the scope of the problem. Additional research is needed to clarify the demographics and numbers of victims in Wisconsin, and how these victims access medical services. Such research could improve medical providers' willingness to screen and provide guidance on which specialties and locations are more likely to encounter victims. Validated screening tools that can be utilized in a busy office setting and evidence-based educational materials for providers that are convenient and easy to access also are needed. These resources could be used to develop county or hospital-specific guidelines and trainings in collaboration with local community partners.

Without the assurance of an effective response, providers may feel that identifying and reporting victims does more harm than good. However, every attempt to assist victims presents another opportunity for them to seek assistance. Identification of victims also provides opportunities to increase awareness and advocate for additional community services. Education of community partners and legislators by the medical community about the unique medical and mental health needs of pediatric sex trafficking victims in Wisconsin could help optimize services and minimize health

**Figure.** Decision Tool for Medical Management of Youth at Risk for Trafficking



Abbreviations: STI, sexually transmitted infection; ED, emergency department; CAC, child advocacy center; SANE, sexual assault nurse examiner.

disparities for this population. However, improved education and awareness within the medical community itself is an important first step.

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