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Abstract

Victims of sex trafficking and women purportedly involved in prostitution voluntarily face a complex web of interconnected challenges when attempting to escape their current circumstances. By analyzing the shared and distinct challenges faced by these women, the paper aims to inform policymakers and service providers, offering recommendations to empower women seeking to escape exploitation through multidisciplinary and interconnected networks of providers. This study surveyed 74 women in Detroit, Michigan, using nonprobability convenience sampling over a 10-month period in 2020. It compared three groups of women who self-reported as victims of sex trafficking, women who voluntarily engaged in some form of commercial sex, and women currently not in the sex industry. The study examined five outcome dimensions: substance use, housing stability, violence, interactions with law enforcement, and healthcare barriers. Among surveyed women, 45 reported sex trafficking experiences, 20 engaged in prostitution voluntarily, and nine were currently neither trafficked nor in prostitution. While some experiences were shared, like drug use and child presence, unique challenges emerged for sex trafficking victims. Victims of sex trafficking reported higher rates of homelessness, violence, lower education, and poorer health compared to others. However, those who were trafficked and those who reported being voluntarily involved in the sex trade had many similar problems. The survey highlights the interconnected barriers faced by women in sex trafficking or prostitution: substance abuse, homelessness, and health problems. All three groups of women reported having children, which underscores the great need for support systems for families of trafficking survivors or those in the sex industry. Educating professionals and raising awareness can enhance responses and interventions, enabling more women to design exit strategies and begin the path to recovery.

Keywords

sex trafficking, prostitution, commercial sex, homelessness, substance use, health problems, violence, escape, exit, sex work, recommendations

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BARRIERS TO ESCAPE: HOW HOMELESSNESS AND DRUG ADDICTION PREVENT WOMEN FROM ESCAPING SEX TRAFFICKING AND COMMERCIAL SEX

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ABSTRACT

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KEYWORDS

sex trafficking, prostitution, commercial sex, homelessness, substance use, health problems, violence, escape, exit, sex work, recommendations

WOMEN WHO WANT TO EXIT the sex industry, including sex trafficking, prostitution, and other forms of commercial sex and commercial sexual exploitation, face a staggering array of interconnected challenges. These challenges include widespread violence and physical abuse, drug and alcohol addiction, and homelessness and housing instability. In addition, limited education, and the inability to access healthcare create further barriers to escaping trafficking and cycles of exploitation. This paper examines the challenges faced by three groups of women who self-identified in the survey as either 1) victims of sex trafficking, 2) engaged in commercial sex (*sex work*), or 3) not trafficked or involved in commercial sex at the time of the survey. The paper is based on a secondary analysis of data gathered from 74 respondents during medical outreach work in Detroit, Michigan. It looks at challenges faced by women who want to escape trafficking or transition out of the commercial sex industry to examine whether those challenges and barriers are the same or similar for trafficked women and those involved in the commercial sex industry and to provide some recommendations for policymakers and service providers.

LANGUAGE AND CONTEXT

At the outset, clarifying the language used in this paper is important. The authors maintained consistency with the terminology used in the initial survey to present the gathered data accurately. However, the authors are aware of and sensitive to the debate that has been ongoing for the last twenty years over the proper terminology of various activities involving a commercial sex act. Academics, service providers, policymakers, and those in the non-profit field have used terms like sex trafficking, prostitution, and sex work to describe compelled commercial sex and commercial sex acts.

The term *sex trafficking* is defined in the Trafficking Victims Protection Act (TVPA) of 2000 and its reauthorizations (Trafficking Victims Protection Act, 2000; Trafficking Victims Protection Reauthorization Act, 2003; Trafficking Victims Protection Reauthorization Act, 2005; William Wilberforce Trafficking Victims Protection Reauthorization Act, 2008; Trafficking Victims Protection Reauthorization Act, 2010; Trafficking Victims Protection Reauthorization Act, 2013; Justice for Victims of Trafficking Act, 2015; Frederick Douglass Trafficking Victims Prevention and Protection Reauthorization Act, 2018; Trafficking Victims Prevention and Protection Reauthorization Act, 2022). The legal definition of sex trafficking is "the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act 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" (Trafficking Victims Protection Act, 22 U.S.C. §7102(11)(A), 2000). The TVPA defines a commercial sex act as "any sex act on account of which anything of value is given to or received by any person" (Trafficking Victims Protection Act, 22 U.S.C. §7102(4), 2000). The term *commercial sex act* emphasizes the economic nature of the act, not the voluntariness. Therefore, references to commercial sex or the commercial sex industry do not, by definition, exclude sex trafficking.

A term that has gained traction among advocates of legalized prostitution is *sex work* (Paul, 2023). This term is not found in federal or state laws.[1] The Joint United

[1] States have a body of law on commercial sex, including statutes prohibiting prostitution, pimping, pandering, procuring, maintaining a brothel, soliciting, and other related law. A search of those laws reveals that the term *sex work* is not utilized.

Nations Programme on HIV/AIDS (UNAIDS) loosely defines *sex workers* as "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating" (UNAIDS, 2002). *Sex work* is a term often used when referring to a "contractual arrangement where sexual services are negotiated between consenting adults" (UNAIDS, 2012). However, the definition does not expressly include consent; it is implied (id., p. 16). Furthermore, opponents of the term argue that it legitimizes an inherently exploitative system while downplaying issues of gender and economic inequality (Underwood, 2014).

For those working on the ground, the legal definitions often do not reflect the realities on the street. People may self-identify—or be identified—as one category but, on closer examination, fall into another. For example, a woman might initially self-identify as a sex worker, but when responding to follow-up questions, she reveals that her pimp beats her or threatens her with violence if she refuses to work. This woman is a victim of sex trafficking. A victim's failure to recognize herself as a victim of human trafficking can be influenced by multiple factors. As in the example above, traffickers use physical violence or threats of violence to keep their victims compliant. At the same time, traffickers often rely on deceit and manipulation, creating intricate and confusing relationships with their victims to control them. In some cases, a person may know that she is a victim of sex trafficking, but shame and stigmatization may prevent her from identifying as a victim and seeking help.

Considering these concerns, the authors have utilized the term *sex work* to the extent that it is necessary to maintain consistency with the language employed in the initial survey. In the initial survey, the participants were asked if they were currently involved in *sex work*. Participants who responded with "yes" were then asked follow-up questions that revealed whether their experiences were consistent with that of a victim of trafficking, such as, "Have you ever been forced to have sex for money?" among others. In reporting the survey findings, the authors have retained the term *sex work* to the extent used in the initial survey. However, in displaying the data, the authors have chosen to substitute the phrase *sex work* with the term *commercial sex* to categorize survey participants who were voluntarily participating in the commercial sex industry and not victims of trafficking.

LITERATURE REVIEW

Previous research has made significant strides in understanding the risks and correlative factors related to the commercial sex industry. A benchmark study, a collaborative effort between the Field Center for Children's Policy, Practice & Research, Covenant House, and the Modern Slavery Research Project, assessed the complex relationship between homelessness and youth in sex trafficking (Greeson et al., 2019). While this study of over 270 people experiencing homelessness provided valuable insights, its scope was limited to homeless youth, leaving a gap in our understanding of the barriers faced by a broader population involved in the commercial sex industry.

Another critical aspect of the multifaceted barriers to escaping sex trafficking involves the link between substance abuse disorders and victimization. Research has indicated a link between those in the sex industry and substance use disorder, especially addiction (Wiechelt & Shdaimah, 2011). A recent report from Polaris indicated that traffickers often exploit drug addiction as a means of control (Polaris, n.d.). As reported by Polaris, from January 2015 through June 2017, 2,238 individuals who potentially experienced human trafficking reported induced or exploited drug use as a mechanism used by their traffickers to maintain control (id.). These findings shed

light on the connection between substance abuse and trafficking; however, they represent only one dimension of a complex issue.

Access to healthcare is another crucial factor influencing the ability of individuals involved in sex trafficking to escape their circumstances. Research studies have highlighted the gynecological, reproductive, and procreative health issues experienced by trafficking victims and the common barriers they encounter when seeking healthcare services (Lederer et al., 2023; Oram et al., 2012; Price et al., 2019). Despite these findings, the literature primarily focuses on isolated aspects of healthcare access, leaving a gap in our understanding of the broader healthcare-related challenges faced by individuals involved in the commercial sex industry.

Previous research on the age of entry into prostitution and its relationship to drug use, race, suicide, education level, and family has been conducted in the U.S. (Clarke et al., 2012; Sallmann, 2010; Taylor, 2011). Many researchers have focused on linking or delinking sex trafficking and commercial sex, but most of the studies have been in other countries (Benoit et al., 2018; Benoit et al., 2019; Coy, 2008; Davy, 2017; Wilson et al., 2015; Meshkovska et al., 2015; Moran & Farley, 2019; Murphy, 2010).

To comprehensively address the multifaceted and interconnected barriers to escaping the commercial sex industry, there is a clear need for conjunctive analysis—a holistic examination that considers various factors simultaneously. This paper contributes to the academic discourse by undertaking a comprehensive study that explores a wide range of potential barriers, including homelessness, substance abuse, access to healthcare, experiences with law enforcement, and violence victimization, among others. By adopting a holistic approach, this research seeks to provide a complete understanding of the complex challenges faced by individuals striving to break free from the commercial sex trade, bridging the gap left by previous studies that have focused on single issues or narrow populations.

METHODS

This study is based on a survey of 74 women in Detroit, Michigan, conducted by the Detroit-based non-profit Street Outreach Teams. This non-profit specializes in *street medicine*, a term describing transitional primary medical care practiced on the street, in shelters, or soup kitchens. Medical care is provided by a multidisciplinary team, typically comprised of a physician, medical support staff, a behavioral health specialist, and a social worker. The team identifies patients by setting up temporary clinics in shelters or soup kitchens or by going into areas known for homelessness, such as parks or abandoned buildings. Street Outreach Teams focused on the Southwest, East Side, and Brightmoor areas of Detroit for this survey.

Although there was no formal research protocol review (I.R.B.) in this survey, the study meets the appropriate ethical guidelines for protecting human subjects' welfare, rights, and privacy. The participants were walk-in clients of a street medicine mobile health vehicle. The survey was administered using the Detroit Street Medicine guidelines, which were used for other similar surveys of unreached homeless populations in Detroit. The survey administrators obtained verbal informed consent from participants. The risk to patients was minimal; patient information was protected and kept confidential, and no personal data was gathered, so information gathered was already de-identified. Patients were informed of their rights before the survey began and told the purpose of the survey. The original survey was administered over a 10-month period in 2020.

The sample is not probabilistic—that is, the survey respondents were not randomly and systematically selected from a larger population to ensure a representative sample. Instead, the sample is a nonprobability sample—specifically, a convenience sample. As such, findings in this study cannot be directly generalized to any larger population group. Study findings can only be attributed to the study sample. All 74 respondents from the original survey are included in this study sample.

This study uses a quantitative nonexperimental design. Specifically, it compares three mutually exclusive groups of women across five outcome dimensions. The study divides the respondents into three categories:

- Women who are victims of sex trafficking;
- Women who reported that they were engaged in commercial sex voluntarily (identified as sex work in the data-gathering stage) and
- Women who were neither trafficked nor involved in the commercial sex industry at the time of the survey.

The five outcome dimensions are:

- Challenges with substance drug use and addiction;
- Experiences with homelessness or unstable housing;
- Instances of violence;
- Interactions with law enforcement; and
- Barriers to healthcare and health-related issues.

All variables in this study are categorical with mutually exclusive categories. Given that this is a nonexperimental design, this study cannot illustrate cause and effect. That is, outcomes cannot be attributed to a specific causal factor. However, because the independent variable is based on three mutually exclusive categories, each category can be treated as a separate group.

STATUS: TRAFFICKED, COMMERCIAL SEX, OR NEITHER

Women were labeled in the data tables as 1) trafficked, 2) commercial sex, or 3) neither. Women were placed in these categories based on their answers to initial questions given in the survey. Women who fell into the "trafficked" category answered "yes" to the question: "Are you currently involved in sex work?" and answered "yes" to at least one follow-up question, such as:

- Have you ever been forced to perform sex for money?
- Were your vital documents ever taken from you?
- Did a "controller" or "manager" ever take the money you received?
- Were you ever compelled to work without pay?
- Did you ever feel that you were not free to leave your workplace?

Women were categorized as involved in commercial sex but not trafficked if they answered "yes" when asked, "Are you currently involved in sex work," but answered "no" to the follow-up questions. The final group answered "no" when asked whether they were currently involved in sex work and were not asked the follow-up questions. Thus, this group was labeled as "neither" in the data gathering stage to reflect that these participants are neither currently involved in commercial sex nor currently a victims of sex trafficking. It is crucial to acknowledge that individuals in this final group stated their lack of *current* involvement in commercial sex. However, it is worth

noting that certain responses within the survey indicate that some of them had either been trafficked or engaged in commercial sex at some point in the past. Despite this overlap, the study treats these three categories as distinct groups. The distribution of the three categories is highlighted in Table 1 below.

Table 1. Distribution of Respondents by Status

Status	Respondents Identifying with Status	Frequency (N=74)
Trafficked	61%	45
Engaged in Commercial Sex (Voluntary, Not Trafficked)	27%	20
Neither Currently Trafficked nor Engaged in Commercial Sex	12%	9

Among the respondents, the majority (61%) were classified under the "trafficked" category. Additionally, 27% of the respondents were categorized as "engaged in commercial sex but not trafficked." When these two categories are combined, it is evident that a significant majority of the participants (86%) were involved in the sex trade in some form. Conversely, only 12% of the respondents reported neither being currently engaged in any form of commercial sex nor trafficked at the time of the survey.

RESULTS

DEMOGRAPHICS

Current Age: The age distribution of respondents who were trafficked displayed a roughly bell-shaped distribution. Among the women voluntarily engaged in commercial sex, the majority fell within the 31–40 age range (approximately 65% of this group). On the other hand, women not currently involved in commercial sex were evenly distributed across three age ranges: 26–30, 31–40, and 41–50. Generally, women who were trafficked tended to be the youngest (approximately 46% were 30 years old or younger).

Age When First Entered Sex Trade: The trafficked respondents reported entering the sex trade at earlier ages compared to respondents who voluntarily engaged in commercial sex but were not trafficked. On average, the majority of trafficked respondents were younger than 25 years old when they first entered the sex trade. Conversely, respondents involved in commercial sex but not trafficked, on average, began their involvement in commercial sex after reaching the age of 25.

Education: Among the trafficked respondents, a significant proportion (74%) either did not complete high school, graduated from high school, or received a GED. Similarly, among the respondents involved in commercial sex, 75% fell into the same educational category. On the other hand, even though the group not involved in commercial sex had a significant proportion of individuals (56%) who did not finish high school, this group showed a more diverse educational profile, with 44% having pursued some college or obtained a college degree at some time in their lives.

Children: In all three categories, a majority of respondents reported being mothers. Indeed, the presence of children is roughly the same across all three categories of

women. Among the respondents, those who were trafficked reported a slightly higher likelihood of having children, with 80% of them reporting parenthood. Women engaged in commercial sex and women not involved had slightly lower probabilities of having children, with rates of 75% and 78%, respectively. These reports raise significant concerns regarding the resources available to these women during their pregnancies or the early years of their children's lives, such as access to affordable childcare.

DRUG ADDICTION AND SUBSTANCE USE

> Shortly after I was trafficked, I started seeking drugs. At first, it was anything to numb the pain of what was happening to me, but in a short time, I began using heroin and quickly became addicted. — Survivor

Table 2. Age When Respondent First Used Drugs by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Age when Respondent First Used Drugs	**Answered (N=45)**
Under 14 years old	33%
14-17 years old	38%
18-25 years old	22%
Over 25 years old	6%
Commercial Sex	
Age when Respondent First Used Drugs	**Answered (N=20)**
Under 14 years old	15%
14-17 years old	45%
18-25 years old	35%
Over 25 years old	5%
Neither	
Age when Respondent First Used Drugs	**Answered (N=9)**
Under 14 years old	33%
14-17 years old	33%
18-25 years old	11%
Over 25 years old	22%

Among all respondents, the initiation of drug use occurred at an early stage in life, with a majority of individuals in each category reporting that they began using drugs during their adolescence. Specifically, women who were victims of sex trafficking had the highest likelihood of initiating drug use before the age of 18. Conversely, women engaged in commercial sex showed a greater tendency to start using drugs after

reaching the age of 18. Interestingly, even among women not involved in the commercial sex industry, there was a higher prevalence of drug initiation prior to age 18.

Table 3. Drugs Used by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Drugs Used	**Answered (N=45)**
Cocaine	100%
Heroin	87%
Marijuana	38%
Meth	24%
Pills (Opiates, Benzos, Other)	24%
Hallucinogens (MDMA, LSD, Mushrooms)	16%
Commercial Sex	
Drugs Used	**Answered (N=20)**
Cocaine	95%
Heroin	85%
Marijuana	40%
Meth	0%
Pills (Opiates, Benzos, Other)	10%
Hallucinogens (MDMA, LSD, Mushrooms)	5%
Neither	
Drugs Used	**Answered (N=9)**
Cocaine	78%
Heroin	56%
Marijuana	44%
Meth	22%
Pills (Opiates, Benzos, Other)	22%
Hallucinogens (MDMA, LSD, Mushrooms)	22%

Cocaine emerged as the most frequently reported drug overall, and this trend persisted when analyzing the data within the three distinct groups. Among those who were trafficked, cocaine and heroin use stood out with rates of 100% and 87%, respectively. Similarly, among individuals engaged in commercial sex, high rates of cocaine (95%) and heroin (85%) usage were observed. Although respondents did report using other drugs, there was a significant decline in the rate of usage compared to usage of cocaine and heroin.

Table 4. Drug Overdose by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Drug Overdose Experience	**Answered (N=45)**
Experienced Overdose	69%
Has not Experienced Overdose	31%
Commercial Sex	
Drug Overdose Experience	**Answering (N=20)**
Experienced Overdose	75%
Has not Experienced Overdose	25%
Neither	
Drug Overdose Experience	**Answered (N=9)**
Experienced Overdose	44%
Has not Experienced Overdose	56%

Table 4 illustrates that women who were either trafficked or involved in commercial sex were highly likely to have experienced at least one overdose, with rates of 69% and 75%, respectively. Among all three groups, women who participated in commercial sex exhibited the highest incidence of drug overdoses. On the other hand, women who were currently not involved in commercial sex displayed the lowest likelihood of experiencing a drug overdose.

HOMELESSNESS

> After I ran away from home, I couched surfed for a while. Then, when my parents' friend wouldn't let me do that, I stayed in a shelter, but it wasn't safe there. I got assaulted in a shelter, my things were stolen, including my ID, and there were too many rules. I just couldn't take it. Living on the street was safer for me than the shelters, and that's how I became homeless. — Survivor

Table 5 provides insights into the housing circumstances of the respondents categorized by status. The findings indicate that the highest rates of unstable housing were observed among the trafficked respondents. Additionally, the group not involved in commercial sex also experienced relatively high rates of unstable housing.

Table 5. Housing Circumstance by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Housing Circumstance	**Answered (N=45)**
Abandoned Building or Drug House	69%
Motel	11%
Private Residence	11%
Outside	0%
Other	9%
Commercial Sex	
Housing Circumstance	**Answered (N=20)**
Abandoned Building or Drug House	45%
Motel	20%
Private Residence	15%
Outside	5%
Other	15%
Neither	
Housing Circumstance	**Answered (N=9)**
Abandoned Building or Drug House	56%
Motel	11%
Private Residence	22%
Outside	0%
Other	11%

VIOLENCE

> My traffickers started pimping me out to their friends – not out on the streets but in apartments. I was literally being sold for drugs. During this time, there was so much violence. I was beaten, punched, kicked, raped, threatened with weapons. — Survivor

The prevalence of violence among victims of trafficking is strikingly high, as evidenced by Table 6. A staggering 96% of respondents who were trafficked reported experiencing violence. The rates of violence exhibited a slight decline among individuals involved in commercial sex but not trafficked, with 80% reporting victimization. Conversely, respondents not involved in commercial sex reported the lowest rates of violence at 58%. This data unequivocally indicates that victims of trafficking face a significantly elevated risk of experiencing violence compared to those involved in commercial sex voluntarily or those not involved in commercial sex at all.

Table 6. Victim of Violence by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Have you been a victim of violence?	**Answered (N=45)**
Yes, I have been a victim of violence.	96%
No, I have not been a victim of violence.	4%
Commercial Sex	
Have you been a victim of violence?	**Answered (N=20)**
Yes, I have been a victim of violence.	80%
No, I have not been a victim of violence.	20%
Neither	
Have you been a victim of violence?	**Answered (N=9)**
Yes, I have been a victim of violence.	56%
No, I have not been a victim of violence.	44%

Table 7 vividly illustrates the profound dangers faced by women involved in trafficking and commercial sex. The data reveals alarming statistics: 82% of trafficking victims endure violence perpetrated by customers, while 60% of those engaged in commercial sex experienced the same. Victims of trafficking also report significantly high rates of violence inflicted by their boyfriends and pimps.

Notably, some respondents in the "neither" category also reported instances of violence involving customers and pimps. This finding strongly suggests that although these individuals may not currently be involved in commercial sex, they likely had prior experiences within the industry.

ENCOUNTERS WITH LAW ENFORCEMENT

> By this time, I had all sorts of charges on my record, but all of them nonviolent – drug paraphernalia charges (not drugs themselves), theft, one prostitution-related charge. Then, I was picked up in a prostitution sting. Because of the previous charges, the judge gave me 10 years in prison. Ten years! I did four years in prison and then got probation and went into a halfway house. — Survivor

Table 7. Perpetrators of Violence by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Who perpetrated violence against you? *(select all that apply)*	**Answered (N=45)**
Customer, John, Date	82%
Boyfriend (Pimp)	60%
Stranger	27%
Other Ladies	24%
Significant Other	22%
Police	18%
Other	9%
Did Not Respond	0%
Commercial Sex	
Who perpetrated violence against you? ***(select all that apply)***	**Answered (N=20)**
Customer, John, Date	60%
Boyfriend (Pimp)	15%
Stranger	10%
Other Ladies	5%
Significant Other	5%
Police	0%
Other	5%
Did Not Respond	10%
Neither	
Who perpetrated violence against you? *(select all that apply)*	**Answered (N=9)**
Customer, John, Date	11%
Boyfriend (Pimp)	33%
Stranger	22%
Other Ladies	11%
Significant Other	11%
Police	0%
Other	11%
Did Not Respond	0%

Table 8. Arrests by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Have you ever been arrested?	**Answered (N=45)**
Yes, I have been arrested.	96%
No, I have not been arrested.	4%
Commercial Sex	
Have you ever been arrested?	**Answered (N=20)**
Yes, I have been arrested.	100%
No, I have not been arrested.	0%
Neither	
Have you ever been arrested?	**Answered (N=9)**
Yes, I have been arrested.	100%
No, I have not been arrested.	0%

Table 8 presents the arrest rates based on respondent status. All three groups reported high rates of arrest. Notably, the trafficked group stood out as the only category without a 100% arrest. However, it is important to highlight that only two respondents within that group reported having never been arrested.

Table 9. Reason for Arrest by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Why were you arrested? *(Select all that apply)*	**Answered (N=45)**
Commercial Sex Offense	56%
Drug Offense	82%
Other	24%
Commercial Sex	
Why were you arrested? *(Select all that apply)*	**Answered (N=20)**
Commercial Sex Offense	40%
Drug Offense	45%
Other	40%
Neither	
Why were you arrested? *(Select all that apply)*	**Answered (N=9)**
Commercial Sex Offense	11%
Drug Offense	44%
Other	44%

Interestingly, the most common reason for women in any of the three groups being arrested was related to drug offenses. The trafficked group had the highest overall rates of arrest, with 82% reporting drug-related arrests and over half of the respondents reporting being arrested for commercial sex-related offenses. The data presented highlights the significance of law enforcement agencies in identifying victims of trafficking, even when they come into contact with them during arrests for charges unrelated to commercial sex offenses. The high arrest rates among trafficked women, particularly for drug-related offenses, underscore the potential opportunities for law enforcement to identify and support victims within these circumstances.

HEALTH

> I had so many health problems from being trafficked. I had multiple STDs and UTIs that led to Pelvic Inflammatory Disease; I was addicted to drugs and alcohol; I had broken bones that didn't heal properly because my trafficker never let me go to the hospital after I was beaten; I had a concussion from my trafficker beating my head on the cement curb. By the time I got out, I was so sick I couldn't hold down a regular job. — Survivor

Table 10. Respondents' Self-Perceived Quality of Health by Status: Trafficked, Commercial Sex, Neither

Trafficked	
How would you rate your quality of health?	**Answered (N=45)**
Poor	24%
Fair	51%
Good	22%
Very Good	2%
Commercial Sex	
How would you rate your quality of health?	**Answering (N=20)**
Poor	5%
Fair	35%
Good	60%
Very Good	0%
Neither	
How would you rate your quality of health?	**Answered (N=9)**
Poor	11%
Fair	22%
Good	56%
Very Good	11%

Participants in the trafficked category reported the lowest overall health quality, with a staggering 75% of women indicating poor or fair health. Conversely, in both the "involved in commercial sex" and "neither trafficked nor involved in commercial sex" categories, a majority of respondents rated their health as good. These findings shed light on the disparate health experiences among the different groups. The high percentage of poor or fair health ratings among trafficked individuals highlights the detrimental impact of trafficking on their well-being. These results underscore the need for health providers to be trained to identify victims of trafficking and for targeted interventions and support services to address the health disparities faced by individuals who have experienced trafficking.

Table 11. Primary Source of Healthcare by Status: Trafficked, Commercial Sex, Neither

Trafficked	
Where do you receive a majority of your healthcare?	**Answered (N=45)**
Emergency Room	80%
Clinic or Doctor's Office	13%
Street Outreach	18%
Urgent Care	9%
Commercial Sex	
Where do you receive a majority of your healthcare?	**Answered (N=20)**
Emergency Room	65%
Clinic or Doctor's Office	15%
Street Outreach	20%
Urgent Care	10%
Neither	
Where do you receive a majority of your healthcare?	**Answered (N=9)**
Emergency Room	44%
Clinic or Doctor's Office	33%
Street Outreach	22%
Urgent Care	0%

*The respondents were asked, "Where do you receive a majority of your healthcare?" implying that respondents should only indicate one category; however, some respondents gave multiple responses.

Table 11 demonstrates respondents' primary sources of healthcare services based on their status. Across all three groups, the most common source of healthcare was the emergency room setting. However, this choice was particularly pronounced among the trafficked group, with 80% of trafficked respondents relying predominantly on emergency rooms for their healthcare needs. Again, this graph illustrates the critical role that all medical providers, especially those in emergency room settings, play in identifying and responding to victims of trafficking.

Table 12. Barriers to Healthcare by Status: Trafficked, Commercial Sex, Neither

Trafficked	
What are the barriers to your ability to access healthcare? *(Select all that apply)*	**Answered (N=45)**
Lack of Transportation	71%
Difficulty Scheduling or Keeping Appointments	58%
Lack of Identification (ID)	38%
Embarrassment	27%
Don't know where to go	16%
Rude Staff/Feel Judged	16%
Lack of Insurance	7%
Commercial Sex	
What are the barriers to your ability to access healthcare? *(Select all that apply)*	**Answered (N=20)**
Lack of Transportation	60%
Difficulty Scheduling or Keeping Appointments	65%
Lack of Identification (ID)	40%
Embarrassment	15%
Don't know where to go	10%
Rude Staff/Feel Judged	20%
Lack of Insurance	15%
Neither	
What are the barriers to your ability to access healthcare? *(Select all that apply)*	**Answered (N=9)**
Lack of Transportation	78%
Difficulty Scheduling or Keeping Appointments	33%
Lack of Identification (ID)	44%
Embarrassment	22%
Don't know where to go	22%
Rude Staff/Feel Judged	11%
Lack of Insurance	44%

Table 12 provides an overview of the barriers to healthcare reported by the respondents based on their status. For individuals who are trafficked or involved in commercial sex, the identified barriers predominantly revolve around the accessibility of healthcare providers. These barriers could be addressed by providing transportation options or flexible means of seeking healthcare, such as walk-in appointments, and providing more resources for mobile healthcare services, such as street medicine

vans and mobile health vans. Also significant is the number of women in all groups who cited a lack of identity documents as a barrier to obtaining care.

LIFE GOALS AND BARRIERS

> When I got arrested, I was finally free of my trafficker, but I still had all my other problems. I was still addicted; I didn't have any place to go to call home, and I didn't know how to live. I had never had a bank account, never paid bills, never shopped, or cleaned house. I didn't know how to make money in any legitimate way. I realized that my worst fear wasn't being beaten by my trafficker. My worst fear was where would I go and what would I do if I got free of him? — Survivor

When the respondents were asked whether they desired to pursue a different path than their current one, nearly all responded in the affirmative (three responded with "N/A"). The respondents were also asked where they see themselves in five years. Some respondents could not articulate specific dreams or goals, responding with "I don't know" or "anywhere but here." Others expressed specific goals for a brighter future. Common answers included getting sober and clean from drugs, being gainfully employed, completing or going to school, and having stable housing. Others included family-oriented goals such as getting married and having children, and multiple respondents expressed their desire to be reunited with their children.

The respondents were then asked a follow-up question to identify what they considered to be the most significant barriers to pursuing a different path. Among all three groups, drug addiction emerged as the most prominent and significant barrier. Additionally, the respondents identified barriers such as financial constraints and relationship problems. The women were also asked to list their top three current needs, revealing essential requirements for their well-being. Responses consistently emphasized fundamental necessities such as food, clothing, shelter, and access to showers. Specialized medical care, including Ob-Gyn, dental, and other healthcare services, were also high on the list of needs. Many expressed a need for drug detox and rehabilitative support.

Additionally, some identified the need for legal assistance in obtaining basic identity documents, such as IDs, social security cards, or copies of birth certificates. Lastly, they expressed a need for a caring community and a sense of belonging. These responses confirm the importance of developing comprehensive support systems that encompass a range of services tailored to the specific needs of individuals who have been trafficked or involved in commercial sex.

RECOMMENDATIONS

In recent research published by the U.S. Department of Health and Human Services National Institute of Health, three types of barriers were identified: extrinsic, intrinsic, and systemic (Garg, 2020). Extrinsic barriers included trafficker control, physical confinement, and the influence of peers. Intrinsic barriers included discrimination, confidentiality, trust in healthcare providers, knowledge of the healthcare system, and emotional reluctance. Systemic issues inherent to the healthcare system included healthcare provider knowledge, complex registration processes, language barriers, appointment times, and service coordination.

In this survey, extrinsic, intrinsic, and systemic barriers are inextricably tied. Women who are trafficked or engaged in commercial sex also struggle with drug and

alcohol addictions, experience homelessness or housing instability, and suffer from serious health problems. Recognizing the needs and realities of these patients and meeting them where they are – out on the street, in mobile and other health clinics, in rehab programs, and in temporary shelters – to assess their needs is vital. Using individualized case management and other holistic, whole-of-person assessment instruments is also critical. Unfortunately, many available services are siloed, making it difficult for women to receive services tailored to their needs. Until we can design housing and shelter services so that physical and mental health services, addiction and rehab services, life skills, and other related needs are all in a one-stop-and-shop center, we must explore other ways to ensure that multiple needs can be met. One possibility is more mobile clinics and services that meet women where they are – on the streets, in inexpensive motels, and other temporary residencies. Another possibility is a more sophisticated system of "warm hand-offs," where Multidisciplinary Teams (MDTs) of service providers from various fields come together on the front end to provide sets of needed services.[2]

Another critical issue is the high percentage of women who have children. In this survey, 80% of women who were trafficked and 75% of women who identified as engaged in commercial sex reported that they had children. In focus groups conducted about pregnancy in trafficking, women noted that service providers and other helper organizations are frequently not set up to assist women with children (Lederer et al., 2023). For example, one survivor of sex trafficking said that she would not go to the local shelters for trafficking victims because they did not accept children. She said that she slept with her two-year-old in an abandoned car over a winter in the Midwest to keep her two-year-old with her (id.). This is not the fault of the shelters; it is a systemic problem. It is difficult to obtain licenses for residential shelters for trafficking victims to keep mothers and children together (J. Allert, personal communication, March 15, 2019; T. Frundt, personal communication, December 13, 2022; M. Gamboa, personal communication, May 10, 2023). To get help, a mother must give up her child or be separated from her child to obtain services. Some agencies are pioneering new forms of care in which, as long as there is no child abuse, mother and child are never separated and go to new kinds of foster care together (Safe Families for Children, n.d.). These agencies see homelessness, unemployment, domestic violence, incarceration, substance abuse, and human trafficking as sources of crisis that, in many government and non-profit systems of care, separate families and particularly separate mothers from their children. Their approach is to provide a host family for the family in crisis. In this way, mother and child or children stay together and receive wrap-around services tailored to their needs (id.).

In this survey, surprisingly, many respondents could not access healthcare or other services because they did not have something as simple as identification papers or transportation to and from a service provider. Social workers, legal aid, and other service providers should have interns or entry-level staff available to help remove these barriers, including obtaining basic identification documents such as duplicate birth certificates, social security cards and numbers, driver's licenses, or walker's IDs.

[2] In healthcare, a "warm handoff" is a handoff that is conducted in person, or live on-line, between two members of the health care team, while the patient is present. This same technique can be extended to handing a person over to another service provider to find housing, rehabilitation center or residency treatment, or other sets of services.

Specialized education and awareness programs tailored to the professionals who come into direct contact with clients and patients are another way to help service providers understand how they may encounter trafficking in their daily work and how to respond appropriately. In a new survey on pregnancy and human trafficking, pregnant victims of trafficking were asked if they had sought help from many different kinds of health providers during the time they were trafficked (Lederer et al., 2023). Ninety percent of victims said they sought healthcare; 80% sought healthcare in emergency rooms ("ERs") in hospitals; 58% sought care in neighborhood or urgent care clinics; and 35% sought care from private physicians. Unfortunately, even though most reported interacting with medical professionals, when they were asked to characterize their general interactions with healthcare providers, only 9.7% reported agreeing with the statement that medical professionals understood what was happening to them." Only 12.9% believed the care they received was "excellent." Only 9.7% reported that medical professionals were "trauma-informed." Only 9.7% reported that the medical professional followed up with them or provided aftercare, and only 6.5% reported receiving helpful referrals (id.).

These dismal results have prompted experts to emphasize that service providers have an ethical obligation to be aware of human trafficking, recognize its signs and indicators, and be aware of and reduce the effects of implicit bias on providing a victim with high-quality care. Some states have passed laws requiring specialized training tailored for service providers to help them identify victims and respond appropriately. For example, in Texas, a new law requires all healthcare providers who have direct contact with patients to take health and human trafficking training once a year (Tex. H.B. 2059, 2019). The law requires the Texas Health and Human Services Commission (HHSC) to approve training courses on human trafficking, including at least one free of charge, post the list of approved trainings on the HHSC website, and update the list of approved trainings as necessary. Completing an approved training course is a condition for registration, permit, or license renewal for certain healthcare practitioners. The State of Texas reviews training produced by nonprofits and other organizations to ensure that the training covers a list of "core competencies" (Texas Health and Human Services Commission, n.d.).

To be approved as a trainer, the Texas HHSC considers five categories. The first category considers the design of the training to ensure that the training has appropriate learning objectives, is created in consultation with survivors, excludes sensationalized imagery, uses evidence-based content, and is free from factual errors. The second category ensures a thorough understanding of basic information about human trafficking, including the definition of trafficking, the federal law on trafficking, the main types of trafficking (sex trafficking and labor trafficking), the difference between trafficking and smuggling, and a description of some of the main vulnerabilities that lead to victimization (victim profiles, and some of the main types of traffickers (trafficker profiles). Third, the training must cover the health impacts of human trafficking, including acute injuries, chronic medical problems, mental health issues, reproductive and sexual health concerns, and the impact of human trafficking on quality of life, autonomy, and independence. Fourth, the training must address how to identify and assess victims of trafficking and include information on patient-centered approaches, clinical settings in which trafficked persons may be encountered, challenges and opportunities when interfacing with trafficked persons, survivor barriers to disclosure, provider barriers to identification and response, potential indicators of trafficking in persons, the role of trauma-informed care in trust-building and communication, safety planning to keep victims and providers safe, the importance of the use of

professional interpreters, the importance of and strategies to have private conversations with potentially trafficked persons, samples of appropriate language to assist with identification, and the importance of appropriate documentation. Finally, the fifth category addresses response and follow-up. The training must contain an emphasis on the importance of the healthcare provider's role in intervention and response, the importance of survivor-centered, multidisciplinary referrals within the healthcare organization and with community partners, a discussion of mandated reporter obligations, a discussion of the implications of law enforcement involvement, information on how to contact your community, local, and/or state resources as well as how to build a trusted local network of resources, the importance of organizational protocols, and information on the National Human Trafficking Hotline number and text number along with any local hotlines. These five categories ensure that each training is comprehensive, trauma-informed, and upholds survivor-informed principles (id.).

A handful of other states have also passed similar laws requiring training for healthcare providers, law enforcement officials, educators, foster care administrators and parents, social workers, child protective services, the hospitality industry, the transportation industry, and other industries, professions, and sectors where there is evidence that human trafficking occurs, and where it is clear that certain professions are first responders to human trafficking (Freedberg & Messinger, 2022). First responders refer to individuals with specialized training who are among the first to arrive and provide assistance or incident resolution or who may be in the unique position of seeing a human trafficking victim in the course of their work. By training first responders on how to identify victims of human trafficking and respond appropriately within their mission and mandate, many of the current provider-related barriers to helping victims escape human trafficking may be alleviated.

STUDY LIMITATIONS

This survey had several limitations. Because it is based on a convenience sample rather than a probability sample, findings in this survey cannot be generalized beyond the sample. These are preliminary findings from a pilot survey, so the sample size is small. The survey is a retrospective self-reporting survey. Self-reporting is a time-honored survey method, but it has several limitations, the main one being bias in reporting. The participants may not always answer honestly; they may choose the more socially acceptable answer rather than the truth. In addition, participants may not always have the required introspective ability: they may not be able to assess themselves accurately.

CONCLUSION

The findings of this survey shed light on the multifaceted barriers faced by women who are trafficked or engaged in commercial sex, particularly regarding their access to healthcare and other essential services. The combination of interconnected issues, such as substance abuse and addiction, homelessness, and health problems, further complicates their situations and highlights the need for tailored, holistic approaches to address their unique needs. The survey findings stress the importance of recognizing and meeting these individuals where they are, both physically and emotionally, and advocate for implementing individualized case management and collaborative, multidisciplinary approaches. Additionally, the survey highlights the significant percentage of women with children who are involved in these circumstances, underscoring the critical need for service providers to adapt their support systems to

accommodate and assist women with children effectively. Moreover, the findings emphasize the necessity of specialized education and awareness programs for professionals who frequently interact with these vulnerable populations, fostering a better understanding of human trafficking and commercial sex, especially for women identifying as either trafficked or engaged in commercial sex they face many of the same barriers to a better life. By addressing these barriers, we can strive towards a more compassionate and effective system that supports the identification of trafficking victims and addresses their needs to work toward their recovery and well-being.

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