Executive Summary: Health Impact Review of HB 1382

Increasing access to emergency assistance for victims by providing immunity from prosecution for prostitution offenses in some circumstances (2019 Legislative Session)

Evidence indicates that HB 1382 has the potential to increase access to and use of emergency assistance for people in the sex trade who are victims of violent offenses, which in turn has the potential to improve physical and mental health outcomes and decrease health inequities for this population and by gender identity and race/ethnicity.

BILL INFORMATION

Sponsors: Pellicciotti, Kraft, Macri, Goodman, Doglio, Pettigrew, Ormsby, Jinkins, Stanford, Appleton, Riccelli

Summary of Bill:

- Provides immunity from prosecution charges to a victim of one of the following offenses, or a person seeking emergency assistance on behalf of the victim: (1) a violent offense as defined in RCW 9.94A.0303; assault in the third degree under RCW 9A36.031; assault in the third degree under RCW 9A.36.041 or an equivalent municipal ordinance; or rape in the third degree under RCW 9A.44.060.

HEALTH IMPACT REVIEW

Summary of Findings:
This Health Impact Review found the following evidence regarding the provisions in HB 1382:

This review makes the informed assumption that providing immunity from prosecution for prostitution charges to a victim or person seeking emergency assistance on behalf of a victim in some circumstances has the potential to improve access to emergency assistance for some people in the sex trade. This informed assumption is based on discussions with key informants at organizations serving people in the sex trade (i.e., by choice, circumstances, or coercion), individuals with lived experience in the sex trade, and staff at the King County Prosecuting Attorney's Office and Juvenile Court.

- **Strong evidence** that increased access to and utilization of emergency assistance (specifically medical assistance) would improve health outcomes for people in the sex trade who are victims of violent offenses.
- **Strong evidence** that improving health outcomes for people in the sex trade who are victims of violent offenses would likely decrease health inequities experienced by this population as well as by gender identity and race/ethnicity.

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Health Impact Review of HB 1382

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February 13, 2019

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Acknowledgements
We would like to thank the key informants who provided consultation and technical support during this Health Impact Review.

A note about language used in this Health Impact Review
Based on recommendations from key informants, analysts use the terms "people engaged in the sex trade" or "people in the sex trade" when discussing individuals who may be impacted by this legislation. We use this language to be inclusive of the continuum of individuals within the sex trade, including those who enter by choice, circumstance, or coercion. When discussing people actively being trafficked we use the term "trafficking victims" to acknowledge their experience of exploitation (i.e., being forced to have sex against their will). When specifically referring to those who have escaped/exited trafficking we use the term "survivors of trafficking" to recognize that not all people who are trafficked survive. When discussing sexual assault, we follow recommendations from RAINN (Rape, Abuse & Incest National Network). We use the term "victim" when referring "to someone who has recently been affected by sexual violence" and the term "survivor" in reference to "someone who has gone through the recovery process, or when discussing the short- or long-term effects of sexual violence."[1] When directly citing literature, unless used in a specific quote, we use person first descriptions of the terminology used by the source material (e.g., victims of rape instead of rape victims) to limit defining individuals by their circumstance or condition.

Contents

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State (RCW 43.20.285). For the purpose of this review 'health disparities' have been defined as the differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.270). This document provides summaries of the evidence analyzed by State Board of Health staff during the Health Impact Review of House Bill 1382 (HB 1382).

Staff analyzed the content of HB 1382 and created a logic model depicting possible pathways leading from the provisions of the bill to health outcomes. We consulted with experts and contacted key informants about the provisions and potential impacts of the bill. We conducted an objective review of published literature for each pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. More information about key informants and detailed methods are available upon request.

The following pages provide a detailed analysis of the bill including the logic model, summaries of evidence, and annotated references. The logic model is presented both in text and through a flowchart (Figure 1). The logic model includes information on the strength-of-evidence for each relationship. The strength-of-evidence has been defined using the following criteria:

- **Not well researched:** the review of literature yielded few if any studies or only yielded studies that were poorly designed or executed or had high risk of bias.
- **A fair amount of evidence:** the review of literature yielded several studies supporting the association, but a large body of evidence was not established; or the review yielded a large body of evidence but findings were inconsistent with only a slightly larger percentage of the studies supporting the association; or the research did not incorporate the most robust study designs or execution or had a higher than average risk of bias.
- **Strong evidence:** the review of literature yielded a large body of evidence on the relationship (a vast majority of which supported the association) but the body of evidence did contain some contradictory findings or studies that did not incorporate the most robust study designs or execution or had a higher than average risk of bias; or there were too few studies to reach the rigor of "very strong evidence;" or some combination of these.
- **Very strong evidence:** the review of literature yielded a very large body of robust evidence supporting the association with few if any contradictory findings. The evidence indicates that the scientific community largely accepts the existence of the association.

This review was subject to time constraints, which influenced the scope of work for this review. The annotated references are only a representation of the evidence and provide examples of current research. In some cases only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question, so are referenced multiple times.

Analysis of HB 1382 and the Scientific Evidence

Summary of relevant background information

- "People engaged in the sex trade" is an inclusive term that means "anyone who has traded or exchanged sexual acts or sexual service for money, food, place to sleep, drugs, or anything of value, regardless of choice, circumstances, and coercion (or combination thereof) that led to their involvement in the trade."[2]
- For the purposes of this analysis "emergency assistance" is understood to include calling 911, accessing emergency medical assistance, or contacting law enforcement (Representative Pellicciotti, personal communication, February 2019).
- Under Washington law:
    - A person is guilty of the crime of prostitution (RCW 9A.88.030) if the individual engages in, agrees to engage in, or offers to engage in sexual conduct with another person in return for a fee. "Sexual conduct" includes sexual intercourse and sexual contact. Prostitution is a misdemeanor offense, which is subject to 90 days of incarceration and a $1,000 fine.
    - RCW 9.94A.030.55 details actions deemed as a "violent offense". Examples include, but are not limited to: a class A felony or attempt to commit a class A felony, manslaughter (I or II degree), kidnapping (II degree), assault of a child (II degree), and robbery (II degree).
    - RCW 9A.36.031 defines assault in the third degree. For example an individual is guilty if their action: "(d) with criminal negligence, causes bodily harm to another person by means of a weapon or other instrument or thing likely to produce bodily harm […] (f) with criminal negligence, causes bodily harm accompanied by substantial pain that extends for a period sufficient to cause considerable suffering."
    - RCW 9A.36.041 defines assault in the fourth degree.
    - RCW 9A.44.060 defines rape in the third degree. Specifically, "(a) Where the victim did not consent as defined in RCW 9A.44.010(7), to sexual intercourse with the perpetrator and such lack of consent was clearly expressed by the victim's words or conduct, or (b) Where there is threat of substantial unlawful harm to property rights of the victim."
- Currently, four jurisdictions in the U.S. have implemented policies similar to HB 1382. Each aims to allow people in the sex trade who are victims of crime to seek law enforcement and medical assistance without fear of prosecution.
    - In 2016, Alaska became the first state in the U.S. to provide victims or witnesses of violent crimes (e.g., sex trafficking, assault, and robbery) immunity from prosecution for prostitution if they report the crime in good faith and cooperate with law enforcement personnel.[3]
    - In 2017, the King County Prosecuting Attorney's Office (KCPAO) adopted the following policy: "A person acting in good faith who seeks medical or law enforcement assistance for someone, including the reporting person, who is the victim of a crime shall not be prosecuted for Prostitution (SMC 12A.10.020,

RCW 9A.88.030) or Prostitution Loitering (SMC 12A.10.010, KCC 12.63.010(G) – where the loitering is for the purpose of Prostitution) if the evidence for the charge was obtained as a result of the person seeking assistance."[4] Unlike Alaska's policy, KCPAO does not identify specific victimizations as eligible for immunity. Instead, the policy is meant to be broadly defined to protect victims (KCPAO, personal communication, February 2019).

- In 2018, San Francisco became the first jurisdiction to implement coordinated policies through the police department and district attorney's office to not arrest or prosecute "persons involved in sex work or other forms of sex trade when they are victims or witnesses of sexual assault, human trafficking, stalking, robbery, assault, kidnapping, threats, blackmail, extortion, burglary or other violent crime."[5,6] The policies also state victims and witnesses cannot be arrested or prosecuted for other offenses including: lewd conduct, prostitution and solicitation laws, loitering for the purpose of engaging in a prostitution offense, public nuisance (California Penal Code 647(a), 647(b), 653.22, and 372, respectively), and misdemeanor drug offenses.[5,6] Additionally, the policies state that reporting individuals are to be referred to community based organizations that serve people in the sex trade.[5,6]
- In June 2018, the California legislature passed Assembly Bill 2243 with bipartisan support. The legislation codified and expanded protections from prosecution for people in the sex trade reporting serious crimes statewide (i.e., extortion, stalking, or violent felony as defined by the California Penal Code).[7] Unlike the policy in San Francisco, the legislation does not grant amnesty from arrest or prevent victims of or witnesses to identified crimes from being held in jail.[8]

Summary of HB 1382

- Provides immunity from prosecution charges to a victim of one of the following offenses, or a person seeking emergency assistance on behalf of the victim: (1) a violent offense as defined in RCW 9.94A.0303; assault in the third degree under RCW 9A36.031; assault in the third degree under RCW 9A.36.041 or an equivalent municipal ordinance; or rape in the third degree under RCW 9A.44.060.

Health impact of HB 1382

Evidence indicates that HB 1382 has the potential to increase access to and use of emergency assistance for people in the sex trade who are victims of violent offenses, which in turn has the potential to improve physical and mental health outcomes and decrease health inequities for this population as well as by gender identity and race/ethnicity.

Pathway to health impacts

The potential pathway leading from the provisions of HB 1382 to decreased health inequities are depicted in Figure 1.

This review makes the informed assumption that providing immunity from prosecution for prostitution charges to a victim or person seeking emergency assistance on behalf of a victim in

some circumstances has the potential to improve access to emergency assistance for some people in the sex trade. This informed assumption is based on discussions with key informants at organizations serving people in the sex trade (i.e., by choice, circumstances, or coercion), individuals with lived experience in the sex trade, and staff at the King County Prosecuting Attorney's Office. There is strong evidence that increased access to and utilization of emergency assistance (specifically medical assistance) would improve health outcomes for people in the sex trade who are victims of violent offenses.[9-15] There is strong evidence that improving health outcomes for people in the sex trade who are victims of violent offenses would likely decrease health inequities experienced by this population as well as by gender identity and race/ethnicity.[16-21]

Due to time limitations, we only researched the most direct connections between the provisions of the bill and decreased health inequities and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- Whether and how reducing incarceration among people in the sex trade would influence health. However, there is very strong evidence indicating that involvement in the criminal justice system is linked to poor health outcomes for the individuals who experience incarceration[22-24] as well for their children.[25-27] The majority of research compares outcomes experienced by justice-involved individuals to outcomes experienced by those without a history of criminal justice contact. As people in the sex trade may have already had contact with the criminal justice system, the literature may not be fully generalizable.
- Whether and how reducing fear of prosecution for prostitution among people in the sex trade who are victimized/assist a victim would influence their decision to report perpetrators to law enforcement. If people in the sex trade had improved access to legal recourse, people who may have otherwise committed violence against them may be deterred, which could influence health for people in the sex trade.

Magnitude of impact

Due to the underground nature of the sex trade, analysts could not identify Washington specific prevalence data on people in the sex trade who experience violent crimes, assault, and rape. However, this section provides an overview of the continuum of people in the sex trade who may be affected by the legislative proposal; discussion of data challenges and gaps; and limited relevant data related to violence and abuse experienced by people in the sex trade.

The continuum of people in the sex trade who may be affected by HB 1382 can be broken into three broad categories of entry: choice, circumstance, and coercion. These categories are not necessarily mutually exclusive. Individuals who enter by choice are "fully consenting to the work and can leave for other employment options but choose to stay for various reasons."[28] Those who enter by choice generally have more privilege than others in the sex trade as they have other accessible options to meet their needs (e.g., food, housing) in a direct way (Reframe Health and Justice, personal communication, February 2019). This allows for entry and exit from the market at an individual's discretion, which provides a stronger position to negotiate safety (e.g., screen clients, require condom use). The second category includes those whose entry is circumstantial. This describes people who "consent to work in the sex trade but [want] to leave, or would prefer other work."[28] Most circumstantial entrants would choose to leave the sex trade

if the barriers limiting their options were addressed and they had access to other flexible, well-paid work (Reframe Health and Justice, personal communication, February 2019). Finally, those who are coerced into the sex trade are not consenting to work but are tricked or forced by another individual(s) (e.g., trafficker, pimp, family member).[28] Trafficking within the sex trade is defined as any form of sexual labor performed under force, fraud, or coercion, or in which the person induced to perform such an act is younger than 18 years of age.[29] Thus, "[a]n individual does not have to be brought in from another country to be a victim of trafficking. Oftentimes, individuals are trafficked by individuals they know, such as a partner or family member."[28] A key informant working with people in the sex trade in Seattle shared unpublished data from interviews conducted in the summer of 2018 in which 49% of interviewees working autonomously within the sex trade at the point of interview reported experiencing force, fraud, or coercion upon entry (Reframe Health and Justice, personal communication, February 2019)

Due to limited data on the sex trade generally, analysts were unable to identify the prevalence of violence against those who could be prosecuted for prostitution under Washington law. Accurately estimating the population involved in the sex trade is challenging because the act of prostitution is illegal. Thus, there is limited incentive for someone in the sex trade to report being the victims of a crime because they can be arrested and prosecuted for prostitution. Such policies severely limit people in the sex trade's access to legal recourse. Therefore, such assaults remain hidden crimes and accurate data assessing the magnitude of those victimized (e.g., violent crimes, assault, rape) in Washington State is unavailable. Multiple key informants shared that criminalization of people in the sex trade fuels coercion by stigmatizing those in the sex trade, which further limits people's options for survival. Data gaps persist, despite growing efforts to train law enforcement and medical professionals to recognize and appropriately respond to people in the sex trade who are victimized.

While analysts were unable to identify any estimates of the adult population involved in the sex trade in Washington, key informants shared some data related to commercially sexually exploited children (trafficking victims). According to a 2008 report, a prevalence estimate of youth being trafficked in the Seattle area was 300-500.[30] However, the study noted that this estimate stems from a review of 1,528 case files and law enforcement reports likely underreport youth being trafficked.[30] Data from April 2014 to June 2018 show that 776 commercially sexually exploited children (CSEC) were identified and referred to services in King County, Washington (King County Prosecuting Attorney's Office [KCPAO], personal communication, February 2019). While more specific data is unavailable, one key informant stated that "hundreds of kids are sexually exploited in Washington" (KCPAO, personal communication, February 2019).

Despite gaps in documentation of violence against people in the sex trade in most parts of the world,[16] limited available evidence indicates that people in the sex trade disproportionately experience violence.[16-18,20,31] For example, a systematic review examining the documented magnitude of violence against sex workers and the factors that shape risk for violence against sex workers included 41 international peer-reviewed studies.[16] Authors found "[e]ver or lifetime prevalence of any or combined workplace violence, physical workplace violence, and sexual workplace violence ranged from 45% to 75% (n = 4 studies; any or combined), 19% to 67% (n = 7; physical), and 14% to 54% (n = 9; sexual) and in the past year ranged from 32% to 55% (n =

3), 19% to 44% (n = 4), and 15% to 31% (n = 3), respectively."[16] Authors note, "[a]ll prevalence estimates came from studies that assessed correlates of violence bivariately or multivariably; studies that included only prevalence estimates were not specifically searched for, and thus this set of studies is an underestimate of the total violence prevalence estimates available in the literature."

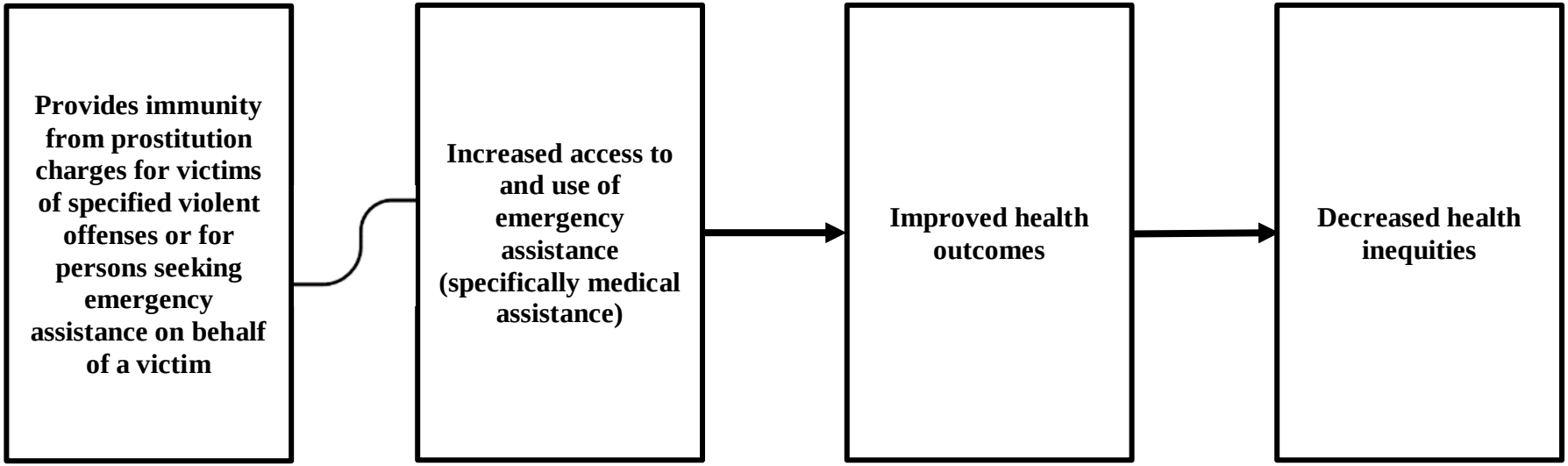
Additionally, a study of 107 female survivors of sex trafficking ages 14 to 60 years of age in the U.S. found that "[n]early all the survivors (92.2%) reported being the victim of at least one form of physical violence."[18] Results show that "[r]espondents reported an average of 6.25 of the 12 forms of violence […] eight of the twelve were reported by half or more of the respondents." See Table 1.

Table 1. Violence and abuse in sex trafficking[18]

Common forms of violence/abuse	% Reporting (N=103)
Some form of violence/abuse	95.1%
Forced sex	81.6%
Punched	73.8%
Beaten	68.9%
Kicked	68.0%
Forced unprotected sex	68.0%
Threatened with weapon	66.0%
Strangled	54.4%
Abused by person of authority	50.5%

While these data provide some indication of the extent to which people in the sex trade experience violence, they likely underestimate the prevalence and effects of violent offenses, assault, and rape for those who can currently be prosecuted for prostitution. We were not able to identify specific data about how many relevant offenses (under RCWs 9.94A.0303, 9A36.031, 9A.36.041, or 9A.44.060) are perpetrated against victims who are or could be charged for prosecution.

Logic Model



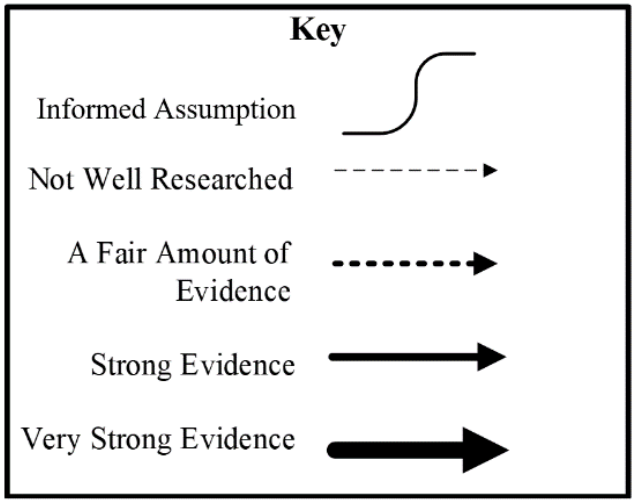


Figure 1

Increasing access to emergency assistance for victims by providing immunity from prosecution for prostitution offenses in some circumstances

HB 1382

Summaries of Findings

Will providing immunity from prosecution for prostitution charges to a victim or person seeking emergency assistance on behalf of a victim in some circumstances increase access to and use of emergency assistance (e.g., medical assistance, law enforcement, 911) among people in the sex trade who are victimized/assist a victim?

Based on conversations with key informants at organizations serving people in the sex trade (i.e., by choice, circumstances, or coercion), individuals with lived experience in the sex trade, and staff at the King County Prosecuting Attorney's Office (KCPAO) and Juvenile Court, we have made the informed assumption that providing immunity from prosecution for prostitution charges to a victim or person seeking emergency assistance on behalf of a victim in some circumstances has the potential to improve access to emergency assistance for people in the sex trade. However, all key informants contacted in the course of this review: 1) addressed policy nuances that may continue to deter people in the sex trade from seeking emergency assistance and 2) highlighted policy implementation as critical to improving access to and use of emergency assistance.

The State of Alaska; King County, Washington; San Francisco, California; and, most recently, the State of California have each implemented policies similar to HB 1382 with the goal of allowing people in the sex trade who are victims of crime to seek law enforcement and medical assistance without fear of prosecution. The rationale underlying each policy is that people in the sex trade are frequently the victims of violent crimes at the hands of pimps, traffickers, and buyers, yet fear of criminal justice involvement prevents victims and witnesses from seeking emergency assistance from law enforcement.[3-6] Moreover, evidence suggests that previous negative experiences with law enforcement and medical personnel as well as fear of stigmatization (e.g., denial of medical care) act as barriers to people in the sex trade seeking emergency assistance.[28,32]

Medical assistance

Evidence in the published literature and anecdotal information from key informants indicates that many people in the sex trade do have some level of access to medical services.[18,20,33] In a 2014 U.S. study of female survivors of domestic sex trafficking (N=107), ranging in age from 14 to 60 years, most survivors reported receiving medical treatment at some point while they were trafficked.[18] Of those who answered the questions about their contact with healthcare (N=98), "87.8% had contact with a healthcare provider while they were being trafficked. By far the most frequently reported treatment site was a hospital/emergency room, with 63.3% being treated at such a facility."[18] Nearly 30% of respondents reported visiting clinical treatment facilities (most commonly Planned Parenthood clinics), and 57.1% had received treatment at some type of clinic (urgent care, women's health, neighborhood, or Planned Parenthood).[18]

However, access to care is not universal and is likely more limited for more marginalized individuals.[20,21,34,35] Two Canadian studies found that "fear of police and police harassment, including arrests, was associated with avoiding healthcare services among street-based cis women and cis and trans women."[34,36] Specifically, a prospective cohort study of 742 street and indoor sex workers in Vancouver, British Columbia, found roughly one-quarter (n=189) reported unmet health needs at least once over the 4-year study period (255 reports of unmet health care

needs out of 2,602 observations).[34] Results indicate that unmet health needs were significantly associated with police harassment including arrest (OR = 1.48; 95% CI 1.13–1.94).[34] Unmet health needs were also significantly associated with lifetime abuse/trauma (OR 1.45; 95% CI 1.10–1.92), recent immigration (i.e. ≤ 5 years) (OR = 2.52; 95% CI = 1.53–4.15) and long-term immigration (i.e., ≥ 5 years) (OR=1.54; 95% CI = 1.00–2.37).[34]

Law enforcement assistance

The long history of mistreatment of people in the sex trade by law enforcement poses a significant challenge to increasing use of emergency services by people in the sex trade. For example, in Seattle/King County, the Coalition on Rights & Safety for People in the Sex Trade (Coalition) conducted its Community Survey on Policy Impacts (2018) with people in the sex trade. The Coalition expects to publish its report on survey findings in spring 2019. A key informant shared unpublished qualitative data from the survey to inform this report. One of the survey questions asked, "Have you ever needed medical, law enforcement, or other emergency assistance for yourself or others while engaging in the sex trade, but hesitated calling 911 for assistance? If so, what are your fears?" (Coalition, personal communication, February 2019). Multiple respondents cited fear of arrest, prison/jail, and/or prosecution as why they have hesitated to or not called 911 for emergency assistance for themselves or others. For example, one respondent shared, "I was raped repeatedly but did not call for help because the last time I was in a similar situations and called 911 the cop took me to jail for prostitution and gave the 'John' a ticket" (Coalition, personal communication, February 2019). Another respondent reported, "I was taken to jail even though i [sic.] was raped they did not take it serious and instead called it prostitution. I will never call the police again ever in the same situation" (Coalition, personal communication, February 2019). Respondents also cited fears of being belittled or not believed, being denied medical help, and of police presence or interference. "The situation can always come back to me," shared one respondent, "my need for assistance doesn't seem to outweigh my crimes to cops" (Coalition, personal communication, February 2019).

The San Francisco Police Department (SFPD) and District Attorney's Office coordinated policies to not arrest or prosecute "persons involved in sex work or other forms of sex trade when they are victims or witnesses of crimes" was adopted after "dozens of Bay Area law enforcement officials were accused of, and some criminally charged with, having sex with an underage sex worker [trafficking victim]."[37] In Washington, data from an unpublished study of individuals working in the outdoor sex market in Seattle found that "50% of [respondents] have experienced police violence while in the sex trade" (Reframe Health Justice [RHJ], personal communication, February 2019). For example, individuals shared experiences in which an officer said they could trade sexual acts to avoid being arrested. After complying, they stated they were arrested (RHJ, personal communication, February 2019). Such experiences align with evidence in other published sources.[19] Moreover, evidence from a systematic review found that multiple measures of policing practices (e.g., arrest, violence, or coercion) remained independently associated with increased violence against sex workers.[16] A study in Britain found that "[s]ex workers who had ever been arrested or imprisoned were more likely to have experienced physical violence by clients."[16] In addition to violence against people in the sex trade perpetrated by law enforcement officials, other key informants shared examples in which law enforcement failed to recognize individuals as victims and to respond appropriately. For instance, a survivor of domestic sex trafficking shared an experience in which an officer stopped

a buyer's car only to tell the perpetrator, "you're lucky I have better things to do" (Real Escape from the Sex Trade [REST], personal communication, February 2019). Interactions like this contribute to harm experienced by people in the sex trade and mistrust of law enforcement.

Staff contacted key informants from the State of Alaska and King County, Washington, to learn whether either jurisdiction had conducted, or knew of, an evaluation to determine whether the policies had increased use of emergency assistance. A key informant from the State of Alaska Department of Law's Criminal Division shared that as of February 8, 2019 he was not aware of any such analysis (Criminal Division, State of Alaska Department of Law, personal communication, February 2019). Similarly, key informants at the KCPAO shared that it's difficult to measure the effectiveness of the policy specifically (e.g., no survey or questionnaire for victims, lack before and after data) as the County has intentionally shifted to prosecuting patronizing charges rather than prostitution charges (KCPAO, personal communication, February 2019). In 2009, people in the sex trade faced charges in King County more than 2.5 times as often as people who bought sex from them.[38] "By 2016, those buying sex faced charges nearly 5 times as often as those in the sex trade."[38] Due to time limitations, Board staff was unable to contact the SFPD or District Attorney's Office regarding the effectiveness of policies implemented in January 2018. Staff did not contact the State of California regarding the new law as it took effect approximately one month prior to this analysis.

Some key informants hypothesized that policies preventing prosecution for prostitution could result in decreasing arrests for prostitution over time, which could further reduce concerns about criminal justice involvement as a deterrent from seeking emergency assistance. At the recommendation of a key informant working with trafficking victims and survivors in King County, analysts contacted the King County Juvenile Court (KCJC) about the effectiveness of the county's policy to not charge youth for prostitution. As with the other policies, no formal evaluation has been conducted to review the policy due to challenges related to collecting data and lack of funding. According to staff, King County has not charged a youth with prostitution since 2014, and arrests of youth for prostitution in the county are trending downward (KCJC, personal communication, February 2019). Referrals to services are increasing, yet there is no evidence the two are correlated (KCJC, personal communication, February 2019).

Without specific data to assess the effectiveness of the policies implemented in Alaska, King County, and San Francisco, staff discussed policy nuances with key informants to determine whether the policy outlined in HB 1382 has the potential to increase access to and use of emergency assistance among people in the sex trade. The majority of key informants believe the policy has the potential to be a positive step in reducing barriers to accessing emergency assistance for people in the sex trade. However, all stressed that how the policy is implemented will determine whether the change actually increases use of services and reporting crimes among this population.

Multiple key informants noted that limiting immunity from prosecution for prostitution to specific types of victimizations is impractical because it places the onus on victims and those assisting victims to know whether or not the crime experienced qualifies for immunity. Key informants also expressed concern that people in the sex trade who come forward to report being a victim of a crime could still be prosecuted for misdemeanor drug offenses. This is of concern

because evidence indicates elevated use of drugs or alcohol among those in the sex trade,[17,18,20] particularly among those experiencing coercion (i.e., forced substance use by traffickers as a control mechanism or use as a means of coping with the immense abuse they suffered).[18] Moreover, another key informant expressed concern that miscommunication about policy nuances (e.g., specific victimizations are eligible for immunity; immunity for prosecution but not detainment or arrest) may undermine HB 1382's effectiveness. For example, if people in the sex trade understand the policy as protecting victims from prostitution charges, but they learn by word-of-mouth that someone was arrested when they reported a crime it is likely to result in people not trusting the policy and therefore not accessing services (RHJ, personal communication, February 2019).

As the first policy implemented it the U.S., Alaska's policy details victimizations eligible for immunity and requires cooperation with law enforcement personnel.[3] The more recently implemented policies attempt to address some of the above concerns. The KCPAO policy does not limit immunity to victims of specific crimes (KCPAO, personal communication, February 2019) and was intentionally written to be broadly interpreted to protect victims of crime.[4] While the San Francisco "Prioritizing Safety for Sex Works" policies do list eligible victimizations, the policies cover a broader set of victimizations, including violence by law enforcement officials.[6,37] Specifically, "[a]ny officer misconduct against sex workers, including retaliation, coercion or coercive intimate acts, is subject to disciplinary and/or criminal action."[6]

Additionally, as evidence indicates that criminal justice broadly (e.g., detainment, arrest, jail, prosecution) acts as a barrier to seeking emergency services, San Francisco's policies state that law enforcement officials will not arrest and the District Attorney's Office will not prosecute persons for involvement in sex work or other forms of sex trade when they are victims or witnesses of specified violent crimes.[5,6] This is the first policy to explicitly protect against both arrest and prosecution. In addition to protecting against arrest and prosecution for charges related to prostitution (i.e., solicitation and prostitution, lewd conduct, public nuisance, and loitering for the purpose of engaging in prostitution), the policies also provide immunity for misdemeanor drug offenses.[5,6] Moreover, the policies state that SFPD and the District Attorney's Office will refer those in the sex trade reporting violent crimes to community based organizations that serve sex workers.[6]

Multiple key informants identified community involvement (e.g., survivors of trafficking, people in the sex trade, community based organizations serving people in the sex trade) as essential to successfully increase use of emergency assistance among people in the sex trade. One key informant noted that San Francisco had leveraged community input to develop and implement its policies (RHJ, personal communication, February 2019). "From 2014 to 2017, the San Francisco Department on the Status of Women formally mediated intensive discussions between the SFPD, sex workers, and other community stakeholders."[39] For example, the policies explicitly address the need for "a training program on sex work and crimes against sex workers to ensure that this [policy] is implemented in a manner that furthers the goals of the reporting of violent crimes and building trust and rapport with this community."[6] It also states "[t]he training shall be developed and implemented in collaboration with community based organizations that serve sex workers."[6]

Key informants agree that communication of the policy change to law enforcement officials, prosecutors, people in the sex trade, organizations serving people in the sex trade, and medical personnel is critical to meaningfully increase use of emergency assistance among those in the sex trade who are victimized. One key informant suggested that the Washington State Department of Commerce's Office of Crime Victim Advocacy could play a role in facilitating the planning and provision of training for service providers in criminal justice, social service, and medical systems as it has specific to human trafficking,[40] as could county-based commercially sexually exploited children (CSEC) task forces (KCPAO, personal communication, February 2019). Key informants who work directly with people in the sex trade or who are survivors themselves desire meaningful involvement in developing an implementation plan (e.g., communication, training, trial, evaluation) to ensure those who contact emergency services to report crimes and access services are treated with dignity, receive the services they request (e.g., medical attention, opportunity for intervention, law enforcement assistance), and are taken seriously (e.g., the crimes reported are investigated and perpetrators held accountable).

Based on conversations with key informants, we would expect that providing immunity from prosecution for prostitution charges to victims or persons seeking emergency assistance on behalf of victims in some circumstances has the potential to improve access to emergency assistance for at least a subset of people in the sex trade. The magnitude of people affected by this policy change will depend on the nuances discussed in this section.

Will increasing access to and use of emergency assistance (i.e., medical assistance) for people in the sex trade who are victimized/assist a victim improve health outcomes for these victims of violent offenses?

There is strong evidence that increased access to and utilization of emergency assistance would improve health outcomes for people in the sex trade who are victims of violent offenses (e.g., rape and assault).[9-15] The strength of evidence for this research question focuses only on the literature related to medical assistance (access to and use of), as it is the most direct pathway to health. The limited available evidence examining interactions between law enforcement and people in the sex trade focus on health outcomes related to repressive policing practices;[36] therefore, analysts deemed this evidence not generalizable to use of emergency assistance.

There is a large body of evidence supporting the positive association between utilization of health services for the early detection and treatment of physical and mental health disorders[41] and improved health outcomes. There is strong consensus in the scientific literature supporting this association, therefore we are providing only a few examples here. A study by the expert panel from the U.S. Preventive Services Task Force found evidence to support that screening tests for HIV are accurate and that antiretroviral therapy (ART) reduces the risk death and sexual transmission of HIV.[11] Note that this does not indicate that all treatments are effective, but rather that there is a very large body of evidence supporting that evidence-based treatments are available.

Victims of sexual assault are at risk of unintended pregnancy, sexually transmitted infections, and mental health conditions.[9] Despite these risks, estimates suggest that only 17% to 43% of victims of rape, generally, seek medical treatment after rape, and 33% of victims of rape never disclose the assault to their primary care provider.[13] Furthermore, evidence indicates that two-

thirds of victims of rape who report to the emergency department report general body trauma.[13] The American College of Obstetricians and Gynecologists (ACOG) recognize acute medical consequences of sexual assault, including injuries ranging from scratches to fractures, head and facial trauma, lacerations, bullet wounds, and death.[9] Long-term health effects include chronic pelvic pain, dysmenorrhea, sexual dysfunction, and psychologic and mental health concerns.[9]

There is strong consensus that immediate medical and psychological care for patients seeking care in emergency settings after sexual assault directly impacts the patient's well-being and contributes to the beginning stages of the healing process.[9,10,12-15] Specifically, time-sensitive care includes "assessing, treating and documenting injuries, identifying risks and providing preventive treatment for negative health outcomes associated with sexual assault including exposure to infection, unintended pregnancy, and long term psychological and physical sequelae..."[12] Moreover, medical follow-up is also required, especially as "long-term manifestations of sexual assault include diminished quality of life, an altered perception of one's health, decreased overall functional status, nonspecific genital symptoms, depression, chronic pelvic pain, and sexual dysfunction."[10] Long-term mental health concerns may include Posttraumatic Stress Disorder (PTSD) and substance use.[9]

Although medical personnel likely treat and interact with patients in the sex trade, evidence suggests that providers are not confident in their ability to recognize and appropriately respond to the health needs of their patients in the sex trade.[31,42] For example, one key informant shared anecdotal evidence that providers often recognize signs of repeat physical and sexual violence but are unsure about how to appropriately respond (Seattle Against Slavery, personal communication, February 2019). Evidence from a 2018 study in Australia indicates that emergency clinicians report "low levels of perceived self-efficacy, and infrequent use of guidelines and tools to support the care of intoxicated women victims of violence."[43] Results show "statistically significant relationships between use of best practice tools (n=32) and knowledge ($\chi 2=6.52$; p=.02) and confidence ($\chi 2=6.52$; p=.02) treating women victims of violence."[43]

The literature reviewed examines the influence on health care access and utilization on patient health outcomes broadly and those specific to sexual assault. The literature pertaining specifically to people in the sex trade: 1) does not assess the relationship between access to care and health outcomes and 2) highlights challenges this population faces when accessing medical care (e.g., stigmatization and lack of medical personnel trained to provide appropriate, trauma-informed, rights-based care).[31,42-44] For these reasons and the purpose of this analysis, we have downgraded the strength-of-evidence to strong evidence rather than very strong evidence.

Thus, there is strong evidence that increasing access to and use of emergency assistance (specifically medical assistance) would improve health outcomes for people in the sex trade who are victims of violent offenses.

Will improving health outcomes for people in the sex trade who are victims of violent offenses impact health inequities?

There is strong evidence that improving health outcomes for people in the sex trade who are victims of violent offenses would likely decrease health inequities experienced by this

population. A growing body of evidence demonstrates that people in the sex trade experience disproportionately high rates of violence and abuse.[16-21] Evidence indicates such exposure to violence is associated with physical[18,20] and mental[17-20] health issues, both acute and chronic, and substance use.[17,18,20]

Evidence indicates that people in the sex trade experience high prevalence of workplace violence.[15-20] For example, 34% of female sex workers in Miami (N=562) reported violent encounters with 'dates' or clients in the previous 90 days.[17] Similarly, a systematic review of 41 international peer-reviewed articles, included 105 estimates of the overall prevalence of workplace violence committed against sex workers (i.e., violence committed within the context of sex work, such as by police, clients, pimps, madams, etc.).[16] Estimates of ever or lifetime prevalence ranged from: 45% to 75% for any or combined workplace violence (n = 4 studies); 19% to 67% for physical workplace violence (n = 7); and 14% to 54% for sexual workplace violence (n = 9).[16] Furthermore, prevalence estimates of violence in the past year ranged from: 32% to 55% for any or combined workplace violence (n = 3 studies); 19% to 44% for physical workplace violence (n = 4); and 15% to 31% for sexual workplace violence (n = 3).[16] Authors note that this set of studies is an underestimate of the total violence prevalence estimates available in the literature.[16]

Physical health problems related to violence experienced within the sex trade are extremely common.[18,20] Physical health outcomes reported by people in the sex trade include: injuries, most commonly to the head or face;[15,18,20] traumatic brain injury;[20] sexually-transmitted disease or infection (STD/STI); other gynecological symptom (e.g., pain during sex, urinary tract infections, and vaginal discharge);[18] rape, pregnancy, miscarriage, and abortion.[18,20] Specifically, a study of survivors of domestic sex trafficking found more than half of survivors who underwent one or more abortions while being trafficked reported that one or more of their abortions was at least partially forced upon them.[18]

In addition to physical trauma, evidence indicates high rates of mental and behavioral health issues among people in the sex trade.[17,18,20] Commonly reported mental health outcomes/symptoms included depression,[17,18,20] anxiety,[17,18,20] nightmares,[18] flashbacks,[18] low self-esteem,[18] feelings of shame or guilt,[18] suicide attampts,[18,19] and Posttraumatic Stress Disorder (PTSD).[18,19] For example, study of AI/AN women in the sex trade found that, based on responses, 52% of the women met all criteria for a diagnosis of PTSD (compared to an 8% prevalence rate in the general U.S. population).[20] Evidence also suggests elevated use of drugs or alcohol among those in the sex trade,[17,18,20] Substance use was particularly high among trafficking victims "either because the substances were forced on them as a control mechanism by their traffickers or because substance use was a means of coping with the immense abuse they suffered."[18]

Evidence indicates that "[p]articipation in the sex trade is often higher among those who have faced family rejection, poverty, or unequal opportunities in employment, housing, and education."[19] According to a U.S. Department of State Report, populations that are particularly vulnerable to domestic trafficking include "children in the child welfare and juvenile justice systems; runaway and homeless youth; [AI/AN]; migrant laborers, including participants in visa programs for temporary workers; foreign national domestic workers in diplomatic households;

persons with limited English proficiency; persons with disabilities; and LGBTI individuals."[45] A key informant at one King County-based organization serving people in the sex trade shared, "of the 716 clients we served in 2018, 68% are LGBTQ" (REST, personal communication, February 2019).

Inequities by gender identity

Key informants shared that as a result of marginalization within broader society and limited employment opportunities, transgender people disproportionately work in the underground economy, including the sex trade. The 2015 U.S. Transgender Survey (USTS) is the largest survey examining the experiences of transgender people in the U.S., with 27,715 respondents.[19] Overall, survey responses show that 12% of USTS respondents "have done sex work in exchange for income—and 9% did so in the past year."[19]

Evidence indicates that transgender people who have done sex work experience high rates of negative mental and physical health outcomes, police abuse, and experiences of violence.[19] Respondents who interacted with the police either "while doing sex work [1%] or while the police mistakenly thought they were doing sex work [2%] reported high rates of police harassment, abuse, or mistreatment, with nearly nine out of ten (86%) reporting being harassed, attacked, sexually assaulted, or mistreated in some other way by police."[19] Within this context, more than half (57%) of all USTS respondents said they would feel uncomfortable asking the police for help if they needed it.[19]

Transgender people in the sex trade experience health inequities related to experiences of violence. For example, lifetime suicide attempts were higher for those who have done sex work (57%), been sexually assaulted (54%), or who were physically attacked in the past year (65%).[19] Additionally, "[t]he rate of HIV was more than […] five times higher among those who have participated in sex work at any point in their lifetime (7.9%)."[19]

Inequities by race/ethnicity

Key informants also shared that people of color are disproportionately represented in the sex trade and experience high rates of violence. Specifically, multiple key informants identified high rates of violence committed against transgender women of color as a health inequity.

In 2018, the Urban Indian Health Institute released its Missing and Murdered Indigenous Women and Girls report in which it identified 506 cases of missing and murdered American Indian and Alaska Native women and girls across 71 selected cities. Of those 506 unique cases detailed in the report, "18 victims (4% of all cases) were identified as sex workers or victims of trafficking." UIHI found that "39% of victims in the sex trade were sexually assaulted at the time of death."[46] In the Minnesota study of AI/AN women in the sex trade, 42% of respondents reported being racially insulted by sex buyers or pimps.[20] Women reported that racial/ethnic prejudice is integral to prostitution, and a majority saw connections between colonization and prostitution of AI/AN women.[20]

Because people in the sex trade experience high prevalence of violence generally, improving health outcomes for those who are victims of violent offenses would likely decrease health inequities experienced by this population. Additionally, as transgender people and people of

color are disproportionately represented in the sex trade and experience high rates of violence, improving health outcomes for people in the sex trade would also likely also reduce health inequities by gender identity and race/ethnicity.

Annotated References

1. **Rape, Abuse & Incest National Network Key Terms and Phrases. 2019; Available at: https://www.rainn.org/articles/key-terms-and-phrases. Accessed February, 2019.**
RAINN (Rape, Abuse & Incest National Network) is the largest anti-sexual violence organization in the United States. The organization's webpage provides recommendations about respectful language choice when discussing sexual assault.

2. **Community Survey for Policy Changes to Protect Rights & Safety. 2018; Available at: http://www.rightsandsafety.org/projects/survey/. Accessed February 2019.**
The Coalition for Rights & Safety for People in the Sex Trade, is a network of more than 12 community groups in the Seattle/King County area. Members promote "self-determination, safety, well-being, and human rights of sex workers and people engaged in the sex trade through public education, policy advocacy, and other activities from empirical, harm reduction, and social justice perspectives." In 2018, the Coalition conducted the Community Policy Change Survey to amplify the voices of people in the sex trade directly impacted by policies enacted in Washington. The full report will be available in spring 2019.

3. **Enrolled Senate Bill 91, 11.66.100 Alaska State, §36 (2016).**
In 2016, the Alaska State legislature enacted a criminal justice reform bill (Enrolled Senate Bill 91). One portion of the law states that individuals cannot be prosecuted for prostitution if they report being a victim or witness of violent crimes, including sex trafficking, assault, and robbery.

4. **Larson Mark. Filing Standard for Prostitution and Prostitution Loitering Cases. In: King County Prosecuting Attorney's Office CD, ed. 24 April 2017 ed. Seattle, Washington2017.**
This memorandum from the King County Prosecuting Attorney's Office to King County Law Enforcement Agencies establishes the filing standard for prostitution and prostitution loitering cases. It acknowledges that persons engaged in prostitution are frequently victims of violent crime at the hands of pimps, traffickers, and buyers. Additionally, it recognizes that fear of being charged with prostitution is a barrier for people in the sex trade from seeking help from law enforcement officials. The policy covers victims and persons reporting crimes from prosecution. The policy does not detail specific crimes, which allows it to be interpreted broadly.

5. **Gascón George. Prioritizing Safety for Sex Workers. In: Attorney OotD, ed. San Francisco, California: City and County of San Francisco.**
This letter from the San Francisco District Attorney's (DA) Office outlines the office's 2018 policy Prioritizing Safety for Sex Workers. "In order to create an environment where individuals who are victims or witnesses of violent crime are able to come forth to report violence [...] [t]he [DA]'s Office will not prosecute persons for involvement in sex work or other forms of sex trade when they are victims or witnesses of sexual assault, human trafficking, stalking, robbery, assault, kidnapping, threats, blackmail, extortion, burglary or other violent crime." Specifically, "persons will not be prosecuted for uncharged offenses Penal code §§ 647(a), 647(b), 653.22, 372, and misdemeanor drug offenses, when reporting" the previously listed crimes. Moreover, "Information gathered from a victim or witness of a violent crime who is engaged in sex work or other forms of sex trade including trafficked persons will not be used in any manner to

investigate and prosecute that person, during the course of the investigation or in the future." Additionally, "[i]mmigration status will not be used by the [DA] against victims and witnesses of violent crime in any way," but may assist "with the application for immigration relief that would benefit the victim or witness." Finally, the policy states the DA's Office will work collaboratively with the San Francisco Police Department and Sheriff's Department on training to implement the polices; the training shall be developed and implemented in collaboration with community based organizations that serve sex workers.

6. **Scott William. Prioritizing Safety for Sex Workers. In: Department SFP, ed. Vol A. 12/19/2017 ed. San Francisco, California: San Francisco Police Department; 2017.**
This San Francisco Police Department (SFPD) Bulletin established guidelines for officers who encounter a sex worker who is a victim or witness of a violent crime and/or who may be subject to arrest. The bulletin acknowledged that: 1) sex workers are vulnerable to violence and face barriers in reporting violent crimes to law enforcement in San Francisco, 2) the criminalization of sex work is one of the primary barriers to reporting violence to law enforcement, and 3) sex workers report fear of arrest as a barrier to reporting violent crimes. To help create a climate where all victims and witnesses, regardless of age (juvenile and adult), have equal access to reporting such crimes, the SFPD and the District Attorney's Office (DA) developed complementary policies for persons of any age engaged in sex work and other forms of sex trade who experience or witness violent crimes. The bulletin states, "members will not arrest persons for involvement in sex work or other forms of sex trade when they are victims or witnesses of sexual assault, human trafficking, stalking, robbery, assault, kidnapping, threats, blackmail, extortion, burglary or other violent crime." Moreover, "members will not arrest persons for offenses including California Penal Code sections 647(a), 647(b), 653.22, 372 and misdemeanor drug offenses, when they report being the victim or witness of" one of the previously mentioned crimes." If a misdemeanor drug offense occurs, and the violator reports being a victim or witness, as described above, "officers shall seize and book evidence as appropriate and document the circumstances of the contact in an incident report. This will facilitate a referral of the case to the District Attorney's Office for a warrant consideration." Officers are also directed to refer sex workers reporting violent crimes to community resources and Victim Services in the District Attorney's Office. The Department is to collaborate with community based organizations that serve sex workers regarding referral cards and training. Additionally, members shall notify the Special Victims Unit when someone identifies them self as a victim or witness.

7. **Assembly Bill No. 2243 Evidence: admissibility, Chapter 27, Statutes of 2018 Evidence Code(2018).**
California Assembly Bill 2243 was signed into law on June 13, 2018, and became effective January 1, 2019. The bill provides immunity from prosecution for prostitution to people in the sex trade who come forward to report serious crimes (i.e., as victim of or witness to) including extortion (Section 519 of the Penal Code), stalking (Section 646.9), violent felony (Section 667.5).

8. **Governor Signs Friedman Bill to Encourage Crime Reporting [press release]. 14 June 2018 2018.**
This press release announces that California Assembly Bill 2243 was signed into law and becomes effective on January 1, 2019. The legislation provides immunity to victims and witness

of specific crimes from being prosecuted for prostitution, codifying a common practice. The document cites a study conducted by the University of California, San Francisco and St. James Infirmary, which found "over 60% of sex workers face some form of assault while engaged in sex work - 32% report physical assault, while 29% reported sexual assault."

9. **American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women. Committee Opinion: Sexual Assault.2014 (Reaffirmed 2016).**
Victims of sexual assault are at risk of unintended pregnancy, sexually transmitted infections, and mental health conditions. The American College of Obstetricians and Gynecologists (ACOG) recognize acute medical consequences of sexual assault, including injuries ranging from scratches to fractures, head and facial trauma, lacerations, bullet wounds, and death. Long-term health effects include chronic pelvic pain, dysmenorrhea, sexual dysfunction, and psychologic and mental health concerns. ACOG states that victims of sexual assault may experience rape-trauma syndrome, which includes general pain, sleeping and eating disturbances, a range of emotional reactions, flashbacks, nightmares, phobias, and somatic and gynecologic symptoms. Long-term mental health concerns may include Posttraumatic Stress Disorder (PTSD) and substance use. ACOG recommends that healthcare providers routinely screen all women for a history of sexual assault, and healthcare providers should offer victims both emergency contraception and sexually transmitted infection prophylaxis. They write, "[e]arly identification of victims of sexual assault can lead to prevention of long-term and persistent physical and mental health consequences of abuse."

10. **Vrees R.A. Evaluation and Management of Female Victims of Sexual Assault. *Obstetrical and Gynecological Survey.* 2017;72(1):39-53.**
Vrees outlines clinical and forensic components of the initial evaluation of victims of sexual assault, outlines counseling and treatment needs, and discusses immediate and long-term sequelae following sexual assault. She cites previous evidence showing that, "immediate consequences for survivors include physical injury, infection, unintended pregnancy, and emotional states such as hysteria, dissociation, and amnesia. Long-term outcomes include sexual dysfunction, depression, anxiety, pelvic pain, posttraumatic stress disorder, chronic headaches, and even suicide." The author notes that medical and psychological treatment and support are important following sexual assault. She writes, "in the setting of complex social issues and acute psychological ramifications, trained patient advocates and social workers provide an important immediate support role to survivors of sexual assault and can provide immediate crisis intervention, counseling and ongoing support services including legal advocacy, assistance with crime victim compensation, and long-term services." She notes that time sensitive care is required for emergency contraception, sexually transmitted disease prevention, and post assault follow-up. Nationally, the rape-related pregnancy rate for women aged 12-45 years is 5%. Medical follow-up is also required, especially as "long-term manifestations of sexual assault include diminished quality of life, an altered perception of one's health, decreased overall functional status, nonspecific genital symptoms, depression, chronic pelvic pain, and sexual dysfunction." She concludes, "this review highlights the importance of prompt medical screening and evaluation for all survivors of sexual assault, as well as coordination of follow-up care, regardless of whether forensic evidentiary evaluation occurs." Future research is needed to determine the efficacy and uptake of sexually transmitted infections prophylaxis and ongoing sexual health screening among victims and survivors of sexual assault.

11. **R Chou, S Selph, T Dana, et al. Screening for HIV: systematic review to update the U.S. Preventive Services Task Force recommendation. Evidence synthesis No. 95.** ***Agency for Healthcare Research and Quality.*** **2012.**
The U.S. Preventive Services Task Force (USPSTF) is an independent panel of experts who systematically reviews the evidence and provides recommendations that are intended to help clinicians, employers, policymakers, and others make informed decisions about health care services. This review, which focused on benefits and harms of screening for Human Immunodeficiency Virus (HIV) in adolescents and adults, included randomized clinical trials and observational studies. Findings indicate that screening for HIV is accurate, screening only targeted groups misses a large number of cases, and that antiretroviral therapy (ART) reduces the risk of death and sexual transmission of HIV.

12. **Bush K. Joint Position Statement: Adult and Adolescent Sexual Assault Patients in the Emergency Care Setting. Emergency Nurses Association, International Association of Forensic Nurses;2016.**
The Emergency Nurses Association (ENA) and the International Association of Forensic Nurses (IAFN) issued a joint statement that patients seeking care in the emergency setting after sexual assault "receive patient-centered and trauma-informed care that addresses their medicolegal and psychosocial needs." They note that, "immediate medical and psychological care directly impacts the patient's well-being and contributes to the beginning stages of the healing process." Care includes "assessing, treating and documenting injuries, identifying risks and providing preventive treatment for negative health outcomes associated with sexual assault including exposure to infection, unintended pregnancy, and long term psychological and physical sequelae..." The statement also notes, "to reduce further re-victimization by providing prompt care and overall better services, patients should be referred to clinicians with education and experience in systematically managing this population."

13. **Linden J. Care of the Adult Patient after Sexual Assault.** ***New England Journal of Medicine.*** **2011;365(9):834-841.**
Linden provides a case vignette for a 20 year old women presenting to the emergency department for sexual assault. Estimates suggest that only 17% to 43% of rape victims seek medical treatment after rape, and 33% of rape victims never disclose the assault to their primary care provider. Overall, two-thirds of rape victims who report to the emergency department report general body trauma, including attempted strangulation; traumatic injuries to the head, face, torso, or limbs; lacerations, abrasions, and bruises; bite marks; and penetrating injuries. Genital trauma is less reported, and anogenital injuries may not be evident after assault. Timely medical care is necessary to provide emergency contraception and prophylaxis for sexually transmitted infections, including gonorrhea, chlamydia, trichomoniasis, Hepatitis B, and HIV. Rape-related pregnancy rates are 5%, and efficacy of emergency contraception decreases after 72 hours. In addition to medical care, victims of sexual assault should also receive emotional and mental health support. Linden cites prior evidence that sexual assault survivors are at an increased lifetime risk for posttraumatic stress disorder, major depression, and contemplation or actual attempt of suicide as well as increased risk of chronic medical problems like chronic pelvic pain, fibromyalgia, and gastrointestinal disorders. All rape victims should be referred for medical follow-up and psychiatric support. The author notes that there is unclear evidence about the use

of HIV-postexposure prophylaxis for rape victims as well as uncertainty about the role of different types of psychotherapy interventions. However, "limited data support a potential benefit of the early initiation of cognitive behavioral therapy, which involves education of the patient about normal reactions to assault, relaxation training, recounting of the experience, exposure to feared (but safe) stimuli, and cognitive restructuring. In one randomized trial, women who were assigned to receive early cognitive behavioral therapy after sexual assault had a significantly greater reduction in self-reported symptoms of PTSD after the intervention than did those receiving only supportive counseling." Linden notes that the Department of Justice, American College of Emergency Physicians, and the World Health Organization all have guidelines for the treatment of patients after sexual assault.

14. **Organization World Health. Guidelines for medico-legal care for victims of sexual violence.2003.**

The World Health Organization provide guidelines for health care professionals to care for victims of sexual assault. As part of these guidelines, they provide treatment and follow-up care guidelines for victims and survivors of sexual assault related to physical injuries, pregnancy prevention and management, sexually transmitted infections, HIV/AIDS, Hepatitis B, patient information, and follow-up care, including medical, counseling and social support, and referrals. They specify that, "patients with severe, life-threatening conditions should be referred for emergency treatment immediately" and "all patients should be offered access to follow-up services, including a medical review at 2 weeks, 3 months, and 6 months post-assault, and referrals for counseling and other support services."

15. **Cybulska B. Immediate medical care after sexual assault. *Best Practice & Research Clinical Obstetrics and Gynaecology.* 2013;27:141-149.**

Cybulska notes nine components of immediate medical care after sexual assault, including: 1) assuring safety and privacy; 2) treating minor and major injuries; 3) managing intoxication or withdrawal from alcohol and drugs; 4) managing medical emergencies (e.g. panic attacks, diabetic symptoms); 5) identifying risk of preventing pregnancy, sexually transmitted infections, self-harm, and suicide; 6) referring for sexual health screening, counseling, and mental health treatment; 7) providing referrals for children and vulnerable adults; 8) providing practical support (e.g. housing); and 9) providing referrals to voluntary agencies. Cybulska notes that most victims of sexual assault, "have no injuries on genital examination. The vast majority of [victims] of rape have extragenital injuries found of which head injury is the most dangerous and may require hospital admission...Major injuries, including head injuries, deep open wounds that require suturing, heavy pelvic bleeding, and rectal bleeding should be investigated and treated in an emergency department of a hospital." The author also note that part of immediate medical care should be the intent to safeguard children and vulnerable adults. Cybulska notes, "systems should be in place to assure risk assessment and referrals to social care. Other vulnerable groups include sex workers, trafficked women, alcohol, illicit drug users, or both, and [people of color]. Access to services and reporting may be delayed or may never happen, as a result of chaotic lifestyle as well as language and cultural barriers. Building trust and rapport is needed to facilitate appropriate care." Overall, the author concludes, "what happens to the victim of sexual assault immediately after the incident may affect the individual's recovery from it, both in physical and psychological terms. Immediate medical and psychosocial care, alongside recovery of forensic evidence and documentation of injuries, affects the well-being of the victims, and

recovery from rape and sexual assault and represents an important part of the beginning of the healing process."

16. **Deering Kathleen N., Amin Avni, Shoveller Jean, et al. A Systematic Review of the Correlates of Violence Against Sex Workers.** ***American Journal of Public Health.*** **2014;104(May 2014):e42-e54.**

Deering et al. conducted a systematic review to examine the documented magnitude of violence against sex workers and to review the factors that shape risk for violence against sex workers. Authors included articles examining "the prevalence and correlates of violence against sex workers (i.e., violence as an outcome) by using quantitative, multivariable methods, published in peer-reviewed journals." Twenty-eight studies met inclusion criteria and were included in the primary analysis on correlates of violence. An additional 14 studies contributed violence prevalence estimates only. Six studies were from North America (Canada, United States, Mexico), while 27 were from Asia, 3 from Central and Western Europe, 2 from Central Africa, and 1 from each of the Middle East, Latin America, Russia, and South Africa. Overall, studies were diverse according to perpetrator, type of violence, and timescale over which respondents were asked to estimate violent acts occurring. Thirty-seven studies were of female sex workers only, 3 studies included female and transgender women sex workers, and 1 study of transgender sex workers only. There were no studies of male sex workers. The 41 articles included 105 estimates of overall prevalence of various violence measures. Specifically, prevalence of "ever or lifetime of any or combined workplace violence, physical workplace violence, and sexual workplace violence ranged from 45% to 75% (n = 4; any or combined), 19% to 67% (n = 7; physical), and 14% to 54% (n = 9; sexual) and in the past year ranged from 32% to 55% (n = 3), 19% to 44% (n = 4), and 15% to 31% (n = 3), respectively."

17. **Surratt Hilary L., Kurtz Steven P., Chen Minxing, et al. HIV risk among female sex workers in Miami: The impact of violent victimization and untreated mental illness.** ***AIDS Care.*** **2012;24(May):553-561.**

Surratt et al. used targeted sampling to enroll 562 Miami-based female sex workers into an intervention trial testing the relative effectiveness of two alternative case management conditions in establishing linkages with health services and reducing risk for HIV. "Lifetime prevalence of abuse was extremely elevated at 88%." Nearly half reported abuse before the age of 18 years, "while 34% reported violent encounters with 'dates' or clients in the past 90 days." Additionally, 74% reported severe symptoms of depression, anxiety, or traumatic stress.

18. **Lederer Laura J., Wetzel Christopher A. The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities.** ***Annals of Health Law.*** **2014;23:61-91.**

Lederer et al. used a mixed-methods approach to collect data from female survivors of sex trafficking. Authors combined qualitative data collection from focus groups and structured interviews with quantitative analysis. Following a feasibility study (one focus group in November of 2011), researchers conducted a series of 11 similar focus groups in U.S. cities from January 2012 to December 2012. Focus groups included 107 participants, all survivors of domestic sex trafficking, ranging in age from 14 to 60 years of age. Following focus group sessions that discussed a range of topics (early childhood trauma, age at which trafficked, etc.) survivors completed an extensive health survey. The survey included three components. First,

survivors reported on more than 100 discrete health conditions (e.g., general health, communicable and non-communicable diseases, dental health, psychological symptoms and disorders, and reproductive health) and violence experienced during trafficking—physical abuse (i.e. beaten, punched, kicked, raped, penetrated with foreign objects, threatened with a weapon, burned with cigarettes, strangled, stabbed, slashed, or forced to have unprotected sex) and other ways they were violated (e.g., participate in pornography, recreate scene from pornographic material, or submit to abuse by a person in authority). Second, they completed a series of open-ended questions about health care (e.g., access to and use of birth control, types of medical treatment sought and whether providers asked or knew about their situations, and reproductive history). Third, they answered questions regarding symptoms experienced after escaping trafficking (i.e., physical and psychological symptoms). Authors analyzed "the frequency with which individual symptoms and experiences were reported by the survivors in this study as well as the percentages of victims who reported at least one symptom or experience in a given category." Out of 106 survivors (one participant did not complete the first survey component), 105 (99.1%) reported at least one physical health problem during trafficking. "The most frequently reported physical problems were neurological—91.5% of respondents reported at least one neurological symptom and 82.1% specifically reporting memory problems, insomnia, or poor concentration." Survivors reported headaches or migraines (53.8%), dizziness (34.0%), severe weight loss (42.9%), malnutrition (35.2%), loss of appetite (46.7%), eating disorders (36.2%). Overall, 71.4% of respondents reported at least one diet-related symptoms. Moreover, nearly 70% reported physical injuries, most commonly to the head or face. Respondents also experienced symptoms not conventionally associated with sexual abuse including, cardiovascular or respirator difficulty (67.9%), gastrointestinal symptoms (61.3%), and dental problems (54.3%). In addition to physical trauma, 98.1% of survivors (104/106) surveyed reported at least one psychological issue while being trafficked, and survivors noted an average of more than a dozen symptoms (12.11). "The most frequently reported problems included depression (88.7%), anxiety (76.4%), nightmares (73.6%), flashbacks (68.0%), low self-esteem (81.1%), and feelings of shame or guilt (82.1%) [...] 41.5% had attempted suicide (one victim reported 9 such attempts) and 54.7% suffered from Post Traumatic Stress Disorder." Overall, the psychological consequences that the victims of trafficking in these focus groups reported were "wide-ranging, severe, and in some cases nearly universal." When reporting on their health experiences after trafficking, "96.4% of survivors reported at least one psychological symptom and an average of 10.5." More than two-thirds of women (67.3%) contracted some form of sexually-transmitted disease or infection (STD/STI). "Survivors reported significantly higher rates of chlamydia (39.4%) and gonorrhea (26.9%) than the next most common disease (Hepatitis C, 15.4%)." Furthermore, 63.8% reported at least one gynecological symptom other than STDs/STIs, with pain during sex (46.2%), urinary tract infections (43.8%), and vaginal discharge (33.3%) among the most common symptoms. Authors note, "[o]n average, respondents reported being used for sex by approximately 13 buyers per day, with a median of 10. Some respondents reported typical days of as many as a thirty to fifty buyers." Despite reporting complications related to pregnancies and their results, authors conclude with confidence that pregnancy, miscarriage, and abortion were all common experiences for survivors in the study. Specifically, more than half of survivors who underwent one or more abortions while being trafficked reported that one or more of their abortions was at least partially forced upon them. One victim noted that "in most of [my six abortions,] I was under serious pressure from my pimps to abort the babies." When asked about experiences of violence or abuse, respondents reported an average of 6.25 of the 12 forms

of violence. Eight of the 12 were reported by half or more of the respondents, including strangulation. Authors note that, "many survivors were dependent on drugs or alcohol while they were trafficked either because the substances were forced on them as a control mechanism by their traffickers or because substance use was a means of coping with the immense abuse they suffered." Results show that 84.3% used alcohol, drugs, or both during their captivity and more than a quarter (27.9%) said that their forced substance use was a part of their trafficking experience. Most survivors reported receiving medical treatment at some point during their trafficking. "Of those who answered the questions about their contact with healthcare (N=98), 87.8% had contact with a healthcare provider while they were being trafficked. By far the most frequently reported treatment site was a hospital/emergency room, with 63.3% being treated at such a facility." Authors noted 29.6% of survivors visited clinical treatment facilities (most commonly Planned Parenthood clinics), and "more than half (57.1%) of respondents had received treatment at some type of clinic (urgent care, women's health, neighborhood, or Planned Parenthood)." Nearly fifty-two percent of respondents who answered (N=81) said that "at least some of the time the doctor knew they were 'on the street,' while the remaining respondents did not believe doctors were aware of their situations." Meanwhile, "almost half of survivors (43.1%) (N=58) said the doctor asked them something about their lives, but only 19.5% of those who answered (N=41) reported that the doctor knew they had a pimp." Results indicate that some victims may seek health care services alone. If trust level and other considerations allow, providers may have the opportunity to ask questions about the victim's situation and provide her with resources like contact information for rescue and other services. Authors reference legal aid strategies as a guidance to "gradually working with the victim's identifiable health problems to elicit important facts about their over-arching situation is likely to be most effective and least intrusive." Authors also recommend extending the Violence Against Women Reauthorization Act to cover adult trafficking victims and adult survivors, as their physical and mental health needs are just as great as those of minor sex trafficking victims.

19. **James Sandy E., Herman Jody L., Rankin Susan, et al. The Report of the 2015 U.S. Transgender Survey Washington, DC: National Center for Transgender Equality;2016.** This report summarizes the results of the 2015 U.S. Transgender Survey (USTS) and provides insights into the impact of stigma and discrimination on the health of many transgender people, including those in the sex trade. Survey results show that "[o]f those who were working in the underground economy [e.g., sex work, drug sales, and other work that is currently criminalized] at the time they took the survey, nearly half (41%) were physically attacked in the past year and over one-third (36%) were sexually assaulted during that time." Twenty-seven percent of respondents who had interacted with police in this context were "sexually assaulted by an officer, including being fondled, raped, or experiencing another form of sexual assault." The USTS also asked respondents who interacted with police while engaging in sex work or when police thought they were engaging in sex work if they were arrested during any of those interactions. "Almost one-third (32%) reported being arrested during at least one interaction," and 19% reported being arrested 11 or more times. Respondents were asked about the outcomes of their arrests. More than half (55%) of the respondents who were arrested pleaded guilty in connection to one or more of their arrests, while nearly half (48%) reported that the charges were dropped on at least one occasion. Survey results show that "[t]ransgender women of color, including Black (42%), American Indian (28%), multiracial (27%), Latina (23%), and Asian (22%) women, were more likely to have participated in sex work than the overall sample."

Authors also note that “police frequently assumed that respondents—particularly transgender women of color—were sex workers.” When asked about interaction with police “Black respondents (50%) and transgender women (40%) were more likely to report that their interaction […] led to an arrest.”

20. **Farley Melissa, Deer Sarah, Golding Jacqueline M., et al. The prostitution and trafficking of American Indian/Alaska Native women in Minnesota. *American Indian Alaska Native Mental Health Res.* 2016;23(1):65-104.**

Researchers interviewed 105 American Indian and Alaska Native (AI/AN) women in prostitution who were in contact with supportive agencies in Minnesota. The women volunteered for the study after seeing announcements posted at agencies or via snowball or chain referral sampling. Research interviews consisted of six questionnaires (i.e., The Prostitution Questionnaire, elements from the Dissociation subscale of the Briere's Trauma Symptoms Checklist, the Post-traumatic Stress Disorder Checklist, self-rating general health scale, the Native American Prostitution Questionnaire) that included both quantitative items and structured open-ended questions. The mean age of respondents was 35 years (range = 18 to 60 years, SD = 11 years). Ninety-eight percent of the women were currently or previously homeless. Of the AI/AN women interviewed, 9% had attended boarding school, and 69% had family members who had attended boarding school. Of the relatives who had attended boarding school, more than two-thirds (69%) were known by the women to have been abused there. Abuse perpetrated by teachers, church officials, and government officials included verbal or mental abuse (100%): spiritual, cultural, or physical abuse (94%); and sexual abuses (27%). Forty-six percent of the women interviewed had been in foster care, in an average of 5 foster homes (range = 1-20, mean = 3, SD = 4.8); and almost half of those who had been in foster care had been abused by their foster families. Overall, 52% of the women had been arrested during childhood and 88% had been arrested as adults; 12% reported being arrested for prostitution as an adult; 39% reported being younger than 18 years when they entered prostitution; 75% had engaged in prostitution in exchange for food, shelter, or drugs; and 45% had been trafficked for the purpose of prostitution. Researcher cited evidence that "prostitution often meets the legal definition of human trafficking, in that pimping or third-party control of a prostituted person cannot be distinguished from trafficking." More than half (53%, n=56) had been raped five to ten times, and 15% had been raped more than 20 times in prostitution. Women reported assault by the man who bought sex (44%, n=46), pimps (15%), or someone who was neither a sex buyer or pimp (27%). More than half (52%) had been physically threatened in the month prior to the interview. Of those, 87% had been threatened with a gun, knife, or other weapon. "Almost three fourths of the women (72%) had suffered traumatic brain injury. Assaults to the head included the following symptoms and sequelae: broken jaws, fractured cheekbones, missing teeth, punched lips, black eyes, blood clots in the head, hearing loss, memory loss, headaches, and neck problems.” Other violent injuries suffered included flesh wounds; broken bones; arm/shoulder injuries; scars or bruises; knee/ankle injuries; and being raped, kicked, strangled, burned, or shot. More than half (51%) of the women interviewed had been diagnosed with physical health problems; 65% of respondents had been diagnosed with a mental health problem, most commonly depression (78%) and anxiety disorders (71%). Furthermore, 40% of the women had been psychiatrically hospitalized. Based on responses, 52% of the women met all criteria for a diagnosis of PTSD; their mean PTSD severity score was 51 (SD=19). This rate compares to an 8% prevalence rate in the general U.S. population. Analysis found that more severe the interviewees’ symptoms of PTSD, the poorer

their health ratings, r = .22, p = .024, N = 101. Moreover, researchers found the more severe the women's dissociative symptoms (e.g., spacing out, memory problems, flashbacks, derealization, not in your body), the more likely they were to report fair or poor health, r=.35, p=.0003, N=102. Some explained how dissociation helped them survive prostitution. Roughly three-quarters of respondents used drugs or alcohol, and a majority of those who used drugs or alcohol (61%) described the need to "chemically dissociate" from the physical and emotional pain during prostitution. "One woman explained that she used drugs 'so it can numb me, so I can do what they want me to do.' Another stated '...That's why I did a lot of drugs—to numb myself—so I didn't know what was going on and I could just leave my body.'" Women reported that race/ethnic prejudice is integral to prostitution. For example, 42% of the women reported being racially insulted by sex buyers or pimps. Similarly, the majority of women saw connections between colonization and prostitution of AI/AN women. Some identified connections with their cultural identities and support from other AI/AN people as ways of surviving prostitution. The overwhelming majority (92%) of interviewees wanted to escape prostitution, and most identified individual counseling (75%) and peer support (73%) as needs to successfully leave the life. Authors state that "[t]he multiple arrests of these women [starting in childhood] prevented their escape from prostitution, because a criminal record was a barrier to obtaining affordable housing, employment, and frequently even essential social services." Authors recommend legal aid (e.g., criminal record expungement); policy reform to decriminalize victims of prostitution to ensure AI/AN women who have been domestically trafficked receive the same access to services as do international victims of trafficking; and cultural competence in mental health care of AI/AN people (e.g., acknowledge and analyze historical trauma, utilize cultural moderators to embrace traditional healing).

21. **Judge Abigail M., Murphy Jennifer A., Hidalgo Jose, et al. Engaging Survivors of Human Trafficking: Complex Health Care Needs and Scarce Resources. *Annals of Internal Medicine.* 2018;168(9):658-663.**

Judge et al. provide an overview of complexities involved in engaging survivors of human trafficking. Specifically survivors' complex health care needs in the face of scarce resources. People exiting trafficking have multiple immediate needs (e.g., food, housing, clothing, financial support, safety and protection, transportation, and acute substance withdrawal treatment) that often go unmet without coordinated, trauma-informed care. In addition to individual needs, victims and survivors experience relational consequences to trauma which strongly affect how they interact with health professionals. "[G]iven the violent nature of human trafficking, any ongoing or perceived threats of violence after exiting may work synergistically with [complex PTSD] relational impairments to undermine health care participation." Authors noted that survivors may exhibit hesitate leaving trafficking due to: 1) fear of change or retaliation, loneliness and isolation; 2) emotional bonding with trafficker; 3) coercive control and emotional manipulation by traffickers; 4) guilt and shame; 5) health problems; and 6) stigmatization and discrimination. "Previous experiences of stigma, judgmental attitudes, and punitive treatment by providers negatively influence health care engagement among marginalized groups." Evidence indicates that survivors of trafficking experience "stigmatizations, discrimination, marginalization, institutional violence, and distrust of official systems, which may include health professionals." Additionally, addressing the influence of coercive experiences with traffickers requires providers to contextualize treatment to the trafficking experience and to be sensitive to the inherent power differential in the patient-provider relationship. Authors cite evidence that

almost no research exists on the "types of health care services that would most effectively overcome barriers and engage human trafficking survivors." However, they list key health service components that may support victims and survivors.

22. **Wu E, El-Bassel N, Gilbert L. Prior incarceration and barriers to receipt of services among entrants to alternative incarceration programs: A gender-based disparity. *Journal of Urban Health: Bulletin of the New York Academy of Medicine.* 2012;89(2):384-395.**
Wu et al. collected data from a random sample of adults (N=322; 83 women and 239 men) entering alternative to incarceration programs in New York City. Researchers collected data though structured interviews including information on sociodemographics, substance use, prior incarcerations, and barriers that had prevented a participant from visiting or returning to a service provider. Less than half of the participants had earned a high school diploma or GED. When analyzing collapsed data for male and female participants, they found that a greater number of prior incarcerations were significantly associated with a greater number of barriers that prevented accessing a service provider. When they analyzed the data disaggregated by sex and controlling for sociodemographic and substance use indicators, researchers found that the relationship between a greater number of prior incarcerations and greater number of service barriers experienced remained significant only for men.

23. **Esposito Michael, Lee Hedwig, Hicken Margart, et al. The Consequences of Contact with the Criminal Justice System for Health in the Transition to Adulthood. *Longit Life Course Stud.* 2017;8(1):57-74.**
Esposito et al. examine the association between incarceration and health in the United States during the transition to adulthood. They applied the Bayesian Additive Regression Trees (BART) to data from The National Longitudinal Study of Adolescent to Adult Health dataset (n=10,785) to model incarceration's effect on health controlling for confounding variables (93 variables, and 36 covariates categorized as: demographic characteristics, prior health status behaviors, engagement in risky behavior, social connectedness, disposition characteristics, parental characteristics, and contextual residential characteristics). Authors examined three health outcomes: 1) an indicator for cardiovascular health (i.e. hypertension or raised blood pressure), 2) a measure of general health status (i.e., excellent/very good self-reported status), and 3) a measure of mental health status (i.e., depression). The analysis of two separate samples found individuals who had been incarcerated were more likely to suffer from depression, less likely to report being in excellent or very good health, and more likely to have hypertension than their peers with no history of incarceration. To examine if the health inequalities between previously incarcerated and never incarcerated individuals was a product of incarceration rather than a product of features that occurred prior to incarceration, they used the BART methodology to estimate how different the health of individuals who had experienced incarceration would be had they actually never experienced incarceration. Results suggest that elevated risk of depression among incarcerated individuals is largely a consequence of their incarceration (~5% both before and after accounting for confounders). Similarly, a prior history of incarceration appears to decrease the probability of reporting excellent/very good health (~10%), roughly half of the decrease in probability before accounting for confounders. Results show no adverse effects of incarceration on hypertension.

24. **London A, Myers N. Race, incarceration, and health. *Research on Aging.* 2006;28(3):409-422.**
London and Myers conducted a review of the literature around health and other outcomes for incarcerated individuals. They highlighted research that indicates that black Americans have worse health outcomes than other racial/ethnic groups, and also are disproportionately represented in the justice system. The authors also outlined data indicating the high rates of injury in jails and prison as well as the high rates of communicable disease among incarcerated and formerly incarcerated individuals. In addition, they highlight research that indicates that incarceration is associated with lower educational attainment, lower income, higher rates of unemployment, and higher involvement in jobs with high risk of injury or exposure to hazardous working conditions. Evidence also indicates that incarceration is associated with divorce and separation of families.

25. **Murray J, Farrington DP, Sekol I. Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: A systematic review and meta-analysis. *Psychological Bulletin.* 2012;138(2):175-210.**
Murray et al. conducted a systematic review and meta-analysis of the literature on parental incarceration and impacts on children's later mental, emotional, and social health. They identified 40 studies that met their strict inclusion criteria. The researchers pooled the odds ratios across all samples in order to determine if children with incarcerated parents had a greater risk of each outcome than children in the control group who did not have an incarcerated parent or parents. These pooled odds ratios indicated that parental incarceration was significantly associated with antisocial behavior among their children even after controlling for covariates. In some subpopulations parental incarceration was significantly associated with children's poor academic performance, poor mental health, and drug use, but this association was not significant for every subpopulation and did not always remain significant after controlling for covariates.

26. **Roettger ME, Boardman JD. Parental incarceration and gender-based risks for increased body mass index: Evidence from the national longitudinal study of adolescent health in the United States. *American Journal of Epidemiology.* 2012;175(7):636-644.**
Roettger et al. analyzed data from the National Longitudinal Study of Adolescent Health (1994–2008). The dataset included 15,558 individuals who had completed interviews for all waves of the study, including 1,205 males and 1,472 females who reported that their biologic mother or father was incarcerated. The researchers found that females who had experienced a parent being incarcerated saw greater increase in Body Mass Index (BMI) over time for than did females whose parents had not been incarcerated. This trend remained significant even after controlling for stressful life events, internalizing behaviors, and a range of individual, familial, and neighborhood characteristics.

27. **Swisher RR, Roettger ME. Father's incarceration and youth delinquency and depression: Examining differences by race and ethnicity. *Journal of Research on Adolescence.* 2012;22(4):597-603.**
Swisher and Roettger analyzed data from the in-home portion of the National Longitudinal Study of Adolescent Health. Due to insufficient sample size for other racial/ethnic groups, only white, black, and Hispanic respondents were included in this study. The researchers found that among all racial/ethnic groups father's incarceration is associated with increased depression and

delinquency for the children, even after controlling for other variables such as demographics and family background measures. In addition, when considering these results by race/ethnicity, the data indicate that among Hispanic respondents, having their father incarcerated is associated with a higher propensity for delinquency than among white and black respondents.

28. **Chicago Sex Workers Outreach Project -. Sex Work and Harm Reduction: Tips for Working with Individuals in the Sex Trade. Chicago, Illinois: Sex Worker Outreach Project - Chicago; 2016.**
This presentation by the Sex Worker Outreach Project (SWOP) - Chicago to the Midwest Harm Reduction Conference defines sex work and discusses the impacts of criminalization and opportunities for harm reduction. SWOP is a grassroots organization run by and for individuals in the sex trade, devoted to improving the lives of current and former sex workers through peer-support, public education, and advocacy.

29. **Trafficking, RCW 9A.40.100 (2017).**
Washington State law defines sex trafficking as the recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion.

30. **Boyer Debra. Who Pays the Price? Assessment of Youth Involvement in Prostitution in Seattle.Seattle, Washington: Boyer Research;2008.**
This report was commissioned and funded by the City of Seattle, Human Services Department's Domestic Violence and Sexual Assault Prevention Division to help facilitate a more coordinated community response to youth involvement in prostitution in Seattle. The assessment "estimated the number of youth (18 years and younger) involved in prostitution and other forms of commercial sexual exploitation in Seattle and the outlying areas"; described trends and patterns in adolescent commercial sexual exploitation; assessed service utilization and service gaps; characterized the degree to which the current system of community-based providers and criminal justice entities coordinate their response to these youth; and made recommendations for service models and interventions.

31. **Cohan D, Lutnick A, Davidson P, et al. Sex worker health: San Francisco style. *Sexually Transmitted Infection.* 2006;82(5):418-422.**
Cohan et. al sought to describe the characteristics of sex workers accessing care at a peer based clinic in San Francisco, California, and to evaluate predictors of sexually transmitted infections. The study included 783 sex workers identifying as "female (53.6%), male (23.9%), male to female transgender (16.1%), and other (6.5%)." Seventy percent of patients had never disclosed their sex work to a healthcare provider before their initial visit to the St. James Infirmary. The reasons for not disclosing one's sex work history included negative past experiences with disclosure (4.8%), fear of disapproval (31.2%), embarrassment (7.6%), and not thinking their sex work was relevant to their health needs (31.8%). Overall, 36% of participants reported sex work related violence (by a customer [27.8%, $p<0.001$], employer/manager/pimp [9.1%, $p<.01$]. police [8.4%, $p = 0.001$]). "Legal history was also significantly associated with violence, with 47.1% of those ever arrested experiencing work related violence compared to 25.9% of those without a history of arrest ($p<0.001$)." In multivariate analysis, sex work related violence was a predictor of STIs (OR 1.9).

32. **Ravi A., Pfeiffer M. R., Rosner Z., et al. Identifying Health Experiences of Domestically Sex-Trafficked Women in the USA: A Qualitative Study in Rikers Island Jail. *J Urban Health.* 2017;94(3):408-416.**

Ravi et al. identify experiences of women regarding healthcare access, reproductive health, and infectious disease while being domestically sex trafficked. "Domestic sex trafficking, referred to as trafficking within the USA, involves US citizens, lawful permanent residents, and undocumented immigrants, and is often disproportionally perpetrated against vulnerable women and children." Authors found sparse data on the healthcare needs and access of this population in the USA, which they attribute in part to challenges in identifying trafficking survivors. They cite evidence that "laws and law enforcement practices have resulted in the criminalization of domestic sex trafficking survivors." Women being trafficked are often arrested for "charges associated with drugs (forced drug use by traffickers to maintain control over victims), weapon possession (for protection from potentially violent buyers), various types of fraud including using a false identity (created by the trafficker), and theft or robbery (through force by the trafficker or buyer)." Researchers chose to conduct the study at the Rikers Island Prison Complex's women's facility (The Rose M. Singer Center) as jails are settings where trafficking survivors' health needs may be discussed directly with survivors without interference from traffickers. Multiple respondents reported jail as their only place of care as required during intake. Twenty-six participants answered "yes" to the screening question regarding being forced to have sex or turn tricks by another individual. Of those, 5 who received full interviews did not meet the legal definition of sex-trafficking and were excluded from the analysis. Participants ranged in age from 19-60 years with an average age of 35.5 years. Participants self-identified as African American or Caribbean American. 42.9% (n = 9), White 28.6% (n = 6), Hispanic 23.8% (n = 5), and one person identified as mixed White- Hispanic 3.8% (n = 1). The types of trafficker they experienced varied among participants. The most common were those who ran trafficking rings, involving groups of women being trafficked (42.9%, n = 9). Other traffickers included drug dealers (23.8%), mothers (9.5%), and intimate partners (9.5%). Social barriers to care were the most notable for survivors of trafficking. Participants reported reproductive and sexual violence and coercion, both physical and psychological, including traffickers limiting or refusing healthcare visits, perpetrating physical violence for seeking services or receiving specific diagnoses (i.e., STI or pregnancy), incentivizing money over safe sex (e.g., limiting access to or use of condoms). For example, participants described traffickers accompanying survivors or sending another trafficked woman with them to medical appointments for intimidation and control purposes. Additionally, participants reported fear of criminal-justice involvement as a barrier to using emergency departments (e.g., arrest for prostitution or substance use) as barriers to receiving care generally. All participants reported using illicit substances such as cocaine or heroin while being trafficked. Authors conclude that health professionals need to account for this population of women when addressing common public health issues and emergent epidemics.

33. **Baldwin Susie B., Eisenman David P., Sayles Jennifer N., et al. Identification of human trafficking victims in health care settings. *Health and Human Rights.* 2011;13(June):36-49.**

Baldwin et al. conducted semi-structured interviews with six key informants who worked closely with victims of trafficking and 12 female survivors of trafficking in Los Angeles, California. Three interviews had experienced sex trafficking and one had experienced both sex and labor

trafficking. Findings indicate that "trafficking victims were prevented from disclosing their status to health care providers by fear, shame, language barriers, and limited interaction with medical personnel, among other obstacles." Survivors shared that traffickers took victims repeatedly to be tested for STIs, pregnancy tests, and abortions without detection. Specifically, traffickers filled out paperwork for victims and talked to staff. Limited language access also functions as a barrier to identifying international trafficking victims in health care settings. Often, traffickers appeared to have personal relationships with the physician at the facility where the victim was brought for care. Payment for health services was often made in cash by trafficker/paid for by trafficker, but the amount was added to the victims' debt owed. One respondent shared that she was forced to stop and work before accessing health services to "pay for" an HIV test. "None of the survivors who visited health care facilities were identified as victims by health care personnel or assisted as such, and none of the survivors or Key Informants knew personally of any case in which a trafficking victim had been identified during a health care visit." This study supports anecdotal reports that human trafficking victims in the U.S. interact with health care personnel, including providers of primary care, sexual and reproductive health care, dental care, and traditional or alternative remedies.

34. **Sou Julie, Goldenberg Shira M., Duff Putu, et al. Recent im/migration to Canada linked to unmet health needs among sex workers in Vancouver, Canada: Findings of a longitudinal study. *Health Care for Women International.* 2017;358(5):492-506.**
Sou et al. conducted a prospective cohort study with 742 street and indoor sex workers in Vancouver, British Columbia, from 2010-2014. Despite universal health care in Canada, sex workers and im/migrants experience suboptimal health care access. Among the cohort, 25.5% reported unmet health care needs at least once in the 4-year study period. Unmet health care needs were significantly associated with recent im/migration, long-term im/migration, policing, and trauma.

35. **US Committee on the Commercial Sexual Exploitations and Sex Trafficking of Minors in the. Press TNA.Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States.Washington, D.C.2013.**
This Committee on the Commercial Sexual Exploitations and Sex Trafficking of Minors in the US report reflects a collaboration between the Committee, the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, the National Research Council, Institute of Medicine, and other experts in the field. Authors identify insurance status as a barrier to young victims and survivors of commercial sexual exploitation and sex trafficking accessing health care services.The report discusses other structural barriers which limit young victims access to health care services and other social services, including fear of justice-involvement (e.g., prostitution charge), particularly in jurisdictions in which individuals 16-18 years of age can be tried in criminal courts as adults.

36. **Platt Lucy, Grenfell Pippa, Meiksin Rebecca, et al. Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies. *PLoS Medicine.* 2018;15(12).**
Platt et al. conducted meta-analyses to assess the extent to which sex work laws and policing practices affect sex workers' safety, health, and access to services. Separate analyses evaluated quantitative studies (40) that measured associations between policing and outcomes

of violence, health, and access to services, and qualitative studies (94) that explored related pathways. Researchers estimated the average effect of experiencing sexual/physical violence, HIV or sexually transmitted infections (STIs), and condomless sex, among individuals exposed to repressive policing compared to those unexposed. Authors found repressive policing of sex workers was associated with increased risk of sexual/physical violence from clients or other parties (odds ratio [OR] 2.99, 95% CI 1.96–4.57), HIV/STI (OR 1.87, 95% CI 1.60–2.19), and condomless sex (OR 1.42, 95% CI 1.03–1.94).

37. **Albarazi Hannah. San Francisco Sex Workers Reporting Violent Crimes Won't Face Arrest. *CBS Local (San Francisco)*. 11 January 2018, 2018.**
This local news article discussed policies adopted by San Francisco to shield people in the sex trade who report a violent crime from being arrested for prostitution. The policy will also "allow sex workers reporting abuse by law enforcement officials to come forward without fear of arrest."

38. **Mirfendereski Taylor. Policy aims to build trust among sex workers "Formalizing an Existing Practice". 9 January 2018, 2018.**
This news article provides data from the King County Prosecutor's Office regarding trends in prostitution vs. patronizing charges in the county, 2009 to 2016.

39. **Albarazi Hannah. How Sex Workers Made San Francisco Safer for Everyone. Next City; 2018.**
This online news article discusses the San Francisco Department on the Status of Women's work formally mediating discussions between the SF Police Department, sex workers, and other community stakeholders in the development of the City/County's policies preventing arrest and prosecution of victims of and witnesses to specified crimes for prostitution and other related offenses.

40. **Washington State Clearinghouse on Human Trafficking. Available at: https://www.commerce.wa.gov/serving-communities/crime-victims-public-safety/office-of-crime-victims-advocacy/human-trafficking/. Accessed July, 2018.**
This Department of Commerce webpage provides reports, resources for victims and survivors, and news updates regarding human trafficking.

41. **American Psychological Association. Evidence-Based Practice in Psychology: APA Presidential Task Force on Evidence-Based Practice. 2006;61(4):271-285.**
The American Psychological Association (APA) created a policy indicating that the evidence-base for a psychological intervention should be evaluated using both efficacy and clinical utility as criteria. The Association President appointed the APA Presidential Task Force on Evidence-Based Practice and the task force published this document with the primary intent of describing psychology's commitment to evidence-based psychological practices. This document, though, also references many research articles providing evidence for the efficacy of a number of psychological treatments and interventions. The reference list for this document highlights the growing body of evidence of treatment efficacy from the 1970s through 2006. Note that this does not indicate that all treatments are effective, but rather than there is a very large body of evidence supporting that evidence-based treatments are available.

42. **Khan A, Plummer D, Hussain R, et al. Does physician bias affect the quality of care they deliver? Evidence in the care of sexually transmitted infections. *Sexually Transmitted Infection.* 2007;84(2008):150-151.**
Khan et al. conducted a survey (stratified random sample) of 15% of general practitioners (GPs)practicing in New South Wales, Australia, to assess practitioners' management of sexually transmitted infections. A total of 409 GPs participated in the study yielding a response rate of 45.4%. Results: "Although over two-thirds (69–72%) of GPs were comfortable in managing STI in heterosexual or young patients, fewer than half (40–46%) felt comfortable caring for patients who were sex workers, indigenous, people who inject drugs, gay or lesbian." Results indicate that "[p]ractitioners who were comfortable were more likely to offer sexual risk assessment, safe-sex counselling, and were less likely to report limited ability to influence patients' risk behaviors." Furthermore, "[p]ractitioner discomfort was positively associated with reporting constraints in sexual history-taking and the need for training in sexual health." Authors concluded that practitioners' care and support for patients with STI are influenced by their inexperience, lack of skills and/or attitudes.

43. **Marshall Amy Jessica, Schultz Tim, Crespigny Charlotte Francis de. Emergency clinicians' perceived self-efficacy in the care of intoxicated women victims of violence. *International Emergency Nursing.* 2018;40(2018):18-22.**
Marshall et al. conducted a mixed methods study to assess emergency clinicians' awareness and use of best practice guidelines and tools and their perceived self-efficacy toward threating intoxicated women victims of violence. In total, 179 emergency clinicians were surveyed and 22 emergency clinicians were interviewed in South Australia. Survey results showed the majority of respondents had not undertaken any education or training specifically regarding alcohol and other drugs (AOD) (n=133, 74.3%) Results showed a "statistically significant relationships between use of best practice tools (n=32) and knowledge ($\chi 2=6.52$; p=.02) and confidence ($\chi 2=6.52$; p=.02) treating women victims of violence." Moreover, there were "statistically significant relationships between previous alcohol and other drug education/training and knowledge (n=43), skills and confidence treating both intoxicated patients ($\chi 2=7.85$; p=.01) and women victims of violence ($\chi 2=11.63$; $p < .01$)." Overall, authors concluded that "[e]mergency clinicians reported low levels of perceived self-efficacy, and infrequent use of guidelines and tools to support the care of intoxicated women victims of violence." Participants reported wanting more knowledge and education/training in caring for intoxicated women who had been assaulted.

44. **Greenbaum Jordan. Child Sex Trafficking and Commercial Sexual Exploitation. *Advances in Pediatrics.* 2018;65(2018):55-70.**
Statistics to accurately estimate the incidence and prevalence for Child Sex Trafficking/Commercial Sexual Exploitation [CST/CSEC] are unavailable "because of the criminal nature of the activity, lack of a centralized database, differences in interpretation of definitions, underrecognition of exploited persons by authorities, and underreporting by victims themselves." As boys and transgender youth are likely underrecognized, total global estimates and proportions of victims based on gender may be distorted. Some of the most common physical effects are sexually transmitted infections (STIs), pregnancy, substance use/misuse, and traumatic injury. Studies document that visits to health facilities are fairly common among

victims. One study found 43% of CST/CSEC victims had visited a health provider in the last 2 months. Similarly, 80% of suspected/confirmed victims had sought medical care in the last 12 months, with an average of 3.46 visits. Potential presenting reproductive health complaints for CST/CSEC Youth include: 1) traumatic injury (often with inconsistent history of event); 2) reported sexual assault; 3) genital-urinary complaint (discharge, pelvic/abdominal pain, abnormal bleeding); 4) HIV/STI or pregnancy test request; and 5) pregnancy-related issues (e.g., abortion or abortion complications). Authors recommend providers use a trauma-informed, rights-based, culturally and gender sensitive approach when they suspect a patient may be a CST/CSEC victim. For example, trauma informed care requires demonstrating respect (e.g., explain reasons for questions and every component of the medical visit, obtain patient's consent/assent for each step and respect their decision to refuse elements of the evaluation/treatment) and facility safety (e.g., interview patient alone, outside presence of companion, ask patient about basic needs [Warm enough? Hungry? Thirsty?]). The article details how the trauma-informed, rights-based approach may be implemented during the physical examination and diagnostic testing phases of the evaluation.

45. **State U.S. Department of. Trafficking in Persons Report June 2016.Washington, D.C.2016.**
This report provides a global overview of human trafficking as well as country specific information and recommendations specific to protection, prosecution, and prevention.

46. **Institute Urban Indian Health. Missing and Murdered Indigenous Women & Girls.Seattle, Washington: Urban Indian Health Institute, Seattle Indian Health Board;2018.**
In 2017, Urban Indian Health Institute (UIHI), a tribal epidemiology center based in Seattle, "began a study aimed at assessing the number and dynamics of cases of missing and murdered American Indian and Alaska Native women and girls in cities across the United States." Researchers sought to "assess why obtaining data on this violence is so difficult, how law enforcement agencies are tracking and responding to these cases, and how media is reporting on them." The study provided a comprehensive snapshot of the Missing and Murdered Indigenous Women and Girls crisis in urban American Indian and Alaska Native communities and detailed the institutional practices that allow them to disappear—"in life, in the media, and in the data."