Human Trafficking & Sexual Abuse Core Competency - 20250127_120041-Meeting Recording

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1h 32m 35s

HO **Heidi Olson** 0:00

Yeah. So some of you, I'm sure, know me and have worked with me. I started my own business about three years ago and was working part time at children's part time for my business. But I just transitioned into teaching and consulting full time. And so it's really.

Exciting to sort of venture out into something different.

Also I miss working with you all and I miss the patients that present to the Ed.

And yeah, so it's wonderful to be here.

Thank you for what you guys do.

I know that you don't get thanked nearly enough and you do such an amazing job of advocating and holding space and.

Deescalating and witnessing really hard things and I know you don't hear. Thank you, but I am thankful and as a saying I have loved working in a partnership with the social workers at Children's Mercy.

So it's wonderful to be presenting.

So let's jump in.

We're. I'm gonna talk a tiny bit about sexual abuse, and I know Sarah's gonna go more in depth kind of about your role and then more focus more on human trafficking.

So of course, this is all extremely heavy content and I am gonna fly through it, so please take care of yourselves as you are processing it throughout today. I'm gonna say some things that are very sexually explicit not to be shocking, but really just to paint a picture.

Of what is going on, and I think sugar coating it doesn't really do us any favors and obviously this is an insanely complex topic. My next 4045 minutes of sharing is just barely scratching the surface.

And really, this is just an introduction.

So I definitely recommend continued education on this topic because it's complex and it's constantly changing, especially with technology.

So.

Obviously you all are.
Experts in this and I don't want to, you know, read a definition for you.
I'm sure everyone here knows what constitutes a sexual abuse.
And sexual assault, the reality.
I guess what I want to point out in all of this is that it's a huge definition and as technology is changing, it's encompassing more things.
So for example, I think sometimes the stereotype of what people think about what sexual abuse is an adult who has touched a child's genitals.
Which, yes, that is sexual abuse.
But it also encompasses things like adults having a child, watch them masturbate or have sex or adults, or someone else showing a child ***********.
It can be someone taking a child's image and create using AI to create child sexual abuse materials. Even though the child wasn't actually harmed, their likeness is being harmed and shared, and that is a crime. And so as we're seeing just this constantly crazy evolving world online.
The ways that children are being sexually abused are changing, and I think what we're seeing a lot is kids who maybe aren't even.
Directly being touched by someone, but they're still being sexually abused, right?
Maybe people are coercing naked photos out of them, or you know.
Asking a child to send a sexually explicit video in exchange for something else.
Right, that's abuse.
It's exploitation, but these to the perpetrator and actually touch the child.
So I think it's good to just broaden our thoughts of what constitutes this abuse as we are seeing just the ever growing world of technology change very, very quickly.
So there's different acronyms in the hospital when we talk about sexual abuse, and so some kids present to the emergency department, and sometimes they're on the floor when this happens. But usually in the Ed and they're receiving there for a safe exam.
So that stands for sexual assault forensic exam and that would be an exam where potentially that child would have evidence collected from their body after a sexual assault.
And Saints S A&E we are sexual assault, nurse examiner.
So that's what we have been.
Specially trained to do is that we have gone through rigorous training to assess for genital injuries, to provide treatment after sexual assault like STI testing, pregnancy

testing, and then collect evidence after a sexual assault.
That being said, there's a very short window in which we can collect evidence or DNA after a sexual assault.
And so if you don't frequently work in the emergency department or haven't had a safe patient yet, there's a specific CR.
Area that has to be met for sane to be activated.
So if a kid comes in and discloses they were sexually abused two years ago, there's no DNA for us to collect.
So sane wouldn't be involved, even though that's a sexual abuse patient.
And I know Sarah will get more into that.
So just kind of an overview there.
Now, sexual abuse is so incredibly.
It's happening all the time.
It's incredibly prevalent, which is heartbreaking, and I didn't put exact stats on here because if you.
Google this if you look it up, you're gonna see different stats on how many people have experienced childhood sexual abuse. Based on the study, and it really varies.
So I'll kind of give you a generalization of breaking down the research and really what we see with kids at children's mercy as well.
But the reality is that it's happening a lot and I think it happens a lot more than people in the general public realized.
So for all of the hundreds and hundreds of sexual assault patients that we see at the hospital through scan and through sane.
That's just the tip of the iceberg.
Those are just kids.
Where there's been a disclosure or concern and someone has brought them in for treatment that is not encompassing every single kid in our community who has experienced sexual abuse.
So if you look at different stats, it'll say anywhere from one in four females to one in six males will experience some type of sexual abuse or assault before the age of 18.
There are other sets that say it's not as prevalent, but that's kind of the highest number in terms of studies.
The reality is it's a lot that a gigantic chunk of kids that we take care of, whether they disclose or not, are experiencing sexual abuse. And the reality is that about 90% of kids who are sexually assaulted have a relationship with their abuser.

It is often times a family member, a trusted person in the world, a pastor, a coach, a teacher.
A family friend.
It's someone who's created a relationship with child and groomed them, so again the whole stranger danger thing.
As most of us know, especially with sexual assault is the outlier. It happens like .0001% of the time.
And because it's the perpetrator's, usually a close relationship that creates all kinds of complexities. As you all know, right?
So maybe Dad is the perpetrator and this child's just closing.
And now Mom's whole world and stability has just been shattered in the moment of that disclosure.
And it can be really, really hard to get everyone to ground.
And be present when we're here in these disclosures. Because it's not just the abuse that has been disclosed that's traumatic. It's the fallout of it as well.
We know that the vast majority of children, so about 90 to 95% who have experienced sexual assault, even a penetrative assault will not have a genital injury after the assault, and that is mind blowing.
I was teaching a class last week and everyone stared at me.
Like what?
That cannot be possible.
It's true of the patients I've seen at children's, it's true in research, the reality is, and I will get into all of the nuances right now, but we've been taught incorrectly specially about female anatomy our whole lives.
So the hymen is not this membrane of tissue like this cherry that gets, quote, UN quote, popped during some type of penetration.
So most kids is that skin stretches a lot in the genitals.
It heals extremely quickly that most kids, if they had an injury.
It's healed by the time we're seeing them or they never had an injury. Even with penetration, even on younger kids, which I know is can be really hard for parents to understand.
And so I think that that's a hard conversation.
We often have is you have a kid coming in with a disclosure.
We believe their disclosure, but there's maybe we don't end up finding DNA and there is no genital injury.

How do we prove that it happened?
Sometimes we can't, and that can be really, really painful for families to say. I want to know for sure this happened and this is just.
A type of crime.
Or can be very, very hard to prove with physical evidence.
So that being said, DNA is less likely to be found after the 1st 24 hours of an assault.
So within that first 24 hours, much higher likelihood that we'll be able to swab DNA from a child's body where they were assaulted after that time frame, there's still a small likelihood in the next kind of three to five days, depending on their age range.
But the odds go down dramatically in that time frame.
And really, after five days, there's almost never evidence found.
So that can be really frustrating too. Again, if a kid discloses a week, a month, a year after their assault, we don't have DNA evidence to prove that it happened.
Unfortunately, because of all of these dynamics have very small percentage of child sexual abuse ends at a conv.
It's less than 3% goes to a jury trial, and the jury finds the defendant guilty.
That being said, there are plenty of plea deals that happen because perpetrators don't want to make a child.
Testify.
In front of their perpetrator.
And so I definitely understand their motivation there. And so a lot of these cases will ended up plea deal.
So there's still some semblance of justice that happens, but it is extremely rare for it to get all the way to a jury trial.
So to give you an example, I have been a sane for 10 years.
I've never testified in a jury trial on a sexual assault patient in Jackson County.
Is that not mind blowing?
I've been subpoenaed.
And then for whatever reason they like, get pushed back, or they.
You know, take a plea deal or whatever.
I've done depositions, but I've never actually testified before jury.
I have another jurisdiction, but of course most of the kids I've seen are from Jackson County and so that just kind of goes to show this is really complex, not to be completely discouraging.
I think that what we're doing when we see acute safe is the right thing to do, but it's

an uphill battle for sure with the criminal justice system.
Another piece to all of this that I think probably a lot of you are seeing, you're going to hear disclosures about.
It's definitely important conversation to have with family.
Is that a lot of children are being sexually assaulted by other children and that creates a lot of painful family dynamics and nuances. When you have siblings that have assaulted other siblings or cousins or, you know whoever it may be where there's this close family relationship and now.
Those children cannot be in the same home.
What we know is that so this headline I have, it came out of the UK last year and they did a study and they were able to say the majority.
Of their perpetrators, again of child sexual abuse, are now children themselves.
So the majority of their perpetrators are under the age of 18.
We are seeing similar statistics in the United States that anywhere from a third to half of the perpetrators committing a crime against child in the United States are kids themselves.
Now we know there's a whole array of why a child's going to act out with sexually harmful behaviors, but we're seeing increasingly more and more that *********** exposure is playing a huge role.
Which of course of a kid.
Has access to a device.
They're seeing *********** over and over and over.
They have mirror neurons in their brain.
They imitate what they're seeing, and often times it is sexual trauma that happens to another child.
And so I I know I've had many conversations with parents being sane in the EDI know you guys have too.
But it's something that I think we're going to continue to see more and more.
So sexual abuse ties into human trafficking. When we look at.
All the indicators, all the predictors of who is trafficked as a child.
The number one thing that all victims have in common is childhood sexual abuse.
Every single survivor I've talked to in my lifetime, they all experienced some type of sexual abuse, incest prior to being trafficked, and of course, it makes a lot of sense if you think about a kid who was being sexually abused, they're being groomed.
They're having their sexual boundaries violated.

Often times there's this exchange that's happening with the perpetrator, right?
Maybe it's dad who's saying. Hey, if you let me do this to you, I will buy you a treat.
I will get you a phone.
Don't tell your mom, right?
So we're creating these secrets.
There's this exchange that's going on.
There's this sexual violation. It's so similar to what traffickers do to their victims.
So it's already grooming kids into thinking this kind of behavior is normal into believing that sex is transactional, that sexual violation and violence is normal as well.
We also know for a lot of kids who are sexually abused, they don't disclose or if they do, they're not believed.
And so.
This is mind blowing, but for most people they do not disclose their childhood sexual abuse until they're in their 50s.
50 right.
That's decades down the road.
So for a lot of kids, they're not telling anyone cuz it's not safe. Or maybe they don't have the ability or the words to share what's happening.
And so they're walking around this gaping wound of having been sexually abused and violated, and they have not been able to process that trauma.
So then how do they cope?
How do you survive?
Well, then, a lot of these kids start using substances to numb out or they're engaging in high risk behaviors, which just then make them more susceptible to being trafficked.
And so we see these two things very closely tied together. And the reason I have this picture on here, this is a trafficking tattoo, this dollar sign.
And I saw a trafficking victim and a trafficking staying a couple years ago and she was telling her story. And it was just such a clear picture of this dynamic where.
She's 21. When I was seeing her, but she started being sexually abused at a young age. By the time she was 13.
She's like, I can't take it anymore.
So she runs away.
She's on the streets in Saint Louis.
How are you supposed to survive when you're 13, right?

So of course the trafficker quickly finds her offers her protection, starts trafficking her again.
This behavior has been normalized into her world, and she had that tattoo on her face, so it was very clear that he was still controlling her even as an adult.
But you could see absolutely her sexual abuse was.
A major risk factor.
So the reality is that we are seeing trafficking victims and victims of exploitation and kids that are high risk all the time, all the time as healthcare workers and we have missed so many of them historically. I personally can think of so many kids before I had educ.
On human trafficking, that all of the red flags were there and it just was chalked up to this kid as a juvenile delinquent.
They keep running away.
They're rebellious, you know, kind of whatever label we were putting on them, you know, 15 years ago.
Not realizing this kid is actually being trafficked and harmed and exploited, and they're asking for help through their behaviors, and we're not seeing it.
And so really quickly, I'll tell you sort of the catalyst for me.
This is almost 10 years ago I saw a 16 year old who the FBI later confirmed was being trafficked.
She never use that language.
They never do.
Right. She came in for STI.
Testing and just throughout the series of her exam. Through her story, I was like in my gut. Something is so wrong with this kid.
But she would not disclose and because there was no disclosure, it was like law enforcement children's division like no one knew what to do with this. Her social work. And I are both saying, like, hey, we think this kids being trafficked, no one would take a report.
No one would do anything.
And it was a really demoralizing experience to just feel like, OK.
We're seeing a need.
What do we do?
And so that changed everything for me, because what ended up happening is we discharged her home with Grandma.

That was a safety plan from children's division. She ran and FBI called a few days later to say we have no idea where this kid is, but we believe she was being trafficked and went back to her trafficker. And I think for me, I just felt like.
Oh my gosh, we failed this kid. Like we didn't have a protocol in place.
We didn't know.
No one knew what to do right?
It just felt like this.
We're seeing this and there's no we don't screening tool. We don't know how to report it.
Take her.
Won't take her apart.
I don't mean it just felt really helpless. And so that was the catalyst for we've got to have better processes in place and we do now, which is wonderful and we will talk about that. But I think we've missed a lot of kids and we'll talk about why.
It's not because people don't care, and it's not because we don't want to do a good job a lot of times it's because we have not been trained on what to do so.
Research bears this out.
There's a landmark study done in 2014 and a couple of similar studies have been done.
Since then that say the same thing that about 90% of trafficking victims.
Were seen by healthcare workers while they were actively being trafficked.
That's a huge number.
And right now about less than 4% of again 1 to 4% depending on the stat you're looking at attracting reports come from hospitals.
That's an abysmal gap. If there ever was right, we're seeing victims of a crime in huge numbers.
We're almost never identifying it, and it's not just healthcare workers. If you look at the stats around law enforcement.
Social workers in the community. Teachers, anyone who's intersecting with high risk populations, right?
People working in non profits detox, they're all missing this population too.
It is definitely not just us, so why?
Why are we missing victims?
Well, I think a huge piece of it is that we don't know what to look for.
So because this has never been prioritized in the healthcare setting, most people get

their education on trafficking from social media from.
Movies from Netflix, from.
Kind of these really new stories like extremely sensationalized versions of trafficking.
And if you think about all of those things, social media, the news movies, they are created to entertain.
So it's the craziest of the craziest stories, and we're basing that on.
Oh, that's what we should be looking for. The person who is, you know, abducted and thrown into a white van and sold into a sex trafficking ring.
Now I have personally worked with hundreds of trafficking victims.
I have talked to tons and tons of survivors.
That is never, ever.
I've never heard that story from a trafficking victim that was like, yes, I was abducted.
I was thrown into this van, you know, and the plot of taking plateau, right.
It's it's much more subtle and nuanced than that.
And so if we're looking for the crazy abduction movie storyline, we're going to miss this population every time.
To that point, you don't. What you don't know.
So if you've never been trained on human trafficking.
What are you supposed to think?
You can only default to what you've been shown. What you've been taught, and so for a lot of people, which Sarah, thank you for the opportunity to teach for a lot of people. They just have never been trained.
So it's well, yeah, I'm. I'm going based off of what I think trafficking should look like.
And unfortunately for I've taught all over the United States and Canada. Now at this point a lot of places where I go into the hospital to say alright, here's what trafficking traff.
Looks like they're like trafficking doesn't happen here.
Like it's not even an issue.
That's why we've never had education. And the reality is like.
Oh no, it's not happening.
It doesn't look like what you think it does.
For a lot of places.
So like my experience 10 years ago, we didn't have an official protocol in place, right?
It was like me and put the poor social worker staring at each other.
Like what do we do now?

Like I remember calling in Boston being like we've called this place this place, this place was this place. Like, I don't know what else to do and her being like, I don't either.
And so for a lot of places, it's everything is very reactive. Instead of being proactive and thinking we are gonna see this population.
So how do we create safe?
Safety for them for a lot of places, they don't use evidence based practices.
So again, they've never even talked to this population.
Say, hey, what would have helped you in a hospital setting?
What did you need?
We just assume that we know.
For a lot of hospitals I know this will not be surprising to anyone, but you know, I've talked to admin to say, hey, this is so important. We have to do a better job with this population and they're like it to generate a revenue. No. OK then we.
Good. We don't need to.
You know, do education on this, which is really, really unfortunate.
And then, you know, I've talked to lots of hospitals are like, yeah, we know it's an issue.
We know we're seeing these patients.
We don't know what to do with them, so we'd rather not open Pandora's box, which is also unacceptable, right?
We have to identify and create resources at the same time, so some of the myths you know, again like people will say things like, well, there's a trafficker following me, my kids around target now.
I don't doubt that there could be a creepy person following someone or.
And their kids are on target.
I can't guarantee it's Saudi trafficker because traffickers are motivated by money.
They want to make as much money as they can and they want it to be low risk.
Abducting a child out of target in front of their parent is not low risk, right? You're going to get.
Caught instantly, there's cameras everywhere, and that kid does not willingly want to go with you.
You want to find a child who willingly wants to go with you.
That means what you are doing as a trafficker is you're not abducting.
That's that makes no sense in their scheme.

Their plans, right?
I find a kid who is super vulnerable and I pray on those vulnerabilities, which means I go online, I find the kid that's posting super sexualized pictures, the kid who's saying I want to kill myself, the kid who says I hate my parents.
The kid who nobody loves me, that's who I target because they're shouting their vulnerability from the rooftop and I start to make them feel seen and loved and meet their emotional needs so that this child bonds to me.
And then by the time I've groomed them for a couple of weeks and I'm like, hey, meet me at the Starbucks, that child, quote UN quote willingly is now meeting with the trafficker and walks off with them.
And it's not on anyone's radar, right?
Because they're not being forcibly abducted, they've met a trafficker.
They're about to be trafficked, right?
But this child has been groomed and trauma bonded, and so for a trafficker that makes way more sense.
So the abduction thing is not really.
Related to trafficking, the way that it gets pushed in social media.
Media and on the news you'll see images like this of people who are physically banned by chains or ropes.
Again, I've never seen that with a trafficking victim because they are psychologically trauma bonded to their trafficker or their trafficker is their parent or grandparent, right?
They have a biological relationship with that person, so they don't have to be chained up.
They have been groomed and manipulated and coerced and they stay put or do what they're supposed to do without asking for help, right?
So we talked about maybe taken again sort of these images of abduction that just are very off base from reality.
Now have I seen kids who have been abducted as a sane nurse.
Yes, but that's usually by a sexual predator, right?
So the motivation is very different.
Sexual predator thereafter, sexual gratification trafficker. They want to make money.
They're not abducting kids, they are grooming and trauma, bonding with kids online.
So here's a real life example. This is a patient I had a couple years ago.
This was a 17 year old female and police had brought her into the emergency

department.
She was high on fentanyl and she came in.
So sort of what had brought her in is that she had been on the run for the last two weeks.
Mom didn't know where she was at. She had.
This is an awful story.
So her boyfriend saw a video of her on Instagram and she was being raped in a hotel room on the Plaza, and it was being live streamed on Instagram.
So he sees this video of a sex fire doing these awful things to his girlfriend. She's clearly high.
She obviously cannot consent to what is happening. He calls her mom. Her mom, of course, freaks out.
Unfortunately, she sees the video she calls law enforcement.
So law enforcement gets the hotel. They don't know what to do, so they bring the patient to the hospital.
So after she sobers up, she's talking to staff and she's like, oh, I was consenting to everything. Like, I wanted to be there.
To do it, I chose to do drugs like everything's consensual. I just want to go home. Can I leave?
Well, Mom is looking through her phone.
And Mom is seeing these transactions on cash app and the cash app, it would be men who were paying her daughter money.
And you know in the like, what are you paying for?
It had like kittens, Peach emojis, things like **** ***.
So it's very clearly sexual images or wording that they're putting on there, that they're paying her money for.
So this is highly concerning.
So, like I said, she's been on the run.
She had dropped out of school several months before. She had just been treated for chlamydia the week before I saw her.
She had several mental health diagnosis, so we had seen her at Children's mercy in the past.
Long history of childhood sexual abuse.
A lot of trauma there.
So is she being trafficked?

Well, I remember as I was walking through the hallway getting stuff ready for exam.
A staff member stopped me and said, like, she's consenting to all this, she not being trafficked.
Here's the reality, right?
She's 17.
Trafficking is different than sexual abuse in that the age of consent goes out the window with trafficking, right?
So any child on the age of 18 cannot consent to transactional sex.
We are seeing transactional sex in her cash app, right?
So even if she says I'm choosing to do this, it doesn't matter.
She's a minor who cannot receive anything of commercial value in exchange for a sex act, and we'll talk more about this definition in a second.
So it all makes sense, but it doesn't matter. She's saying she's consenting or not.
This is still trafficking and obviously she was high.
There's a lot of, like, difficult dynamics that are going on.
We later on found out that likely it was a family friend who was trafficking her, who took her to that hotel.
To meet with the 21 year old sex buyer and there was child sexual abuse materials created of her right.
So there's just a lot of crimes that happened, even if she's not naming it or realizing it.
And so this is what trafficking is going to look like with our patients sort of versus the taken abduction model of things.
So I'm sorry this is a little bit blurry, but when we look at the definition of trafficking.
There, when we're talking about adults. So right there's a different threshold for children.
But with adults, these three things have to be in place.
You have a vulnerable person who's being taken advantage of by a third party, so that third party is doing some kind of act. Whether it's recruiting, you know someone to sell for sex, transporting them to a hotel, maybe transferring them to a sex buyer, keeping them in an.
Apartment receipt of person the sex buyer.
There's some act happening to this person by a third party.
And there's some type of manipulation that's creating that act.
So whether it's coercion.

You know, fraud threat, abuse of power so that they can make money off of that person. So to like, throw all the legalese at the window at its most basic form, it's a vulnerable person and a vulnerability can look like anything from wanting to be loved, to not.
Having anywhere to live, to being addicted to drugs, to living in poverty, to having unprocessed trauma and like it can run the gambit, right?
You've got a vulnerability. You've got a trafficker who preys on that.
So he can make money off that person, whether it's through forced prostitution, ***********, exploitation, forced labor, right.
Lots of different ways that he can make money off these people, and sometimes he will make money off of multiple types of trafficking, right?
Yes, I'm forcing you to have sex with these sex buyers and also you're going to sell drugs for me, right?
So it doesn't.
It's not a mutually exclusive where you're either, you know, labour trafficked or sex trafficked. Two of these things can happen at once.
And often do.
So we see sex trafficking most often as healthcare workers.
I think it's partially because we have the most resources that we poured into this in the United States.
And so, you know, some hospitals are screening for this.
They're on the lookout for it now, so we're identifying it most often, but of course we see labor trafficking too.
I think we just struggle to identify it because we don't have as many screening tools resources.
Places for victims to go, things like that.
Domestic servitude is a type of Labor trafficking.
So if we think of au pairs or nannies or housekeepers, sort of in that work realm where people are coerced, manipulated into a job, and they're not being compensated, forced marriage with minors can be a type of trafficking forced criminality.
So we will have traffickers who, and I'm actually going to show you case study in a little bit where that was going on, who are forcing their victims to like I was saying sell drugs or.
Commit shoplifting or forged checks or other types of crimes were sometimes

victims are getting arrested even though they were forced into it because there's all that trauma bonding and that brainwashing they're thinking, oh, I chose to do this for my boyfriend.
Oh, I'm helping him.
We're just trying to pay rent.
There's actually trafficking going on, things we don't see as often in the United States are triad soldiers and organ harvesting.
But those are types of trafficking as well.
So like I was saying with an adult, you have to have that third party present that force, fraud and coercion.
But with minors, like I said, consent is irrelevant with transactional sex.
So the threshold is much lower with the population. We're working with a minor cannot consent to sex acts in change for anything of value.
So if a kid is saying I traded, you know, I guess this person a *******. So I can have a place to sleep last night. Guess what?
That's trafficking.
Someone is sexually exploiting that child.
So if there any sex act in exchange for anything of value?
Doesn't have to be money if you've got a 13 year old patient that is saying I sent a naked photo to this person so they would give me tokens for this video game.
Guess what?
That's exploitation of a minor, right?
That's technically trafficking, and so we have to look for those exchanges, even though it doesn't fit the stereotype of like well, there's no pimp and there's no, you know, money being exchanged or whatever with a kid.
It doesn't matter if there's a transaction, we are.
Marking this as exploitation slash slash trafficking.
And we will let the investigators kind of go with it from there, but that's our piece is to identify is there some kind of exploitation happening?
The trafficker doesn't have to be present, right with a kid. They don't have to have a third party.
I we took care of a 14 year old couple years ago and I remember she told our same nurse.
Yeah, I have sex on the weekends for money.
So that like I can pay for my cell phone and I can buy my cute clothes like she

thought it was totally normal.
She does not have a trafficker, but she's 14.
So guess what?
This is considered trafficking.
The sex buyers who are paying for sex with a kid could be charged with trafficking.
All we know if our patient population and what we're seeing around the United States is the majority of trafficking today with kids has an online element.
That's how they're meeting their traffickers or their ads are being posted online, or there's some type of child sexual abuse material or sees them naked photos slash child *********** that is involved with their trafficking.
So there's some element of.
Online.
Solicitation, exploitation, grooming. What's going on?
Now most people wanna know when I teach how many people are being trafficked.
How many people are being trafficked in Kansas City?
How many people are being trafficked in Missouri?
I don't know.
No one knows if they give you if someone gives you an exact number, like 47 people are being trafficking in Kansas City. They are lying to you because we can't quantify this problem.
We can estimate so if people are kind of coming up with a guess based on research.
Great.
But we don't know exactly.
Exactly the scope of the problem. We know it's big.
But we don't know if it's, you know, 3000 people, 4000 people, because we are struggling to identify this population as professionals obviously, right?
We're identifying less than 1% as healthcare workers and professionals in general, so we are not really helping with quantifying the problem right now.
Victims don't self identify even kids. They don't see themselves as victims. A lot of times, and so they're never going to come to us and ask for help and be like.
I'm being trafficked.
They're gonna say it other ways, which we'll talk about in a second, but they're not gonna use that language. So they're not self identifying.
We're not identifying them.
Traffickers aren't gonna like Mark on the next US census.

Like, yeah, I'm trafficking 3 people.
Go ahead and count that. Like we don't have a way to quantify and so we don't know. But what we do know again is kind of looking at estimation, so about 40 to 50 million people are being trafficked around the world.
It's the fastest growing crime in the world.
It's not going away anytime soon.
Unfortunately, so it's extremely relevant to our work.
It's extremely relevant that we identify it because we know it's increasing in number.
We just don't know exactly how bad it is, but we know it's a massive problem. Like I said, we know many people about the stats are 50 to 60% of people are trafficked by a family member or an intimate partner, 50 to 60. I think those kids.
Are almost never on our radar.
Right. It's like, oh, Mom brought them in.
Everything's probably fine when the reality is.
She might be the trafficker I work with, the trafficking survivor. The last couple of months, and she was trafficked by her dad from the ages of 14 to 20.
She's in her 50s now.
And talked about right, just the way she encountered. She's was in a psych hospital for two weeks.
She was in a group home for kids.
She did detox.
She saw healthcare workers.
She was in school while she was being trafficked.
She was encountering tons of healthcare or tons of professionals.
Not once identified, not even as a victim of child abuse, right.
Like much less trafficking.
And so I think familial trafficking can be really it's not on our radar a lot of times unfortunately like I talked about social media and technology are playing a huge role with all of this and we'll talk about males in a second. But we know males we know.
Transgender youth are being trafficked a much higher rates than we previously thought.
Again, I think a lot of times males weren't even on our radar.
It's just females who are being trafficked.
You know, and it they're being trafficked by non familial traffickers and it looks so much different than that.

And really, it doesn't matter where we're at, whether we're talking about a rural community, urban community, the United States, somewhere else at the core of it, it's always vulnerable people who are being trafficked no matter what.
And they look different in a different community.
But it's vulnerable people that we need to really keep an eye out for.
And again, like I said, vulnerability doesn't always equal.
Poverty or?
Trauma. It can look like things of a kid having unlimited access to a device, and they feel really lonely.
It can be a vulnerability that looks like that.
So a lot of people will hear things like Kansas City is number 2 in the World United States for trafficking.
It's a hub again.
Here's the reality we don't actually know that.
So what we do know is that if we look at tracking as a business model, demand drives traffic.
So demand for looking at supply and demand.
Are the sex buyers we want to pay for sex? If I'm a trafficker? And remember, my motivation is to make money, I'm going to go to an area where I can make money.
So of course there's going to be more trafficking in Kansas City than in rural you.
Know western Kansas.
Because there's more demand.
Because more people live here.
So just based purely on the size of the population, of course there's going to be more trafficking.
There was a study done.
About 10 years ago.
And they looked specifically at how many sex buyers are in Kansas City.
And this is alarming.
This is a very alarming stat. They found that they put up these fake sex ads online and counted how many people are looking to pay for sex in Kansas City.
And they found that about 15% of our male population is actively looking to pay for sex.
That's about 106 thousand men at any given time.
So yeah, if there are over 100,000 people looking up here for sex.

How many victims are here?
Thousands. I would venture to guess. There was also a study done with the FBI in independence and I don't know what it is about independence, but I have had the most awful tracking cases from there.
So they were in independence. The FBI was looking at child sex trafficking and they put it fake ads advertising kids being sold for sex.
And there was, like, a certain lingo they used so that sex was like, no, this is a minor.
And they had over 500 responses.
In 24 hours of people knowingly wanting to have sex with kids, being willing to pay for it, we also know there's a high demand to exploit. Watch kids be exploited, sexually abused kids who are under the age of 1. There's a huge demand for that. So then.
That's a population that can't even disclose to us. So the reality is in that study that was done 10 years ago, I think there were eight cities that were.

S **Summers, Lisa J. 02** 37:41
Thank you.

HO **Heidi Olson** 37:42
Studied.
And Kansas City was number 2 in that study.
So that's where the number 2 stat comes from, but that wasn't looking at every city in the United States.
So again, in terms of how terrible is trafficking, it's hard to know.
It's absolutely a problem.
So don't hear me saying that. We know there's a ton of demand here, but this is what I want to drive home.
It doesn't matter if there's an intersection or an Interstate or a highway or whatever.
Going through a city.
If there's demand there, there's going to be trafficking. So I hear that a lot from people like, oh, this place is terrible.
'Cause, they're on I-70 or whatever.
I-70 is irrelevant.
You could be in the middle of nowhere, and if you have sex buyers, you're going to have trafficking. And so I think that's what we really have to look at is it's happening

everywhere.
And here's the reality.
Why do would we want our city to be a hub?
I think sometimes there's almost this like badge of honor. Like Kansas City is the worst. We don't want our city to be the worst, right?
We don't want this to be happening around us. It's extremely traumatic.
So we know it's a huge issue, but how big of an issue?
Again, it's very hard to compare the entire United States.
States to Kansas City, so.
What we can look at again, if we're looking at demand, what drives demand, we can look at how much *********** is being viewed in the United States.
So we know that habitual **** use is tied to paying for sex.
Many sex.
Former sex buyers that I have talked to over the last couple of years are like, yeah, I was addicted to ***********.
My brain's getting this dopamine hit from viewing it, and eventually it's not enough anymore.
And so now I want to act out the things that I'm watching so I can get that same dopamine hit in my brain.
And where can I do that?
Oh, I can just go online and pay for sex, right?
Super easy. Super convenient.
So if we look at how much *********** the United States is consuming, it's crazy.
This came from *******.
They show their stats at the end of every single year, and the United States is always year after year after year, viewing so much more *********** than any other country. Like it's not even close.
Right. Because we have this very high appetite for paying for sex, the United States for objectification that is related to all of this. the United States is the number one consumer of sex worldwide.
So we're driving demand to society.
We are driving the fact that trafficking is happening here because there are people saying, yeah, we'll pay for it.
This can be a commodity in our society, even though it's illegal and we'll go to other countries and drive demand there as well.

And so it's absolutely a problem.
A massive problem.
So let's talk about males and transgender victims for a second.
Very few studies have been done on males, but the ones that have been done are so important and I think that it's again sometimes this is not even on our radar when it needs to be.
I remember, man, this is probably. I don't even know a long time ago was I just started working at Children's Mercy and I was actually working at a nurse. And I remember I took care of a teenage boy.
And now, looking back, he had every sign and every risk factor being exploited.
And remember, he had this horrendous sore throat.
And no one could figure out where it was from.
Eventually we did swabs, and he had gonorrhea, and I remember it was like the perception was like, oh, he's just being a bad kid and he's not disclosing, like, the sexual activity he's involved with.
And now looking back, I wonder, was he being trafficked and we completely missed that because again, it was this mentality like, only girls are trafficked only females.
So with this.
Study in particular what they looked at was how does trafficking differ from?
Sorry, I just looked at the time.
I will wrap it up here in a second.
Sarah, how does trafficking vary between, you know, males and females? These males who are trafficked as young boys were much more likely to be tortured and it be live streamed versus in person meetings.
Their moms were often their traffickers.
They were being trafficked through sort of big organizations like.
Like organized sports pedophile rings.
And so we know.
Absolutely. It looks a little different from males, but still highly traumatic.
I'm going to skip this just for the sake of time.
You guys can go back and look at these slides.
There is another study done with males who were being trafficked, and here's what I want to point out.
Service providers who worked with these males said it takes great patience and great sensitivity to build rapport with males who've experienced exploitation, which I

would agree.
I would say males.
But the very few I've ever screened for trafficking at children.
It was challenging to build rapport with them.
They were very, very resistant to any of the questions I wanted to ask, which makes sense, right?
I think there's a lot of stigma and shame, especially with males.
So again, if we think about vulnerabilities, there are many.
And so he was just kind of. And I know you guys know this.
Who is being trafficked?
What are the trends we see with kids at children's mercy?
It's kids that we're seeing often times for a mental health crisis.
Or something else where we realize there's exploitation going on.
We talked a lot about *********** already, but here's what I would say with the kids that we're seeing.
Again, at the hospital. Is that because so many kids were taking care of are being exposed to so much *********** and it's so desensitizing?
Here's what's happening. They're seeing ****.
It's absolutely impacting kind of how they see themselves, how they see the world, then they're going online and people are asking them to create child *********** or C spam. They're doing it without a second thought, right?
Because it's I've been desensitized to this.
It's no big deal.
That picture never just stays with the stranger, they send it to get shared thousands of times.
Now their inboxes are just getting full on, you know, whatever.
Their people are sliding into their DMS on Snapchat, Instagram, whatever it is.
And people are saying, hey, you're cute. Send me more content. I'll send money to your cash app if you send me another naked photo, I'll send you whatever. If you send me another video.
Does 12 year old are taking care of? Probably does not think I'm being trafficked, right?
They're probably like I'm awesome because people are sending me money and they think I'm hot because there's this been a societal grooming into thinking. This is where your worth comes from.

I'm seeing that a ton with kids.
One of the last patients I took care of.
This a 12 year old disclosed 20.
Different people that she had had sexual encounters with in one year and God bless the social worker that worked with me that day. If you're on here, it was challenging and she did not think that she was being sexually abused or assaulted by these people who clearly were.
Taking advantage of her, she was meeting all of them on Snapchat.
This video I'll have Sarah send to you.
It's about social media and we just don't have time to get into it.
But really, showing the vulnerabilities on social media for kids and how easy it is for predators and traffickers to find kids.
Here's common apps we see, but there's no limit to the amount of apps that predators and traffickers find kids on. If you can send a direct message or videos and photos, there's absolutely predators and traffickers on there.
Of course, AI is also playing a role in all of this. Unfortunately, the trend we're seeing with a lot of kids is that they are taking photos of their classmates, like completely innocent photos, like from someone's Instagram or whatever.
Snapchat, they are putting it through AAI generator, which there's tons of apps that exist right now.
And creating naked images or you know, full on sex acts that they are that look completely realistic of kids that are in their class. One in 10 kids have done that so far. That is against the law.
It's creating child sexual abuse materials and so this is something to be aware of.
Let me just get through a couple of this stuff.
So what do you guys look for with kids real quickly?
I'll go through this and wrap it up.
Of course.
What is their social history like?
What are the vulnerabilities it's going to be subtle.
Right. So again, they're probably not gonna have like overt signs of trafficking.
It's picking up on all the little vulnerabilities. Have they been abused before?
Are they currently being seen for a mental health crisis?
Do they have a history of suicidal ideation? Suicide attempt?
Are there signs of self harm?

Are they using substances?
Do we have concerns about reproductive health?
You know, how old were they?
The first time they had sex, have they had an abortion?
These are huge indicators of trafficking.
Most kids won't have trafficking tattoos.
That happens more with adults. I've seen it very.
Few times, but you might see things like dollar signs, words like loyalty, the traffickers name the word Daddy.
But again, that's going to be far and few between kids who are on the run are hugely vulnerable.
So if you're seeing these things, especially in conjunction with one another, your brain needs to be thinking Ding, Ding, Ding, exploitation, trafficking, you know, are they not in school anymore?
Is there some kind of attachment? Trauma, right. They don't have healthy adults in their world.
They're sending, you know, nude photos and images of people are asking for them.
These are huge indicators of exploitation and trafficking, so I'm going to skip this case for this case study too.
But you guys are welcome to look at it.
So very quickly, sane uses a screening tool.
It's been validated and we've built on it.
We've used it thousands of times at this point.
It works so, so, well, insane. We build rapport.
We practice before we use it like we're very sensitive about how we're administering it, 'cause. We don't want it to be re traumatizing.
It works beautifully.
So if there's an acute safe that a St. is going to see and they are between the ages of 12 and 17, same will automatically screen them for exploitation and tell you their results. If a kid is high risk, so having a lot of those symptoms, I just.
And signs that I just named.
The Ed and they're not a safe patient. They're not going to be safe by saying an Ed provider can screen them and ask those questions as well.
So if we have a kid, we screen.
We're going to tell you guys social work and Sarah will get into what you do with

that information.
But we're going to tell you so that you can make the correct reports, because trafficking is not always obvious.
The screening is so, so important. In 2021, we identified over 100 kids that we screened in the emergency department that either were high risk or we knew there was some type of exploitation or trafficking. That's insane.
And that wasn't every kid in the Ed.
Those were just ones you guys notified us about or they were there for sexual assault.
Abar should obviously be completed whenever there's a screening done, and.
Risk factors warrant a report, meaning if we have a kid who is saying yes to every single risk factor, but they are not disclosing trafficking, we have seen so many of those kids who are actually being trafficked, they're just not ready to disclose that.
So I know Sarah will get more into that so real quickly.
Here's my contact information. Sarah, I'm sorry for going a couple minutes over.
I just have so much to say on this topic.
You guys are welcome to have my slides.
Review them.
There's a couple videos in there that if you have time to look through I think are really helpful.
Well, one of them is of trafficking survivors telling their story with healthcare workers.
So please don't hesitate to reach out and I know that you're sane.
Leadership team is also incredible, so please reach out to them too if you have other specifics.

Lee, Sarah, E LCSW, LSCSW 48:44
Thank you so much, Heidi.
That was great.
I know you have so much information to share.
That is so it's wonderful.
I'm gonna go ahead and share my screen.
I just wanted to share when Heidi had mentioned earlier about.
Court cases in in the time that I've been at children's, I've only had one jury trial for sexual abuse at Jackson County.
Two total but one in Jackson County total that went to jury.

But yeah, lots of plea deals.
So it just struck me when you when you said that.

Sarah, do you want me to stick around while you present?
I can, if you would, like for me to stick around for questions or anything. OK. Perfect.
I'll be here.

Yeah, that would be great.
That'd be great.
OK.
Here we go.
OK, so I cannot see.
The comments and things so we can hopefully have time for comments at the end and you can ask questions to Heidi and I, but this is our human trafficking and sexual abuse core competency.
There are some things that Heidi spent a lot of time on that I'm going to skip over, but a lot of information on.
Just what we do as social workers, and I apologize the.
Mouse doesn't wanna click all the way sometimes, so our objectives will be to provide updates and best practices with trafficking and sexual abuse to increase our knowledge and to increase our knowledge about collaborating with law enforcement, child protection agencies and other community partners for reporting and then also.
To enhance our documentation skills involving sexual abuse and trafficking.
So I'm gonna quickly just show you.
A few places that I'd like for staff to look at for child abuse and neglect education, but we do have a child abuse and neglect policy here at children's mercy and I will send out slides. Where'd my mouse go?
And so all this will be on there as well. But just so you know, you can go to the scope and find our child abuse and neglect policy.
There we go.
And you can look at the tool kit for abuse and neglect on the scope and that is here.
And I apologize, it's not wanting to.

Be a little be very quick.
But there's lots of information here. I think it also has tips for trafficking sexual abuse as well.
And then our core competency for social work is in our should be in our teams pages under core competencies. You can find the document here that has a lot of information on our how to respond to sexual abuse and sex trafficking.
So today we'll talk about identifying sexual abuse and trafficking.
We'll do.
We'll discuss some safety issues and planning assessment interventions documentation and then some follow up and resources.
So I won't go through the.
Definitions, just as Heidi explained, the sexual abuse is is pretty lengthy and then with trafficking.
When it comes to minors, the force, fraud and coercion.
Is irrelevant.
There does not need to be force, fraud or coercion involved with.
A minor that any kind of sex act in exchange for something is considered trafficking.
So it's important to note that with minors, like I said, consent is irrelevant for transactional sex.
A minor cannot consent to exchange sex acts for anything of value.
There does not have to be a trafficker present for a child to be sexually exploited.
And like Heidi, really honed in on social media and that is where children are beginning the sexual exploitation and finding *********** and then.
Connecting with.
Traffickers or pedophiles that want to exploit children.
The majority of trafficking with minors has an online element, so they meet the traffickers online.
And then, like I said, with child **** and and other.
Online avenues. So for red flags with trafficking victims, there are many.
This is just a few and the way that we identify a red flag is we have to do the assessment so these kids are not walking in, sharing all this information and we're we're, you know, we're getting a consult because they have 10 red flags we're having to.
Do the assessment either by sane provider by social work.
Or the bedside providers.

Is identifying some information, but then we have to also complete an assessment to get more of this history. To understand why they might be vulnerable and and even if they aren't disclosing trafficking, they are. They could be at risk of it.
The social work may be consulted in various areas throughout children's mercy. It could be a child coming in for sexual abuse through the Ed or UCC.
It could be a child presenting for behavioral concerns to the EDA, Urgent Care center, and then during their assessment, they disclose sexual abuse history.
A patient presents to the Ed as a runaway from a home or facility. Sometimes will get foster children that come in with the children's.
Division worker and they're wanting them screened for trafficking because of concerns that that could have occurred while they were on the run.
A patient discloses sexual abuse during a therapy session, so sometimes those things come up in other areas of the hospital and then patient could also disclose during a clinic or outpatient appointment.
When trafficking needs be further assessed is when they present for as like I said earlier, as a runaway children's division requesting a trafficking screen, a patient discloses that photos or videos were taken of the patient or the assault. A patient discloses that they've received drugs. Money G.
A place to stay, etcetera.
Anything in exchange for the sex or sexual acts?
And then patients that have had multiple Std's and or reports having.
Multiple partners. Those two are patients that we need to be consulted on to further assess.
So sexual abuse and trafficking cases have a flow chart in the that is utilized by Ed providers and it's you can view it here. But basically we are the first contact to be called. So once the sexual abuse or sex trafficking is identified, social work is going to.
Be contacted and our response is to obtain some history and we'll go into detail about how to obtain that history.
The first thing we're going to be looking at is.
The time of contact.
They link the time that the last contact was for the sexual act, and so that's something that we will be responsible for obtaining from the provide the caregiver or from the patient themselves.
What we also need to determine immediately is if the child is safe. So is the child

disclosing abuse by the person that's with them at children's mercy is the alleged perpetrator even nearby.
Could they be in the waiting room?
The parking lot is the adult with the patient, not a legal guardian.
So does the adult with the patient seem to be someone that is?
Someone of concern?
Someone that may not be appropriate for that to be bringing in a child.
To the emergency department.
So those kind of things could raise alarm and we need to further assess those and do what's best for that to keep that child safe.
And does the so part of the first three that I discussed, we would want to implement probably a one to one or to determine some more information from the caregiver prior to, you know calling off the one to one or something different with the safety plan.
But we need to 1st if we if we have those concerns, we need to do a one to one and then social work needs to further assess the situation.
There's also times where the adult that's present is say they were told to bring the child in by children's division.
But they're, but they're telling you they don't believe the child or it's obvious that they're not being supportive of what the child is disclosed. If those are concerns.
And that's the person that's with them.
Then a one to one is is important to do as well, because that guardian or whoever is with them could.
Be trying to get them to change their story, or just being insensitive to the situation and causing more trauma on that child in addition to what's already occurred.
So how social work will respond is we'll speak with the provider and nurse to determine who's with the patient.
We'll meet with the caregiver and determine if the adult is a legal guardian to the patient.
What their role is with that patient, if they're not a legal they're not a guardian.
Determine how they know the patient and if it's appropriate to contact the parent guardian to have them aware the patient's here.
That's if they we feel like that person is a possible trafficker or perpetrator.
Social work and provider may decide that a one to one safety plan is needed and that can be implemented by social work and then the provider would put in an order.

For the one to one, security may be needed to stand by. If there's a concern for eloping.
And be available if it's necessary to escort the adult out of the hospital if it's determine the adult is not a parent or guardian, they do not have the right to have any legal information about any medical information about the patient.
There are times where children are come in for a safe with a safe adult.
That's not the legal guardian, and that's just that's OK, 'cause, you can seek care.
For abuse, you can give consent if you bring a child in or you know if abuse is the concern. The Ed can continue to treat that child.
However, it just needs to be determined if that person is a safe adult for them to be with.
So social work will determine if by talking with the parent guardian when the assault occurred, if it's been less than five days for pubescent female.
Then it qualifies for an acute exam or they have acute symptoms.
So that's when we would call the same nurse and we would discuss the next steps with the same nurse.
For a pre pubescent female or any male of any age.
The last date of contact has to be 3 days or less or they have a or may possibly they have acute symptoms than a sane nurse could also come in.
So for anything beyond those time frames, we would need to schedule them in our scan clinic and that would be a referral that would be made-up on their discharge from the ER and then they would be seen in the ER for a medical screen and then they.
Could do labs or any other testing?
That's necessary at that time as well. They just wouldn't have a forensic exam.
So questions for patient and caregiver, these are some questions we just want to make clear when we are meeting with the parent. So we understand what the contact was when it happened and kind of how what initiated the disclosure.
So where were you when the child made the disclosure?
What situation led up to the disclosure?
What were the exact words? It's also important to have to know the exact words.
So that we know exactly what the child's disclosed and what did you do with that information.
Did you tell anyone?
Did you report it to anybody?

Did you notify anyone else about the disclosure?
Did you just come straight to the ER?
So those are the things that we're trying together initially and then we go on to complete our psychosocial assessment and and complete the rest of the information necessary for a patient at risk assessment.
There are times where the child may not have the child, may not have disclosed to the parent or caregiver. Whoever brought them to the emergency room, and so we're having to gather that information.
Ourselves so that we can know how to properly proceed with the next steps medically.
We don't want to complete a forensic interview, but talking with a patient and getting some necessary information is not a forensic interview.
Children will usually be scheduled for a forensic interview and also they'll be interviewed by Child Protective Services.
So they'll have a couple of other interviews that are necessary after they're in the ER or at the children's mercy.
The social work may decide to complete that cursory interview.
And then we want to limit it to what happened, by who?
Where did it happen?
When did it happen and what body parts touched during the assault?
What skin to skin contact was there?
It's important to also obtain consent for the exam and ensure autonomy throughout the exam process.
How can we?
How do we talk to to our patients? Teens in the ER to assess for trafficking, to assess for concerns? We also can do that as social workers to engage with the patient.
And teen about.
To further assess if there's any additional needs aside from the sexual assault that's been disclosed.
Or maybe there hasn't been a disclosure and there's just these concerns for trafficking and we need to kind of decipher what's going on.
These are just an example of some questions that we can ask a patient and come to the bedside, ask them if they're OK. Are they safe?
Are you scared or frightened by people in your everyday life, at home or at school at church?

Are there people in your home where you live that make you uncomfortable or scared?
Can you tell me names of people than your life that you feel comfortable talking to?
If anyone ever.
We're trying to force you to do something that you did not want to do.
So it's important to assess who they might feel safe with. Who can we call?
And and help support them if we need to get someone there.
And to assist in identifying sex trafficking, social work may also ask has someone given you or offered you money or drugs gifts, or a place to stay in exchange for sex or sexual acts?
Has someone forced you or made threats towards you to engage in sex or sexual acts with them or with others?
Has anyone ever taken photos or videos of you with or without clothes on without your consent, engaging in sexual activity?
And if you're a child, you don't have to give consent.
So are human trafficking screenings at children's mercy are done by a provider so social work can ask the questions.
We just cannot complete the screening tool that's used in Children's Mercy Hospital, so this is a a copy of the screening tool that you'll see on your screen.
The first questions are going to be more of those risk factors. Those medical questions that might lead a child to be more at risk of being trafficked.
The last questions I think 7.
Through 10 are those more direct questions about?
Being forced to, you know, do anything they didn't want to do sexual acts given in exchange for something and the photos or videos.
So a children's mercy ER provider can choose to complete that screening tool, and if they have trouble, you know, identifying what to do, you can direct them to call.
The scan on call provider or the same provider and they should be able to direct them to the tool and how to utilize it if a child.
Is high risk or positive for trafficking.
Social work is consulted and we would do be completing those human trafficking hotlines, and Nick Mick reports.
Sane will complete these screenings if they are completing a sane exam, and social work will complete all necessary reporting.
Trafficking is not always obvious. Like Heidi mentioned, it's important to screen when

there are concerning behaviours.
So if there's a runaway disclose multiple sex partners.
Other red flags may initiate a console and a trafficking screen, and then saying does keep data on the screenings.
So I just want to go over some trauma informed sensitive practices when you are engaging with patients that come in for sexual abuse or trafficking concerns.
Just to be aware of, you know, being compassionate, being honest, making the environment as comfortable as possible.
I always grab a warm blanket when I go into the room and and ask if they like the blanket. If there's anything else I can do with the lights in the room to to allow them to to just be it. Be comfortable as much as possible in the.
Situation. We want to empathize with them.
Imagine what you would want someone to say in this situation.
It's, you know, the first thing that I always say is I'm sorry.
I'm sorry that this happened to you.
This is not your fault.
And then what can I do to support you during this time?
You want to normalize the experience.
Create a sense of safety.
You're in the right place.
The staff here are here to make sure you get your needs met and we take care of you.
You want to validate their questions and comments so.
Whatever they have to say, just validate their concerns. It may be something that seems you know, irrelevant to you, but it may be very important to them.
So validate that and then foster trust.
Talk about things in non medical terms.
Make sure they know the next steps of the process.
Make sure they know what to expect next during the exam.
I always you know, before Sean even gets there, I'm telling them that we're just going to make sure that your body is healthy.
We're here to make sure everything is healthy and that's, you know, that's as much as I go into the medical part. I always reassure them that the that the nurse is going to explain in detail all the medical steps that they'll be taking.
And we want to ensure that there's always a safe discharge plan.

Social work will develop the safe discharge plan for the patient in collaboration with the medical team and determine, you know, if we need to involve if we're involving children's division and and other agencies, then we need to coordinate with them if they're available.
There's sometimes where CPS is not like on the Kansas side is not available after hours.
So you want to collaborate when you can, and you also want to ensure the safety of the child when.
And they leave the hospital.
Safety could involve removal of the child from the home if the perpetrator is is still there and there's no means of getting them out.
So maybe coordinating what's the best thing for them, whether that's physician custody or an admission temporarily until we can get a permanent discharge plan.
And it's also important to document the discharge plan or the safety plan.
I'm sorry when you are completing initial, initially completing those one to ones or the restrictions or if we put place a child on blackout social work responsible for printing that blackout order in and completing that template that alerts for safety plans and restrictive visitors.
So we are mandating reporters, so we're going to be contacting our community agencies to report all disclosures of sexual abuse and sex trafficking.
We're gonna be disclosing or sharing reporting that information to children's division of Missouri. Kansas is DCF or if there's an outside state that we need to report to that we report to where the victim resides and that's where we're reporting to.
Social work will report all disclosures to law enforcement.
Reports are made where the crime has occurred, so if the crime occurred over in Kansas, but the child lives in Missouri, we're getting Kansas law.
Enforcement involved. And when it comes to trafficking reports, we are we have a protocol for reporting to the national hotline for trafficking.
And nicknic for missing and exploited children, as well as sending an e-mail to our FBI unit in Kansas City.
That is a secure e-mail group that goes to other law enforcement units in the area as well.
And they collaborate with supporting.
The local law enforcement agency that's involved.
For trafficking, social work may also decide to make a referral to Kansas legal services

or the legal aid to assist with any immigration issues or other legal needs to help remedy their situation.
I just spoke with a legal aid representative today and they do have an online referral link that is on their website that they said we can use ourselves to.
To make those referral.
So we don't to use Kansas legal services if they if it's something that we think legal aid in Missouri can assist with, we can also do that as well.
So contacting law enforcement?
Just a couple of things I want to point out.
We always want to report to law enforcement if a child's disclosed sexual assault to anyone.
We want to report to law enforcement if the exam shows concerns for sexual assault, but maybe there's not been a disclosure or if another child's disclosed on the behalf of the child, say a sibling saw the sexual act and disclose that information.
And if there's any skin to skin to contact in a perpetrating nature, that would need to be reported.
If there are any concerns that a child's not ready to disclose, however, after your assessment you have concerns or there's red flags that sexual abuse may have occurred or trafficking may have occurred, then you would also be notifying law enforcement.
One example of that is if you find out that they've been in in a home of someone on the sex offender registry or something where there's a high risk situation and but yet no one's made a disclosure.
Law enforcement needs to be notified.
No matter what the alleged perpetrator's age, this is something that that comes up quite often is child on child reports, and our concern is that the child that's.
Heidi had mentioned children who have been perpetrated on often become perpetrators, and so.
They the whole situation needs to be investigated by by law enforcement. If a child is doing those kind of things to another child.
'Cause, they've learned that somewhere or they're in a situation where they're probably not safe. If you ever have any questions about reporting underage sexual activity.
Do have a standard work on that?
And the link is in in the in the slides that you can go to and it just talks about the risk

factors of when you know when to determine kind of to report or not report based on the the ages of the children and teens involved is usually.
What that involves?
And if a police are unable or unwilling to respond to the hospital, just document that in the par. Make every effort to make that report.
Don't rely on the family to make those reports. We really need to be making our reports ourselves when we're concerned about abuse.
And then the contact information here for the FBI.
Task force is there for the urgent and the.
Non urgent numbers, the trafficking hotline and the nikmik.
This is an example of the form that we use for emailing to our human trafficking FBI.
Task force so please be sure to use the template an e-mail to those e-mail groups below they will they look at every e-mail that we send them.
They determine if they want to, how they want to.
Respond whether they want to support, assist, defer those things that they determine on their own, and will often times reply back to us to let us know.
If there's any additional information or follow up.
Patient at risk assessments are always completed any time there's a consult for trafficking or sexual abuse, a par needs to be completed by the end of your shift and assure that all demographics are included, especially the the safety plan. If you can include the safety plan information of.
Where that child's going, that's really important as well.
And then all pars are reviewed by scan.
And then look, we talked about earlier, always use that template.
Now it's kind of embedded in our.
Assessments but go to that template and use our safety plan template along with those blackout orders.
And then often times there's a bridge screen follow up. If IPV is identified and any kind of legal note if legal information is is provided, that is new to the patient's situation.
Just real quickly.
If you're the disclosure or the consult occurs in one location, a children's mercy and they're transferred over to the ER for further exam.
Just this is just a slide to say like this is how we would assess, determine the safety collaborate. We do all the parts that we would normally do, except we may need to

pass off like the law enforcement report or.
Or notify, you know, social work in the ER that the child's going to be transported.
And this is how they're going to be transported. And what else needs to be done.
And then anytime we send a hand off for an admission or to the skin clinic, we need to do that through our message center, hand off protocol.
So I want to go over now that we we got about 10 more minutes left, I wanted to share a couple of slides. This is going to I guess I would ask that you unmute yourself to share because that would be a little easier for me 'cause I.
Don't have the chat function available, so social work received a call from a detective before 13 year old female arrived at the Ed.
With their mom for a safe, the patient disclosed sexual abuse by her stepfather.
The patient's disclosure included that she'd been given medicine last night and the next thing she remembers was a stepfather was inside of her.
And she had vaginal pain, Mom told social work that she does not believe patient because she has cameras in the home and the patient shares a room with her two year old sibling.
Mom called patient a liar and demanded proof that anything happened, Mom said.
Stepfather's on parole and he could go back to jail.
What do you do next?
Who would like to share what they would do next?

SE **Shaffer, Sarah, E** 1:19:30
I would maybe separate Mom and the patient to talk to the patient a little bit more about what happened and then go and talk to mom and just be like we have to take the patient's word for it.
So we're gonna, if you can send, we're gonna go ahead with the safe exam.

Lee, Sarah, E LCSW, LSCSW 1:19:52
Yeah. Yeah, I think that's great. Separating them and then possibly implementing A1 to one if we don't think Mom's gonna be real supportive. What do you think about that?
And that's something we can do if we, you know, after talking to Mom, we still feel like, you know, things aren't going to go well, if if it's just mom and the child there.
All right. So the next one is a 16 year old and this one is one that I just want to point

out some risk factors for and. And and after we share.
The scenario so 616 yes.

Stallbaumer Rouyer, Jennifer, S 1:20:40
Sarah. Sarah, before we, before we move off that that I heard her also seem to ask or to suggest that if the mom consents to the exam and I just want to clarify if the mom's not believing her but the child wants the exam, I don't know.

Lee, Sarah, E LCSW, LSCSW 1:20:44
Sorry.

Stallbaumer Rouyer, Jennifer, S 1:20:56
How the child would have to be. But if the mom is refusing to consent to the exam but there is that concern for sexual abuse, can we override a parent's ability to? Consent. Or do we need to honor that decline?

Lee, Sarah, E LCSW, LSCSW 1:21:10
If the so if the parent's not consenting to the exam.
And it's like a child.

Stallbaumer Rouyer, Jennifer, S 1:21:16
Correct.
Your scenario that you just did.

Lee, Sarah, E LCSW, LSCSW 1:21:21
Yeah. Let me go back.

Stallbaumer Rouyer, Jennifer, S 1:21:22
Put the mom declined to consent to the sexual abuse exam, and so therefore we would not complete it.

Lee, Sarah, E LCSW, LSCSW 1:21:29
If the mom declined it, we would not complete the exam.

Stallbaumer Rouyer, Jennifer, S 1:21:32

OK.
I was just checking.

Yeah.
Now if the what we have to have is the child's consent on top of the parent's consent.
But yeah, if the parent is not consenting to the same exam, then we would not be able to do the same exam.

Ask a question.

Is there an age where?

What would that be if it was like a teenager?
Sorry, yeah.

If if it. Yeah, I mean, if a team comes in on their own, it would be it would fall under my understanding it would fall under sexual adolescent sexual health.

No, it's OK, that's my question too.

But if a teen is coming in with their parent, I think that's where it gets tricky on who can give consent.
'Cause the parent is there.

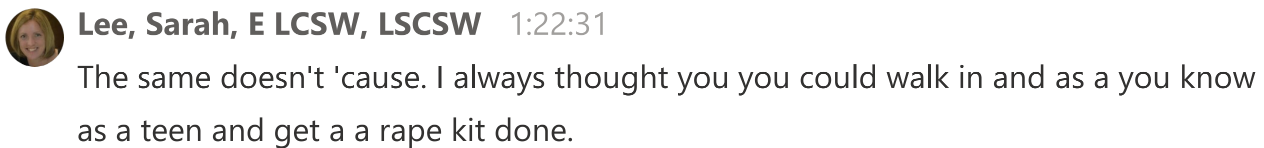
Sarah, I can chime in from a sane perspective.

Lee, Sarah, E LCSW, LSCSW 1:22:18

Yeah.

Heidi Olson 1:22:20

So two things not to open a whole can of worms, but the last thing update I went to, we actually found out from legal we do not fall under reproductive care like Satan no so.



Lee, Sarah, E LCSW, LSCSW 1:22:31

The same doesn't 'cause. I always thought you you could walk in and as a you know as a teen and get a a rape kit done.

Heidi Olson 1:22:37

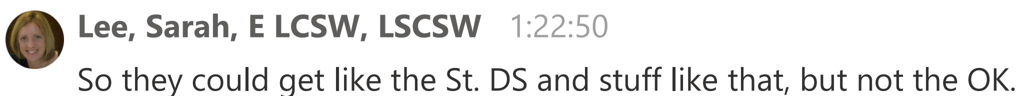
Yes.
We all thought that too.
So Austin, Sarah and Carrie, your way to explain.

Lee, Sarah, E LCSW, LSCSW 1:22:41

OK.

Heidi Olson 1:22:44

Sort of. Some nuances we found out about that, but we don't like fall under Title 10 or anything like that.



Lee, Sarah, E LCSW, LSCSW 1:22:50

So they could get like the St. DS and stuff like that, but not the OK.

Heidi Olson 1:22:50

So that's one thing.
Right, yes.
So that's a whole thing, but.
Kind of what we teach the Saints is that, like, pubertal and pre pubertal sort of the cut offs. If we have a pubertal patient that we feel like can consent and the parents

don't want to, we go with the child.
Wishes so.

Lee, Sarah, E LCSW, LSCSW 1:23:10
We go with it, OK?

Heidi Olson 1:23:10
Like if a 1213 year old wants to do it and Mom saying no, we'll we will do the exam if the kids OK with it.

Lee, Sarah, E LCSW, LSCSW 1:23:18
OK.
Good. That's good to know.
I don't see that often where there's one or the other, or one without the other.

Heidi Olson 1:23:22
Yeah.

Lee, Sarah, E LCSW, LSCSW 1:23:24
So that's great.
So they can consent, but they can't go in by themselves and consent. Is that what you're saying?

Heidi Olson 1:23:31
Yeah. Yes.
And I'll I'll have same follow up to kind of see how they're addressing that. But that was a whole thing we talked about at our last update.

Lee, Sarah, E LCSW, LSCSW 1:23:39
OK.
Well, more to come on that one.
That's a good question.

Harris, Danica, LCSW 1:23:44
Hey, Sarah.

Lee, Sarah, E LCSW, LSCSW 1:23:45
Yeah.

Harris, Danica, LCSW 1:23:46
You're getting some other questions and I know you can't see the chat.
The question is if a if a parent would refuse the exam, do we then escalate or report this?
So I don't know if you want to speak to that or if someone else wants to speak to that.

Lee, Sarah, E LCSW, LSCSW 1:24:06
I would think that would be something that would be part of our reporting.
So, like we would be reporting that the parent refused the same exam today.
But it doesn't mean that, like children's division, may not or may respond and like bring make the mom come back the next day.
But we wouldn't be like taking custody in order to.
I mean, I don't of a situation we would take custody in order to complete a sane exam immediately.

Camerer, Michelle, H LSCSW, LCSW 1:24:39
Sarah, I just wanna point out that our policy, our consent for medical care policy, shares it with a minor as alleged have been physically, mentally, emotionally, or sexually abused or neglected.
No consent is required to medically examine the minor in order to determine whether abuse occurred, so just wanted to throw that out there for everyone. You know, we're going to be giving our presentation in a few weeks on consent, but.
To Heidi's point, I think those are in line with one another.

Lee, Sarah, E LCSW, LSCSW 1:25:09
So that's for determining abuse. But does that include a sane exam?
So we would go ahead and I guess I'm not understanding.

Camerer, Michelle, H LSCSW, LCSW 1:25:18
Well, we can get further clarification, but it specifically addresses sexual abuse.

Lee, Sarah, E LCSW, LSCSW 1:25:24
OK.
Are there other questions about that first?

Harris, Danica, LCSW 1:25:36
There there is a question in general that comes from something you mentioned earlier, but I do think it's worth having a little bit more of an explanation. One of the questions was maybe just explaining why social work would be the ones to interview the patient about what seems.
To be more medically related, IE what body parts were touched, obtaining consent, etcetera.
That was the question.

Lee, Sarah, E LCSW, LSCSW 1:26:00
Yeah. So the social work is the first contact in the ER.
So once they've been triage social, if if there is not a caregiver to obtain that information from, then we would be the ones to talk with the the child about.
What? You know what contact occured so that we can determine what what steps need to be taken next as far as a sane exam or medical screen.
But that's that's the way it's that's our that is the way the flow chart is for.
For establishing.

Falbo, Ashley, M LCSW, LMSW 1:26:42
What if the doctor's already involved?
And the doctor consults us 'cause. There was an acute disclosure.
And the doctor didn't ask any more information.

Lee, Sarah, E LCSW, LSCSW 1:26:58
Well, if the doctor's already involved and already has, the has already heard the disclosure, then we would our role might just be to determine when the last contact was.
If they haven't asked that question, is that what?
Is that what you're saying, asking?

Falbo, Ashley, M LCSW, LMSW 1:27:20

Well, just some things that have come up have been like, oh, the patient says.
This super vague disclosure and social workers told about it, but it's not enough of a disclosure to report, so we need more info.
So, just as in like why would social work then be the one to go get more info versus the doctor with what seems to be more medically related questions. I've just seen it come up.

Lee, Sarah, E LCSW, LSCSW 1:27:48

Yeah.
Well, I think.
Our expertise is in how to talk with patient or children and teens. And so I think it would be trauma informed for us to be the ones to try to obtain that information in a in a manner that might be different than the medical provider obtaining the inform.
So it's a discussion you can have with the doctor to determine who wants to go back in.
But my point in sharing the information is how we can.
Establish that information.
When we're the ones attaining it.
So I had like three more, three or four more case scenarios, but when running out of time, so if there are any other questions related to what we've already gone over, we can.
Heidi and I can answer those or and then I can just share the the slides.
There was a couple I wanted to.
To get to but one of the things that we really need to understand is our role is, is to complete those assessments.
With with either the caregiver or possibly needing to talk with the with the teen.
And sometimes our consults are going to be very vague, like the one that is in front of you. The consults very vague.
We don't know exactly why they're concerned about trafficking.
It's not black and white, and it doesn't have to be.
It can be concerns that the provider has has shared with us and then what can we do in as a social worker to further assess, to determine if anything else needs to be done.

There may not be anything that needs to be done or reported, but we we need to ask the questions and we need to do those things because we could be missing a child that that could possibly be being trafficked.
If we're not.
So that's what I'm gonna end today is just being aware that we do have the skill set to talk with patients and to intervene and assess and determine what next steps need to be done. And reporting needs to be done and how to and make ensure that the. Child's safe.
Thank you guys so much for joining us today.
Hope you have the rest rest of your afternoon as really well.

◉ **Falbo, Ashley, M LCSW, LMSW** stopped transcription