Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

______________________________ ______________

Maya Lakshman Date

A Preliminary Assessment of "Framework for Addressing Re-Traumatization of Survivors of Commercial Sexual Exploitation of Children (CSEC)" based on Stakeholder Input

By

Maya Lakshman
Master of Public Health

Behavioral Sciences and Health Education

____
Dabney Evans, MPH, PhD
Committee Chair

____
Elizabeth Walker, MPH, PhD
Committee Member

____
Colleen McBride, PhD
Department Chair

A Preliminary Assessment of "Framework for Addressing Re-Traumatization of Survivors of Commercial Sexual Exploitation of Children (CSEC)" based on Stakeholder Input

By

Maya Lakshman

Bachelor of Science
Emory University
2017

Thesis Committee Chair: Dabney P. Evans, MPH, PhD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
In the Behavioral Sciences and Health Education
2019

ABSTRACT

A Preliminary Assessment of "Framework for Addressing Re-Traumatization of Survivors of Commercial Sexual Exploitation of Children (CSEC)" based on Stakeholder Input
By Maya Lakshman

Survivors of Commercial Sexual Exploitation of Children (CSEC) experience severe mental and emotional trauma, as well as re-traumatization due to the repetition of distressing experiences to multiple professionals. The system that is currently in place to address survivors' mental health needs is limited and does not take re-traumatization into account. A multi-disciplinary framework was created by the principal investigator to display specific ways that law enforcement, clinicians, and social workers can collaborate with one another. The purpose of this project is to assess the feasibility of implementing this framework designed to reduce re-traumatization among survivors of CSEC.

Focus group discussions (FGDs), and in-depth interviews (IDIs) were utilized to explore the perspectives of four groups of stakeholders on the framework, as well as determine the changes that should be made to the framework to increase feasibility and effectiveness. From November 2018 to January 2019, three mixed FGDs and three IDIs were conducted. Law enforcement, clinicians, social workers, and survivors were recruited for the FGDs, and survivors were recruited for the IDIs. The FGDs were used to generate group conversation regarding the feasibility of the four parts of the framework and the effect the framework would have on reducing re-traumatization. The IDIs were informed by results from the FGDs and focused on attaining adult CSEC survivors' perspectives on the framework.

The majority of stakeholders believed that the framework could effectively reduce re-traumatization among CSEC survivors because of its promotion of inter-professional collaboration. They proposed various suggestions that were integrated into a revised framework, such as the creation of consistent, case-by-case protocols for professionals, allocation of resources toward ensuring mandated therapy attendance, and an alert and contact system for collaboration during data sharing. Survivors also provided suggestions for a more survivor-centered framework.

The findings of this project indicate the importance of studying re-traumatization of CSEC survivors and affirm the need for a comprehensive framework. The findings additionally provide insight into the resources currently available in Georgia and the ways that a framework such as this one could be implemented. The findings serve as the foundation for future collaboration and research on the ways that each part of the framework can be implemented. The stakeholder perspectives documented in this project may be transferable to other counties and states, and can be used to improve available mental health resources for CSEC survivors. The results will be used to guide pilot implementation of the framework.

Keywords: *CSEC, mental health, re-traumatization, qualitative research methods*

(Word Count: 398)

A Preliminary Assessment of “Framework for Addressing Re-Traumatization of Survivors of Commercial Sexual Exploitation of Children (CSEC)” based on Stakeholder Input

By

Maya Lakshman

Bachelor of Science
Emory University
2017

Thesis Committee Chair: Dabney P. Evans, MPH, PhD

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
In the Behavioral Sciences and Health Education
2019

ACKNOWLEDGEMENTS

First and foremost, this project is dedicated to all of my participants. They made this possible. I am beyond grateful for supporting and believing in this project and for sharing their perspectives, experiences, and knowledge with me. And for all the survivors who participated, I am beyond appreciative for their candor and willingness to speak with me. It was truly my honor.

This project would not have been possible without the support of agencies all around Atlanta. Thank you so much, Heather Beitz and iResearch Atlanta, for her generous funding for this project. I appreciate her willingness to support this endeavor and for the incredible work that iResearch Atlanta is doing in the mental health field. I would like to thank Judge Vincent Crawford, Ms. Shayla Choice, and Mr. Colet Odenigbo for their support with recruitment, for generously offering the DeKalb County Juvenile Court spaces for the focus groups, and for so much more. I would also like to thank Mr. Jerry Bruce, Director Tom Rawlings, Dorsey Jones, and Dr. Jordan Greenbaum for providing insight on this project at its inception and for their guidance throughout, and to both the Georgia Supreme Court's Committee on Justice for Children and DeKalb County Board of Health for their support, both through funding and mentorship. A special thanks to Ms. Almanzia Opeyo and Ms. Monique Farone from DeKalb County Board of Health-this project would not have become what it is without both of them.

To both Dr. Dabney Evans and Dr. Liz Walker, my sincerest thanks for encouraging me throughout this process. I thank them for the answering a million questions and for going through dozens of edits for this project. From the very beginning, they have both believed in me and in this project. I am so excited to continue working with both of them as we take this project forward, first as a manuscript and hopefully in the future, in the form of pilot implementation. Definitely the best committee I could have asked for.

I also would like to thank Rollins for the incredible education I received here. I met students and faculty that have changed the way I see the world. I have learned so much these past two years, personally, academically, and professionally.

Finally, this project was also made possible by my two incredible research assistants, Sarina McCabe and Kiannah Kossari. I am in awe of their compassion and brilliance, as well as the unique perspectives they brought to the project. They are incredible individuals and I am excited to continue this work with them.

To my friends, both at Rollins and beyond, thank you for supporting me through these last two years (and for the late-night writing sessions and editing)! To my family, thank you for listening to me talk about this project for months on end and for sticking by me.

I am so excited to see where this project goes next!

TABLE OF CONTENTS

Narrative **1**
Definitions **3**

Introduction **8**
Commercial Sexual Exploitation of Children 8
CSEC, Trauma, and Mental Health 9
Limitations of Current Mental Health Resources 9
Proposed Framework 11
Theoretical Foundations 11
Purpose of this Project 13
Literature Review **15**
An Overview of CSEC in the United States 15
Risk Factors for CSEC 17
Recruitment of CSEC Victims 20
Trauma 21
Mental Health Consequences of CSEC 24
Stigma 27
Mental Health Resources Currently Available for CSEC Survivors 28
Re-Traumatization of Survivors of CSEC 30
Gaps in the System: What Needs to be Done? 31
Conclusion 34
Methods **35**
Setting 35
Study Ethics and Informed Consent 35
Research Methods 36
CIs 39
FGDs 40
IDIs 41
Data Management and Analysis 42
Results **46**
Protocols for Interagency Data Sharing 47
Type of Data Reported *47*
Alert and Contact System *49*
Implementation *51*
Training Priorities for Stakeholders 51
Victim and Risk Factor Identification *53*
Consistent, Up-to-Date Protocols *55*
Survivor-Informed Trainings *57*
Trainings for Foster Parents *58*
Therapy for Survivors and their Families 59
Court-Mandated Attendance to Therapy *60*
Therapy for Guardians *62*
Referrals and Risk Evaluation *63*
Foster Placements for Survivors *64*

Potential Impact of Framework on Stakeholders 65
Benefits *65*
Re-Traumatization *67*
Challenges *68*
Elements of Survivor-Centered Care 70
Trauma-Informed Focus *70*
An Environment of Trust: Reclaiming Power and Control *72*
Survivor Involvement in the Framework *74*
Conclusion **75**
Discussion **76**
Effects on Re-Traumatization 89
Limitations and Strengths 90
Conclusion and Implications 91
References **94**
Appendices **104**
I: Semi-structured Focus Group Discussion Guide 104
II: Semi-structured In-Depth Interview Guide 107
III: FGD and IDI Combined Coding Tree 110
IV: FGD and IDI Combined Codebook 112
V: Framework for Addressing Re-Traumatization Among Survivors of Commercial Sexual Exploitation of Children (CSEC) 126
VI: Framework for Addressing Re-Traumatization Among Survivors of Commercial Sexual Exploitation of Children (CSEC)-***Revised (1)*** 127
VII: Framework for Addressing Re-Traumatization Among Survivors of Commercial Sexual Exploitation of Children (CSEC)-***Revised (2)*** 128

NARRATIVE

Caged by a tumultuous home life while also suffocating in toxic peer circles at school, 13-year-old Liam desperately sought emotional refuge. He did not find it with adult mentors like his teachers, who were already drowning in their overcrowded classrooms and overburdened schedules. Liam and his mother quarreled constantly and his siblings mocked him. When Liam asked his mother to stop calling him her 'daughter' and call him by 'Liam' rather than 'Leah,' the argument exploded into a violent fight so loud that the neighbors called the police. The itch to belong proliferated in his feelings of isolation, and Liam began to seek a sense of solidarity elsewhere. He found it in the shadows, the blind spot of the adults and caregivers around him. He began spending his free time with the mature kids who skipped school and went where they wanted instead of returning home. He found out that many of these kids traded favors for jewelry, new clothes, and video games. Some of them even spent several days 'vacationing' with men who bought them gifts before returning home.

A woman told Liam he could be a part of their family if he played "the game" and protected their family secrets. Liam felt like he had found a true refuge and escape. He had everything he longed for: a community and a purpose. However, when Liam found himself losing control and the game consumed his life, he started to feel trapped. The gifts he received no longer measured up to the turmoil he felt, and Liam found himself without an escape.

The police soon discovered the "game" and all the places that the men would take Liam and the other kids. Liam's world began to crumble. Police, nurses, and other uniformed adults hurled questions at him. Many of them asked the same questions, forcing Liam to repeat his story multiple times. They undressed him, forced him to give up the names of his friends, and left him

alone in a room for hours at a time. When he repeated his story to person after person, they scrutinized his every word for inconsistencies and berated him when he misspoke. Badly shaken and overwhelmed, Liam staggered through his story each time. When he fumbled or needed to pause to collect himself, a nurse accused him of being uncooperative, saying, “Come on, I don’t have all day.” He simultaneously felt like he had betrayed himself and had been a traitor to his friends. He was put on a list to go live in a safe house, but he never received a placement. While sitting in the waiting room, he overheard a couple of social workers talking, “There’s no space for a kid like that! He/she’s a safety hazard.” Liam felt tears welling up in his eyes.

On the car ride home, his mother hissed, “How could you let this happen?” and “What were you thinking?” With advice from the court, she signed him up to start attending therapy sessions. During Liam’s first therapy session, his therapist pressured him to tell him what had happened. Towards the end of the session, the therapist muttered under his breath, “No one does that to a kid unless they’re asking for it...” Engulfed in guilt, betrayal, and a profound despondency deeper than ever before, Liam spiraled into a dark corner. He grew bitter, lashed out at his siblings, and stayed away from his house for long hours. A few police officers caught him one night and returned him home. His mother kicked him out a week later.

Liam had no choice but to return to the streets. He reconvened with his friends from “the game”. Law enforcement found him hanging around with a bunch of older men and interrogated him. He flew into a rage and snapped at them. They asked him why a “girl like you” would spend time with delinquents and why he acted like a boy. When Liam started to cry, they derisively laughed at him. Everywhere around him, reminders of what had happened consumed Liam. A song on the radio, or even certain smells would transport him back to a motel room, an

unfamiliar man's car, to the cackle of a zipper as he waited with his eyes screwed shut for the man to finish.

Liam felt as though no one understood him, and more than that, that nowhere was safe. His friends from the "game" seemed to be the only people who connected with him, and they offered him relief in the form of needles, bottles, and sex. With his 18th birthday coming up, Liam felt increasingly empty and lost. Feeling angry with himself, resentful toward his mother, and wallowing in a deep sense of faithlessness, Liam saw no clear path to begin healing from the cyclical trauma he sustained.

ACRONYMS AND DEFINITIONS

Acquired Immune Deficiency Syndrome (AIDS): A disease characterized by a severe loss of the body's cellular immunity, lowering ability of immune system to fight against infection; a set of symptoms caused by HIV.

Cognitive Interviews (CIs): A face-to-face interview of each participant in the focus groups within a private space to collect preliminary data on the feasibility of the model and shape the question guide that would be used during the focus groups.

Cognitive-behavioral Therapy (CBT): "A form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders and severe mental illness" (American Psychological Association).

Coercive Sex Work: This term is used to define any sexual act that is prompted by the usage of force, fraud, or coercion. This term pertains to both minors and adults.

Commercial Sexual Exploitation (CSE): A type of sexual abuse in which anyone is sexually exploited for money, power, or status.

Commercial Sexual Exploitation of Children (CSEC): According to the U.S. Department of Justice, "The commercial sexual exploitation of children (CSEC) is sexual abuse of a minor for economic gain" (Albanese, 2013, p. 1). This term is used synonymously with child sex trafficking or domestic minor sex trafficking.

CSEC: "a type of sexual abuse in which children are sexually exploited for money, power, or status" (Greenbaum & Crawford-Jakubiak, 2015)

Commercial sex: ''any sex act on account of which anything of value is given to or received by an person'' (Trafficking Victims Protection Act, 2000).

Diagnostic and Statistical Manual of Mental Disorders (DSM-V): The handbook used by healthcare professionals in the United states and the world as a guide to diagnosing mental disorders (American Psychiatric Association, 2013).

Diffusions of Innovations theory (DOI): The process by which an idea or theory gains momentum and is implemented in a society or social system; there is emphasis on the idea that some members of a community are more or less likely to adopt the new idea than others (Rogers, 2002).

Focus Group Discussions (FGDs): A qualitative research method and data collection technique where groups of people discuss a topic or issue in-depth. A moderator facilitates these groups (Kitzinger, 1994). In this project, clinicians, law enforcement, social workers, and survivors were brought together to discuss the model.

In-depth Interviews (IDIs): A qualitative research technique that is used to conduct intensive individual interviews that are focused on specific products or ideas. In this project, the interviews were conducted with survivors, in order to gain more nuanced and detailed perspectives.

LGBTQ+: An acronym for lesbian, gay, bisexual, transgender and queer or questioning. These terms are used to describe one's sexuality or sexual orientation and gender identity (Human Rights Campaign).

Major Depressive Disorder (MDD): A mental health disorder that causes a persistent feeling of sadness and loss of interest in activities of daily life. It affects how one feels, thinks and behaves and can lead to feeling that life isn't worth living (DSM-V, 2013).

Minor: In the United States, a minor is any individual under the age of 18.

Pimp: A pimp is any person who exploits someone sexually for monetary gain. A pimp can be male or female, adult or minor, a family member, friend, boyfriend, or stranger. A pimp is also known as a trafficker, exploiter, or john.

Posttraumatic Stress Disorder (PTSD): A psychiatric disorder that manifests in people who have experienced or witnessed a traumatic event. The symptoms of PTSD include flashbacks, psychological distress, physiological reactions and avoidance of stimuli related to the trauma (DSM-V, 2013).

Principal Investigator (PI): Someone who utilizes purposive sampling to identify clinicians, law enforcement officers, social workers, and survivors (Cresswell & Plano Clark, 2011).

Prostitute: A person who sells his or her body for sexual purposes is called a prostitute. When the term prostitute is used, is implies that the person is willingly selling his or her body, with no regard for unseen factors (Rand, 2010).

Research Assistant (RA): A researcher employed by a university or researcher for the purpose of assisting in academic research.

Re-traumatization: A reminder of past trauma that results in re-living the traumatic event. This can be triggered by repetitive questions about the event. Re-traumatization can simulate or worsen the psychological effects of the actual traumatic event (Bounds et al., 2015).

Safe house: A placement in a secure location where a survivor might be housed and kept safe. Safe houses are meant to be untraceable by traffickers and typically provide support services for victims of violence (International Women's Development Agency, 2016).

Sexual grooming: This occurs when the exploiter showers the victim with gifts and compliments while taking on the role of a boyfriend to try and gain trust from the victim. (Smith, 2008).

Sex tourism: Travelling to a location to take advantage of the lower regulation of prostitution and other sexual activities in a foreign country (Clift & Carter, 2010).

Sex Trafficking: The recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act (Trafficking Victims Protection Act, 2000).

Sexually Transmitted Disease (STD): A disease transmitted through sexual contact.

Stigma: Is a mark of disgrace attributed to a particular circumstance, quality, or person.

Stockholm Syndrome: The bi-directional bonding between hostages and hostage-takers that are perceived by the hostage to be necessary for survival (DSM-V, 2013).

Survivor: This term refers to someone who has exited the sex industry through escape, choice, or rescue.

Survival sex: The trading of sex acts to meet individuals' basic needs for survival (i.e., food, shelter, etc.) These individuals might not have experienced the overt force, fraud or coercion of a trafficker, but they felt that their circumstances left little or no other option (Bigelsen, 2013).

Trafficker: A trafficker is anyone who uses humans for monetary gain. A trafficker uses violence, lies, and manipulation to lure victims. This term can be used synonymously with exploiter.

Trauma bonding: "A form of coercive control in which the perpetrator instills in the victim fear as well as gratitude for being allowed to live." (U.S. Department of Health and Human Services [HHS], n.d.)

Trauma-informed care: Care of a whole person, taking into account past trauma and the resulting behaviors and coping mechanisms when attempting to treat a patient (Greenbaum & Crawford, 2015).

Trauma reenactment: Behavioral enactment and automatic repetition of the past (Van der Kolk, 2003).

INTRODUCTION

Liam's story exemplifies the nuanced nature of the stories of many survivors of commercial sexual exploitation of children (CSEC). His experiences are tragically common. The following sections will explain the factors that put children at risk of being CSEC victims, the mental health consequences of CSEC, the current resources available for survivors, and the ways in which flaws in the resources often harm victims and survivors.

Commercial Sexual Exploitation of Children

The commercial sexual exploitation of children (CSEC), "a type of sexual abuse in which children are sexually exploited for money, power or status," is a widespread global issue with far-reaching mental health consequences for survivors (Greenbaum & Crawford, 2015). CSEC includes trafficking for prostitution, sex tourism, early marriage, pornography, stripping and "survival sex," or the exchange of sexual activity for basic necessities (Greenbaum 2015). In the United States, children are sold through a variety of online sources, such as Craigslist and Backpage (Smith, 2008). In 2016 alone, there were at least 10,506 minors being trafficked for commercial sex (Swaner, Labriola, Rempel, Walker & Spadafore, 2016). There are several individual, family, and community-level factors that can put children at higher risk for being victims of CSEC, including sexual orientation and/or gender identity, lack of family support, and neighborhood violence.

Traffickers and pimps use a variety of strategies to lure children into prostitution; many of which relate to the minor's dependency on them (Albanese, 2007). According to one survivor, "pimps might create a sense of ownership by giving victims new identities and supplying fake identification" (Hotaling, Miller, & Trudeau, 2006, p. 185). Victims might not willingly admit that they are being trafficked, instead denying they have traffickers and claiming that they are

helping their “boyfriends” (Priebe & Suhr, 2005). The relationship between CSEC victims and traffickers continue as a result of trauma laced with intense loyalty and attachment, which occur in the presence of danger and deception (Carnes, 1997).

CSEC, Trauma, and Mental Health

Victims and survivors of CSEC have typically experienced severe and extreme trauma, as well as PTSD. Studies involving survivors also identified a high prevalence of depression and anxiety, alongside symptoms such as headaches, fatigue, dizziness, and back/stomach pain (Hemmings et al., 2016). Many CSEC victims face trauma bonding, “a form of coercive control in which the perpetrator instills in the victim fear as well as gratitude for being allowed to live (U.S. Department of Health and Human Services [HHS], n.d.)

The mental and emotional trauma, as well as trauma-bonding, that CSEC victims face can make them susceptible to returning to coercive sex work. Often, their emotional vulnerability makes it easier for their exploiters to find them again (Jülich, 2008). The system that is currently in place to address the mental health needs of survivors is limited and does not take into account the potentially unique needs of victims (Aberdein & Zimmerman, 2015).

Limitations of Current Mental Health Resources

Law enforcement and healthcare professionals currently follow certain models for addressing the mental health needs of survivors of CSEC. Healthcare professionals have recommended a model of trauma-informed care, which includes recognition of the impact of multiple traumatic events across the individual’s life-course, as well as a commitment to victim empowerment and safety (Family Violence Prevention Fund, 2005; Greenbaum & Crawford, 2015; Macy & Johns, 2011). Other authors also highlight the importance of giving control of conversations to the survivor instead of pressuring them to discuss their experiences before they

are ready (Kung, 2014). Healthcare professionals have also suggested a screening tool for identifying victims and needs assessments to identify potential longer-term health problems, in order to ensure that survivors receive the care and support that they need post-trauma (Aron et al., 2006; Varma et al., 2015). There has been little research on psychological therapies with CSEC survivors, such as psychotherapy, cognitive-behavioral therapy, and individual and group therapy; however some think that these could be useful with this population (Baldwin et al., 2011; Baráth et al., 2004). In regard to law enforcement, research has emphasized the importance of trainings for the police force and other officials on how to interact with victims of CSEC in a trauma-informed manner (Wernham, 2005).

Multiple studies have brought up changes that must be made to existing mental health services that are currently available, and have advocated for the development of specific service models, including multi-agency working and trauma-specific services (HM Government, 2007; Hom & Woods, 2013). Poor information sharing and lack of communication between providers are barriers to coordinating a victim's care (Dottridge, 2006). In a similar vein, researchers have reported a dearth of knowledge about CSEC victims' rights among healthcare professionals, as well as a lack of knowledge of mental health among legal personnel (Isaac et al., 2011). Resources currently available for survivors' mental health are not comprehensive and have not taken into account the case-by-case nature of CSEC. Survivors need support that has been individually tailored to their cases and experiences (Hemmings et al., 2016). Survivors are often asked a multitude of questions about what they have experienced by several different professionals. The repetition of distressing experiences can be re-traumatizing for survivors (Borland & Zimmerman, 2010; Green & Tomkins, 2014; Kung, 2014).

Proposed Framework

The framework being examined in this project sheds light on some of the limitations of current resources described above while aiming to significantly reduce the re-traumatization that CSEC survivors face. It proposes a unique method for interagency data sharing that accounts for potential privacy and confidentiality concerns. The multidisciplinary framework consists of four key parts: a secure, password-protected database for logging pertinent survivor information, a court-mandated therapy program, relocation placements that would ensure collaboration between law enforcement and clinicians, and wraparound trainings for social workers, law enforcement, and clinicians on the principles of trauma-informed, survivor-centered care (See Appendix V). This framework is unique as it reorganizes the existing roles of law enforcement, medical professionals, and social workers in a way that maximizes the time and resources of all stakeholders, while also emphasizing collaboration.

Theoretical Foundation

Diffusions of Innovations Theory (DOI) provides a framework through which to understand the factors that might influence adoption of the above framework by the main stakeholders, including law enforcement, clinicians, social workers, and survivors themselves. DOI Theory was developed by prominent sociologist E.M. Rogers in 1962, and originated to explain the process through which an idea gains momentum and spreads through a social system (Rogers, 2002). The theory emphasizes that all members of the social system do not simultaneously adopt this new idea, but rather some members are more likely to adopt it than others. As described above, a comprehensive framework to reduce re-traumatization among CSEC survivors is a new health innovation. The DOI framework explains the stages by which people adopt this innovation: awareness of need, decision to adopt or reject, initial use of the

innovation, and continued usage of the innovation. These stages are further broken down into factors that influence adoption. For adoption to be successful, adopters must see the innovation as better than the framework it is replacing (Relative Advantage), consistent with their values, experiences, and needs (Compatibility), simple enough to understand or use (Complexity), testable (Trialability), and observable (Rogers, 2002). In other words, an individual or group must recognize their own needs and believe that the innovation would help them. These factors, as well as the individuals' knowledge and overall perceptions of the innovation would influence whether they adopt or reject the innovation.

Rogers applied DOI to preventative innovations, or new ideas that require action at a certain time to prevent a negative consequence at a later time (Rogers, 2002). The framework to reduce re-traumatization is an example of a preventative innovation, as its implementation would aid in preventing further trauma to CSEC survivors. Rogers explains that preventative innovations are less likely to be adopted due to the perceived rewards and benefits being delayed or intangible. Therefore, it would be difficult for the adopters to perceive whether or not the framework is better than the system it is replacing. Following Rogers' model, it is essential that the perceived characteristics of the framework, specifically relative advantage and compatibility, support the implementation of the framework.

To our knowledge, this is the first comprehensive framework that has been developed to address the mental health needs of survivors of CSEC. For this reason, DOI has not yet been used to conceptualize aspects of uptake of interventions concerning this topic. DOI integrates all components of group decision-making, highlighting the most relevant factors in whether or not the proposed framework would be adopted by the stakeholder groups.

Purpose of this Project

As mentioned, the framework of interest in this project includes a thorough strategy to reduce re-traumatization among survivors. Although there is some understanding in the research community about the mental health needs of survivors, no comprehensive solutions have been brought forward. The purpose of this project is to assess the framework using stakeholder input, which would therefore help determine the relative advantage of implementing this framework, as well as the compatibility of it with stakeholders' needs and values. As described in more detail above, the stakeholders who would ultimately need to adopt this framework are law enforcement agencies, social workers, clinicians, and survivors.

Specifically, this project seeks to assess the proposed framework for reducing re-traumatization of survivors of commercial sexual exploitation of children using stakeholder input. In doing so, it will examine how stakeholders perceive the framework in terms of its feasibility and efficacy. This project additionally tests the explanatory power of the DOI for preventative innovations as applied to frameworks targeting mental health of vulnerable groups such as CSEC survivors.

Research Question

What are stakeholders' perceptions on the feasibility and perceived effectiveness of *Framework for Addressing Re-Traumatization Among Survivors of Commercial Sexual Exploitation of Children (CSEC)?*

Research Aims

Aim 1: Examine stakeholder perceptions of the framework.

Aim 2: Identify the parts of the framework that should remain the same and what should be modified to address the needs and concerns of all stakeholders.

Aim 3: Describe solutions that stakeholders presented to concerns with feasibility of the framework.

Aim 4: Document the perspectives of survivors of CSEC on the potential usefulness of the framework.

LITERATURE REVIEW

An Overview of CSEC in the United States

Commercial Sexual Exploitation of Children (CSEC) is defined as "a type of sexual abuse in which children are sexually exploited for money, power, or status" (Greenbaum & Crawford-Jakubiak, 2015). The Trafficking Victims Protection Act (TVPA) of 2000, which includes CSEC as a form of sex trafficking, defines the latter as "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act'' (p. 7) and a commercial sex act as ''any sex act on account of which anything of value is given to or received by an person'' (p. 8). By this definition, then, any minor in the United States who is used in a commercial sex act is considered a victim of trafficking (Rand, 2010).

Minors currently comprise the largest group of trafficked persons in the U.S. (Shared Hope International, 2007). In 2016, there were at least 10,506 minors being trafficked for commercial sex in the United States (Swaner et al., 2016), and at least 325,000 at risk for becoming such victims (Estes & Weiner, 2002; Hughes, 2007). In another estimate, Shared Hope International (n.d.) reported that 100,000 children are victims of CSE in the U.S. annually. Others argue that due to the lack of data, the hidden nature of the issue, and lack of sufficient attention to the issue, there are no reliable estimates of the extent of CSEC in American society (Stransky & Finkelhor, 2008). The inability to identify and locate victims makes it much more difficult to conduct research on CSEC (Mitchell et al., 2011; Fong, 2010).

The demand for children stems partly from the fear of contraction of AIDS or other STDs, which results in buyers' preference of "younger, more virginal girls" (Hotaling et al., 2006). Younger children are targeted because they bring in more profit (Boxill & Richardson, 2007). Of CSEC victims in the United States between 2008 and 2010, 94% were female and 83%

were U.S. citizens (Banks & Kyckelhahn, 2011). In another study, the researchers found that only 10% of study participants had been brought into the country from elsewhere, and 90% had been trafficked domestically (Estes & Weiner, 2001). The average age at which children are lured into coercive sex work is between 11 and 14, although some children are forced into it as early as the age of five (Smith, 2008).

CSEC includes trafficking for prostitution, sex tourism, early marriage, pornography, stripping and "survival sex," or the exchange of sexual activity for basic necessities (Greenbaum 2015). Commercial sexual exploitation is a business, and in the U.S., children are being sold not only on the streets but also via online sources (Smith, 2008). Traffickers typically advertise children online for sexual purposes through hundreds of Web sites, but also search for potential victims through social networking sites such as Facebook and MySpace (Oosterbaan, 2008). Traffickers and exploiters publish realistic advertisements for employment or other opportunities on Craigslist, Backpage and other sites to lure victims into commercial sex businesses, then in turn, post ads on the same sites to sell them (Shared Hope International).

Traffickers and pimps target children and youths at several locations, such as bus stations, arcades and malls. They often target runaways (Albanese, 2013). While some CSEC victims are forced to perform sexual acts in exchange for drugs or money for and by their relatives, also known as "familial prostitution," other victims are groomed by traffickers while they are still at home and attending school (Smith, 2008). Sexual grooming involves the pimp or exploiter taking on the role of a boyfriend and showering the victim with gifts and compliments in order to gain loyalty and trust (Smith, 2008). Sexual grooming is one of the most common ways through which children can get involved in coercive sex work.

There are multiple types and forms of CSEC; some involve the presence of a third party and others might appear to be orchestrated by youth themselves. A study examining the law enforcement records of 132 cases of CSEC in the United States split them into three categories (Mitchell et al., 2012). They found that the largest proportion of sex trafficking cases (57%) involved third-party exploiters, or usually less organized operations with pimps (individuals who control prostitution and sex rings) as well as more organized commercial organizations (such as brothels and parlors). The second largest proportion of cases (31%) involved cases where youth would participate in sexual acts without an identified pimp (the police could not find a pimp); this is most likely referring to cases of survival sex where victims feel that they must sell sex in order to manage a living. The smallest proportion of cases (12%) involved child sexual abuse with incentive of payment. In the last case, family and nonfamily members facilitate the exchange of sex with youth in return for money (Mitchell et al., 2012). Experts, however, consider the last case to be more in line with child sexual abuse rather than commercial sexual exploitation of children.

Risk Factors for CSEC

There are various elements that can make children more vulnerable to sexual exploitation, including individual, family, and community factors.

Individual

Individual risk factors for sexual exploitation can include race, sexual orientation, gender identity, and childhood traumatic experiences. A study of 13 young female victims by Williamson found that 91% experienced high rates of physical, emotional, and sexual abuse prior to being exploited, 64% experienced high rates of parental substance abuse, and as mentioned previously, many experienced runaway behavior or homelessness. In a study by Walls and Bell,

increased risk for sexual exploitation was associated with identifying as African-American or 'Other Race', identifying as LGBTQ+, being a prior drug user, attempting suicide, and having parents who were/are substance abusers (Walls and Bell, 2011). LGBTQ+ youth are at high risk for commercial sexual exploitation due to stigma, social marginalization, overall vulnerability, and homelessness (Cochran et al., 2002). Childhood sexual abuse heightens victims' emotional vulnerability, putting them in danger of exploitation (Stoltz et al., 2007). These risk factors all indicate that unsupported youth are most at risk for being exploited.

Youth may also experience an inability to make clear decisions and may engage in dangerous situations, due to fearlessness, recklessness, and low developmental maturity (Stoltz et al., 2007). An example of such risk-taking behavior might include substance abuse. Youth are more affected by drug use and abuse because they are in a developmental period of experimentation and impulsivity (Stoltz et al., 2007). The low developmental maturity witnessed in children and adolescents puts them at high risk for being victims of CSEC.

Family

Lack of family support puts youth at significant risk for sexual exploitation. Both homeless and thrownaway youth (those who are told to leave home or not allowed to return) are at especially high risk (Estes & Weiner, 2001; Bigelsen, 2013). These children often have been exposed to dysfunctional families (domestic or family, psychiatric disorders, substance abuse, criminality), abuse and neglect, or juvenile justice issues. Family dysfunction, defined by participants as a lack of parental involvement, negative behavior modeling (i.e. substance abuse), and domestic violence, resulted in a lack of support and skewed perception of normality, and was therefore cited as a determinant of commercial sexual exploitation (Konstantopoulos, 2013).

Young girls who are (or whose families) are associated with gangs, or girls who come from areas with high crime rates and poverty are also at high risk for CSEC (Smith et al., 2009).

Low familial and societal supports can also result in discontinuous schooling, another risk factor for sexual exploitation and trafficking (Coy, 2008). In a London-based study consisting of life-history interviews with a sample of 14 women (aged between 17 and 33), Coy found that many women have high rates of school exclusion and were more likely to discontinue their education (Coy, 2008). Less-educated youth were at greater risk for CSEC, presumably due to a dearth of knowledge and resources (Coy, 2008).

Family dysfunction and other circumstances might lead children to enter foster care. According to Coy, a large proportion of women who engage in survival sex reported early involvement in commercial sexual exploitation, despite being in foster care (Coy, 2008). Children may also end up in foster care due to familial abuse and neglect of their mental health conditions or physical disabilities (Deutch, 2015). As a result, they might find that escaping and running away to the streets is a better option, not knowing the risks of homelessness and CSEC.

Community

Neighborhood violence and cultural and societal norms within a community can also be risk factors for CSEC. Youth who are associated with gangs or living in very high crime areas are at risk (Shared Hope International, 2013). Similarly, there is a high risk for CSEC in regions with high rates of adult prostitution, poverty, or transient populations (military bases, truck stops, convention centers) (Smith et al., 2009). Lastly, community attitudes that normalize gender bias and discrimination, sexualization of girls and women, and pimp culture add to youth vulnerability for CSEC (United States Department of State, 2013).

Recruitment of CSEC Victims

Victims of CSEC may be recruited by strangers, peers, or relatives and are then groomed and seduced with hopes and promises of money, attention and opportunities (Smith et al., 2009). Those who exploit CSEC victims are colloquially referred to as pimps. They may pretend to be photographers looking for models, producers looking for actors, or may simply approach younger girls at schools and shopping malls (Hotaling et al., 2006). Recruiters, who may be hired by pimps, do not limit themselves to a particular age or gender. Rather, they look for vulnerable people (Williamson & Prior, 2009).

There are two main types of pimps: the "smooth talking" pimps and the "guerilla" pimps. The former type targets people with low self-esteem and who are looking for a sense of belonging. They provide affection, and then lure them into sexual exploitation. The latter are more immediately violent; guerilla pimps kidnap victims and transport them to unknown locations, where they might rape and beat them (Hotaling et al., 2006).

Many pimps first gain victims' trust through affection and elaborate gifts (Friedman, 2005). This is quickly followed by emotionally abusive behaviors, such as telling victims that no one cares about them (Hom & Woods, 2013). Sometimes the manipulation can include addictive drugs, therefore making victims dependent on the pimp for their supply (Fowler et al., 2010). Children can be manipulated for short or long periods, but the hopes and promises eventually fade into beating, choking, burning, sexual assault, gang rape, psychological abuse, threats and blackmail, all in order to maintain control over victims (Estes & Weiner, 2001; Raymond & Hughes, 2001; Smith et al., 2009). Traffickers frequently alternate between cruelty and kindness, as this creates a strong bond between the trafficker and the victim. These are all strategies that keep the commercial business of sex trafficking thriving (Raymond & Hughes, 2001).

Victims are treated like property. Some pimps tattoo their names on victims as a permanent reminder, and others threaten to kill victims' families should they run (Boxill & Richardson, 2007; Reid & Jones, 2011). The nature of recruitment, as well as these convoluted dynamics between victim and exploiter, can lead to intense and prolonged psychological and physical trauma for victims (Lederer & Wetzel, 2014; Smith et al., 2009).

Distrust Towards Authorities

Many victims of CSEC either fear or deeply distrust authorities, including law enforcement, social workers, and clinicians. Sex workers and victims of sexual exploitation might believe that the sole purpose of authorities is to prevent them from making a living (Marcus et al., 2014). This feeling, coupled with a fear that police cannot or would not be able to protect them, prevents them from reaching out for help. Furthermore, due to harassment they might have encountered, they might believe that authorities despise them and view them as criminals, which may be true in some cases (Helfferich et al., 2011). This perceived stigma is usually very real. Lloyd, a survivor and an advocate, states that most victims of CSEC do not trust the police due to continued abuses, and are far more likely to return to their pimps (Lloyd, 2011). This distrust towards authorities inevitably draws victims closer to their exploiters, otherwise known as trauma bonding.

Trauma

Trauma is defined in everyday language as a highly stressful event, or even a deeply distressing or disturbing experience. Psychological trauma differs slightly in that it also overwhelms and hinders an individual's ability to cope. Psychological trauma is unique to the individual experiencing it and can manifest as a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995). Traumatic events might "overwhelm the ordinary systems of care

that give people a sense of control, connection, and meaning" (Herman, 1997, p. 33). The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V, 2013) defines trauma more specifically as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
>
> • Directly experiencing the traumatic event(s).
>
> • Witnessing, in person, the event(s) as it occurred to others.
>
> • Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
>
> • Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (American Psychiatric Association, 2013).

The human response to trauma, or Post-Traumatic Stress Disorder (PTSD) has been described by five principal features: 1) persistence of startle response, 2) proclivity towards explosive outbursts of aggression, 3) fixation or hypervigilance towards the trauma or similar stimuli, 4) constriction of personality functioning, and 5) atypical dream life (Kardiner, 1941). The trauma response is a complicated one, and a biphasic model has been used to represent it. The response to psychological trauma might alternate hyperarousal and numbing phases, where hyperarousal manifests as aggressive outbursts, intrusive recollections in the form of nightmares and reenactment of situations reminiscent of the trauma, while numbing manifests as social isolation, emotional withdrawal, and an avoidance of any intimate relationships out of fear of

violation or further trauma (Van der Kolk, 2003). Reenactment, a form of hyperarousal, can also appear as voluntary, such as the "choice" of victims of sexual exploitation becoming prostitutes, or physically abused children "exposing" themselves to dangerous situations (Van der Kolk, 2003).

Clinical literature defines psychological trauma as "an affliction of the powerless" (Herman, 1997, p. 33). As mentioned by Van der Kolk, reenactment might be a consequence of the afflicted feeling powerless to stop future traumatic events from occurring, leading to a variety of impairments in social and psychological functioning. Trauma is not simply a one-time occurrence in an individual's life, but rather the result of ongoing experiences and a series of traumatic events throughout their lives (Kessler et al., 1995).

Although trauma was once considered to be a rare phenomenon, recent scholarship has shown it to be quite common in the US. A nationally representative study from the 1990s, The National Comorbidity Survey, found that around 60.7% of men and 51.2% of women had experienced at least one of 12 traumatic experiences (Kessler et al., 1995). In an urban sample of 1,256 patients in inner city Atlanta, 87.8% reported some form of significant trauma in their lifetime. Rates of trauma exposure were similarly high for both female (n=767, 86.1%) and male (n=472, 90.9%) subjects. The most common types of trauma exposure were accidents, interpersonal violence, and sexual assault. The lifetime prevalence of Posttraumatic stress disorder (PTSD) in the population was 46.2% and the lifetime prevalence of major depressive disorder (MDD) was 36.7% (Gillespie et al., 2009). A meta-analysis on the prevalence of PTSD among trauma-exposed children and adolescence reported a 15.9% prevalence rate (Alisic et al., 2014).

Extreme trauma can often lead to further debilitating mental health conditions, as the defining characteristic of a traumatic event is its capacity to provoke fear and horror in response to the threat of injury or death to oneself or one's loved ones. People exposed to such events, as described above, are more vulnerable to developing PTSD or MDD (Yehuda, 2002).

It is important to note that these disorders can also occur together. PTSD and MDD can be comorbid, leading to individuals with both disorders facing greater social, occupational, and cognitive impairment, higher levels of distress, and higher likelihood of attempted suicide (Flory & Yehuda, 2015). Prominent risk factors for the development of both PTSD and MDD are childhood adversity, specifically abuse and maltreatment (Gilbert et al., 2009). In a large sample of adults, a strong association was found between retrospective reports of childhood sexual and physical abuse and comorbid mood and anxiety disorders (Hovens et al., 2012).

Victims of CSEC are at risk for developing a variety of mental health conditions, including PTSD and MDD, as a result of the abuse they face. Often, the traumas they have experienced prime them to be reluctant to seeking out help or participating in examinations, which might further endanger their mental health. Failure to recognize and address the mental health consequences of victims and survivors of CSEC could lead them to heightened dangerous behaviors (Rothman & Bair-Merritt, 2018).

Mental Health Consequences of CSEC

As a result of intense trauma, many victims of CSEC experience significant psychological adversity (Choi et al., 2009). The damage to victims' mental health is pervasive and extreme enough to affect them long after they have been rescued. A study examining mental health outcomes among adult women who had been sex trafficked reported that the vast majority of women had at least one type of mental health problem. Generally, the longer that women were

in coercive sex work, the poorer their mental health (Muftić, 2013). Additionally, women who were deceived or manipulated into being sexually exploited prior to maturity evidenced far poorer mental health outcomes than women who were sexually exploited for the first time at an older age (Muftić, 2013). Survivors of CSEC typically experience elevated rates of mental health conditions such as depression and PTSD due to the intense trauma of sexual exploitation (Muftic & Finn, 2013; Pierce, 2012).

PTSD, Depression, and Cognitive Impairment

Female victims of sexual exploitation in the United States face rates of PTSD ranging from 27% (Wells & Mitchell, 2007) to 50% (Twill et al., 2010). According to the DSM-V, symptoms of PTSD include recurrent memories or dreams about the traumatic event, flashbacks, psychological distress, physiological reactions, and avoidance of stimuli related to the trauma (American Psychiatric Association, 2013). To be given this diagnosis, a person has to have been exposed to an extreme stressor to which they responded with fear, helplessness, or horror, as well as display three distinct symptoms: 1) reexperiencing the event in some capacity, 2) avoidance of reminders of the event, and 3) hyperarousal for the months after (Yehuda, 2002). Exposure to traumatic events can often result in "nonspecific" symptoms such as palpitations, mood swings, aggression, and reluctance to undergoing particular examinations (Yehuda, 2002). In a 1994 study examining rates of PTSD among adult survivors of childhood sexual abuse, 69% of the 47 survivors met the full DSM-III criteria for PTSD (Rowan, 1994).

The studies have also revealed depression rates of up to 60% (Roe-Sepowitz, 2012). A study conducted in Northern California with sexually exploited youth revealed high levels of depression and anxiety, as well as anger and attachment problems. Of these youth, more than 30% also engaged in moderate to severe self-harming behavior (West Coast Children's Clinic,

2012). More recently, the DSM-V defined MDD as a common and serious mood disorder in which individuals experience persistent feelings of sadness and hopelessness. Symptoms include depressed mood most of the day, diminished pleasure in activities, fatigue or loss of energy, feelings of worthlessness or guilt, inability or diminished ability to think clearly or concentrate, and possibly even recurrent thoughts of death or suicidal ideation (American Psychiatric Association, 2013).

Cognitive impairment is another consequence that has been reported among sexually exploited youth. In a study done in Europe with sexually exploited adolescents and women, almost two-thirds reported memory problems (Zimmerman et al., 2006). Other research has indicated that youth who have experienced complex trauma due to child maltreatment have high rates of cognitive, emotional, and psychosocial impairment (Bolger & Patterson, 2001).

Stockholm Syndrome

Mental health consequences can be difficult to identify and resolve for a variety of reasons. In some situations, children might be reluctant to reveal that they are being exploited (Jülich, 2008). In other cases, a phenomenon called Stockholm Syndrome is relevant. Stockholm Syndrome, although not a diagnosable disorder in the DSM-V, is defined as the bi-directional bonding between hostages and hostage-takers that are perceived by the hostage to be necessary for survival. This concept can be easily applied to CSEC, where the child may choose to stay with their exploiters because they feel that they could not survive without them (Jülich, 2008). Nurturance and protection are basic needs for children and they will search as much as they can for that in any environment they are placed in, including in the hands of their exploiter. Jülich's study showed that young girls often felt abandoned and conflicted when the abuse stopped or when they were away from their abuser. The study also showed that young girls tend to not

reveal that they were sexually abused, even upon interrogation by authorities. This is typically because their abuser told them that they would be blamed and that no one would believe them. Unfortunately, in many circumstances, this might be true due to lack of family and community support (Jülich, 2008). This is likely to also bond the victim to her exploiter due to the feelings of isolation and inability to escape.

Stigma

Stigma, in short, is a mark of disgrace attributed to a particular circumstance, quality, or person. Stigma can also be conceptualized as the as the result of five interrelated processes (Link & Phelan, 2006):

- A person or persons is labeled as “different”;
- Dominant social norms and values link “different” with undesirable characteristics and/or fears, which leads to the creation of negative stereotypes surrounding these persons;
- Labeled persons are identified in terms of a single attribute, which soon morphs into their defining characteristic. This labeling allows others to “other” them into a separate social category;
- Labeled persons experience blame and discrimination, and in some situations, resentment; and
- Power is exercised through an individual’s access to key resources, which determine their ability to resist the labels of stigma.

Although stigma has been examined in several contexts, there is limited research on the stigma faced by victims and survivors of CSEC both while in “the life” and after, while trying to seek help.

Sexually exploited youth face stigma from their communities for the life they are leading, and additionally face stigma for what their community might deem as sexual promiscuity, various life challenges and health issues that often come along with exploitation (Saewyc et al., 2013). Stigmatization of sexually exploited youth can lead to them isolating themselves and choosing to not seek out treatment or care. Due to sometimes years of experiencing stigma, youth might also internalize what they have heard others say about them, and therefore become even more vulnerable (Holger-Ambrose et al., 2013). Sexually exploited youth might also find it easier to not disclose their activities or hide information from authorities because of the stigma they face from society and their own communities. This is a problem, because victims of CSEC are in great need of services (Benoit et al., 2005; Pheterson, 1990). Furthermore, the direst consequence for these individuals would be staying in “the life”.

Stigma makes it increasingly difficult for sexually exploited youth to reintegrate into their communities, but more importantly, to seek out therapy or other services for what they have been through. These youth are soon left with nowhere to turn; they cannot (or do not want to) return to their families or communities and they might not see talking to authorities as a viable option. This leaves them especially vulnerable to returning to coercive sex work, and their emotional vulnerability makes it easier for their exploiters to find them again (Jülich, 2008). Although exact numbers of children who return to coercive sex work are not available, the number is considered to be significant (Walker, 2013).

Mental Health Resources Currently Available for CSEC Survivors

In order to improve the system that serves survivors, the system that is currently in place to address the mental health needs of survivors must be examined. Sexually exploited children typically come to the attention of the court system through welfare, delinquency, or ‘crimes

against children' cases. In these cases, youth often benefit from the appointment of a guardian *ad litem* or Court-Appointed Special Advocate (CASA) volunteer. Guardian *ad litems* are responsible for understanding the youth's current circumstances, advocating for what they need during a case, and coordinating care and services. These advocates can be instrumental in ensuring that survivors do not have to repeat their experiences to multiple professionals (Green & Tomkins, 2014).

The mental health-specific services that are currently available include psychotherapy, cognitive-behavioral therapy, and individual and group therapy (Abu-Ali, 2011). Other forms of therapy include art therapy and counseling with a torture treatment specialist (Goździak, 2008). There are also specific treatment options available through healthcare professionals, which have been shown to be highly effective for sexually exploited youth (Goździak, 2008).

Trauma-informed care for CSEC, which advocates for trauma-sensitive care when treating victims and survivors, is being developed currently and has thus far been successful (Greenbaum & Crawford-Jakubiak, 2015). The goal of trauma-informed care is not simply to directly address the impacts of trauma, but to also impart an understanding of trauma at a systemic, organizational, and service level. Trauma-informed care can also be depicted in a three-pillar model, including 1) Safety, 2) Connections, and 3) Managing Emotions (Bath, 2008, p. 18). Children who have experienced complex trauma might feel unsafe and as a result, might act aggressively or withdraw even further from adults they interact with (Seita & Brendtro, 2005). There have also been initiatives to develop screening tools for identifying victims (Varma et al., 2015).

Creating a place where youth feel safe is key to beginning their healing process. In order to create this safe environment, high quality, trusting relationships must be established between

the survivors and the adults around them. Positive outcomes and successful healing is directly related to positive connections with caring adults, care providers, and mentors (Asay & Lambert, 1999; Benard, 2004). Along with strong connections and a creation of a safe environment, children who have had severe trauma, the trauma-informed care model puts emphasis on providing tools for children to develop effective emotion regulation strategies. Emotion regulation is what pulls together the healing process for those who have experienced trauma, and is additionally a significant protective factor against future events (Alvord & Grados, 2005).

New curricula are being developed frequently for training law enforcement on how to interact with victims and survivors of CSEC in a trauma-sensitive manner (Wernham, 2005). Additionally, statewide task forces in certain states have written about the importance of some form of a data-sharing mechanism, but one has not been developed or implemented yet (Walker, 2013). There is a multidisciplinary juvenile court in Sacramento, California that addresses many of the mental health challenges that face the sexually exploited and at-risk youth they serve. All court staff members are provided with trainings and resources to become more trauma-informed, and the court works with social workers and other parties to develop therapies. Depending on their needs, youth are court mandated to treatment. This program currently only exists in Sacramento (Liles et al., 2016).

Re-Traumatization of Survivors of CSEC

Commercial Sexual Exploitation of Children (CSEC) is a highly complex issue. Given the number of entities working in this topic, victims and survivors work with several different professionals throughout their justice seeking and healing processes. Investigations in sexual abuse cases typically rely on determining the credibility of the victim's testimony, which might subject victims to repeated questioning (Bounds et al., 2015). The repetition of distressing

experiences can be very traumatizing for survivors (Green & Tomkins, 2014). The Child Victims' and Child Witnesses' Rights Act (18 U.S.C. § 3509) states that children have the right to not cooperate with law enforcement questioning. This should normally act as a prevention mechanism from re-traumatization (Bounds et al., 2015). Unfortunately, this act is rarely enforced. Children are not only questioned repeatedly by law enforcement, but also by social workers, forensic interviewers, and clinicians.

Gaps in The System: What Needs to be Done?

Of foremost importance in working with survivors is the recognition that survivors are the true experts of their experiences. Each survivor's case and situation must be considered individually, as each experience is unique. One of the most significant gaps in the current work done to support survivors is that it does not take into account the potentially unique needs of victims (Aberdein & Zimmerman, 2015). Any solution created must be survivor-informed.

Accordingly, each group that works with victims and survivors of CSEC has their own individual responsibilities and perspectives on the issue. There are three main groups that interface with survivors: law enforcement, clinicians, and social workers. The trauma-informed model must be reinforced in training programs for all three of these groups. In order to begin the work to address mental health needs among victims and survivors of CSEC, identification measures must be improved. A major first step in this process would be to establish consistent language and terminology surrounding CSEC among survivors, advocates, social workers, clinicians, and law enforcement. Consistent language would ensure that those who are being sexually exploited are correctly classified as victims (Bounds et al., 2015).

Additionally, safe houses for survivors are incredibly limited (Barnert et al., 2016). Although there are at least one or two safe houses in most U.S. cities, some are far better quality and safer than others due to availability of private, state, and federal funding (Rand, 2010).

Law Enforcement

There are many online training resources for law enforcement and certain agencies offer CSEC trainings, but these trainings are not mandatory and are not required. Law enforcement must be trained in Trafficking Victims Protection Act (TVPA) laws, as well as on sex workers' perception that they cannot trust the police and other authorities. Training must also include the tremendous trauma and mental health consequences that sexual exploitation and trafficking can have on the body and mind. Input from survivors in this training is critical. Lloyd explains, "when compassion and belief in your potential comes from a cop… or some other unexpected source, it can feel so significant" (Lloyd, 2011, p. 146).

In addition to participation in trainings, law enforcement must work with child welfare more frequently to ensure that victims receive the care they need. Responses towards CSEC victims must look further than arrest and detainment, which are common "solutions" to what appears to be juvenile delinquency and prostitution (Bounds et al., 2015). Training will ideally also protect children from further victimization during the investigation (Bounds et al., 2015).

Law enforcement must work more frequently with clinicians and social workers in order to develop resources for sexually exploited youth. Reliable and high-quality mental health treatment options must be available, and juvenile courts must work to create mandated therapy options.

Clinicians

Clinicians in certain hospitals and other clinical settings are being trained on victim identification and trauma-informed care, but these trainings are optional and remain unrequired. Clinicians must be aware of signs of sexual exploitation. Along with trauma-informed trainings, clinicians must first establish a compassionate and trusting relationship with patients. They must make sure to not re-traumatize patients through stress-evoking questions. Clinicians must be advocates for victims of CSEC, and emphasize to authorities that the children are in need of help. CSEC victims are far more likely to reveal that they are being sexually exploited if they sense that they can trust the clinician. New research advocates for nurses at the forefront of efforts regarding sex trafficking (Bounds et al., 2015).

Upon creating rapport with the child, clinicians should administer mental health assessments and should determine whether the child feels safe and comfortable (Greenbaum, 2015). Healthcare professionals must be informed about the resources available for sexually exploited children. They should work to create additional resources, considering the appalling shortage, and connect children to these services (Todres, 2014).

Social Workers

Similar to the trainings offered to law enforcement and clinicians, trainings for social workers are not mandatory, however most social workers ultimately end up receiving the trainings. Social workers must work with clinicians to create and deliver mental health services to CSEC victims and survivors. They must additionally work with law enforcement to make sure that victims and survivors receive these services. More organizations are needed to assist children who want and need to heal from trauma inflicted by sexual exploitation (Dalla, 2006). This might include placements for children, or other less serious therapy options. Escape plans

might include a physical move to an area away from family and community influence, life skills and job trainings, or access to a completely new social network (Murphy, 2010). Social workers must work to train other case managers and survivor advocates following trauma and survivor-informed models. Well-trained advocates are always needed, considering the complex and unique needs of victims and survivors (Rand, 2010).

Conclusion

Commercial Sexual Exploitation of Children (CSEC) affects an unknown number of children in the United States. While many efforts and resources have focused on the anti-trafficking movement, very few have targeted the immense mental health needs that victims and survivors have. Furthermore, with the limited data on CSEC, we know little about how we can minimize the survivors' trauma. Research has been done on the gaps in the system that serves survivors, but with each group working in their silos, there have been minimal efforts to integrate these gaps into a framework that addresses re-traumatization and survivors' other mental health needs. The purpose of this project is to assess the feasibility of implementing the framework designed to reduce re-traumatization among survivors of CSEC.

METHODS

Although research on Commercial Sexual Exploitation of Children (CSEC) has increased exponentially in the last few years, there is still minimal research on victims' and survivors' mental health needs. The purpose of this project was to assess a framework that would reduce re-traumatization among survivors. Qualitative methodologies, including cognitive interviews (CIs), focus group discussions (FGDs), and in-depth interviews (IDIs) were used to collect and analyze data. This chapter outlines research design, participant information, participant recruitment, and research procedures.

Setting

The research was conducted in Atlanta, Georgia. Despite housing only 3.2% of the United States' population, Georgia has the 7th highest known number of human trafficking cases in the United States (United States Census Bureau, 2014; Polaris Project, 2018). This state, along with many others in the South, has many factors that influence its high amount of trafficking. First, there are several interstates that span the Southeast part of the country. The accessibility of these routes makes it very easy for traffickers to transport victims for long distances. Atlanta also has a very large international airport, and hosts several corporate and convention entertainment events yearly. This city was purposively chosen for this project due to its high number of trafficked children.

Study Ethics and Informed Consent

The Institutional Review Board (IRB) of Emory University determined that the study was exempt from full review, however IRB procedures were maintained to protect the rights of

participants and ensure confidentiality. Informed consent for the project was obtained at the onset of each CI, FGD and IDI. Participants were read a detailed explanation of the project and its risks and benefits. Participants were told about de-identification, and what the project will be used for. Although the project was determined by the IRB to be of low risk to participants, a safety plan was prepared in the case that survivors who participated in the project were re-traumatized. This included recommendations for mental health services. Participants were additionally notified that participation was completely voluntary and that they could withdraw from the project at any point with no negative repercussions. Prior to each CI, FGD, and IDI, participants were asked to consent to being recorded, as well as permission to store the recordings and transcriptions on the researcher's password-protected computer device. Verbal consent was collected from all participants and recorded.

There was minimal risk to the participants, as their participation was voluntary and all information collected was kept confidential. All identifying information was removed from the transcripts.

Research Methods

Measures

A semi-structured, open-ended question guide format was used to probe cognitive interview, focus group and in-depth interview participants (See Appendix I). Questions were conversational, brief, direct, and focused on participant experiences (Krueger, 1998). The question guide followed a direct sequence from specific to general questions about the framework. It began with a few introductory questions about individual experiences, followed by specific and general questions about different parts of the framework and its feasibility. The

questions on the guide focused on how the framework could reduce re-traumatization among survivors of Commercial Sexual Exploitation of Children.

Recruitment

Recruitment for CIs, FGDs, and IDIs were conducted as part of the same process. The principal investigator (PI) utilized purposive sampling to identify clinicians, law enforcement officers, social workers, and survivors (Cresswell & Plano Clark; 2011). The PI reached out to faculty at Emory University Schools of Medicine, Law, and Nursing, as well as two nonprofits in Atlanta (Haven Atlanta and City of Refuge), and provided them with a short description of the project. Most contact was initiated through email. The PI additionally allowed two of the project partners, DeKalb County Juvenile Court and DeKalb County Board of Health, to participate in recruitment efforts through convenience sampling. DeKalb County Juvenile Court sent the short description of the project to all law enforcement officers and social workers on their ListServ who currently work with or had previously worked with CSEC survivors. DeKalb County Board of Health sent the short description to several of their clinicians who typically work with survivors of CSEC.

Eligibility for CIs, FGDs, and IDIs were assessed using screening questions during recruitment, as the eligibility criteria were the same for all three. Once participants were identified, the PI determined eligibility. Eligibility questions were asked via email or phone, depending on the preference of the participant.

Eligibility Criteria

- Clinicians, law enforcement, and social workers must have been working in their given field for at least five years; survivors must have been out of the life for a minimum of ten years.

Participants needed to be:

- Above the age of 18;
- Residents of Georgia;
- Capable of providing consent to participate;
- Speak and understand English; and
- Comfortable with being audio recorded during the FGDs.

Exclusion Criteria

- Cognitive interview participants could not participate in focus group discussions.
- Survivors who participated in CIs or FGDs could not participate in-depth interviews.

The PI selected one individual from each of the four group types for the cognitive interviews (one clinician, one law enforcement officer, one social worker, and one survivor). The four individuals recruited to be cognitive interviewees were emailed a short description of the project, the purpose of the cognitive interviews, and an invitation to participate. The first participant recruited from each group accepted the invitation. All other participants were invited to participate in focus group discussions. Survivors who did not wish to participate in focus groups were invited to participate in an in-depth interview. Recruitment continued until one cognitive interview had been completed with an individual from each group, for a total of four interviews.

Once cognitive interviews were completed, recruitment for focus groups began. As mentioned above, those who participated in cognitive interviews were not eligible to participate in the focus group discussions. A recruitment script was delivered to potential participants (from the same group of eligible participants) over email. The script included: purpose of the focus group, who will be attending, time commitment needed from participants, importance of focus groups and project, and what future communication will look like. Interested participants were

emailed the three focus group dates and asked to choose which date worked best for their schedule.

Sample

The participant pool for CIs, FGDs, and IDIs consisted of stakeholders, defined as clinicians, law enforcement, social workers, and adult survivors of CSEC. All stakeholders either currently interface with survivors in their professions, or have interfaced with them in the last five years. Eligible participants included:

- Clinicians: physicians, nurse practitioners, forensic nurses, and clinical psychologists;
- Law enforcement: district attorneys, public defenders, judges, investigators, and police officers;
- Social workers: Psychologists, service providers, and community educators; and
- Survivors: Survivors of Commercial Sexual Exploitation of Children (CSEC) who were in "the life" in the past thirty years.

CIs

The final sample for CIs consisted of four individuals: a clinician, a law enforcement officer, a social worker, and a survivor. Cognitive interviews were conducted face-to-face at the office of each participant. Each cognitive interview was held in a private space within the office to ensure confidentiality. Dates and times were selected individually for each participant.

Formative CI Procedures

The purpose of the interviews was to collect preliminary data on the feasibility of the framework, and evaluate the focus group question guide with professionals prior to conducting the focus groups. To improve the flow of the focus groups, data from CIs was collected through

informal interviews using the same interview guide that was used for focus groups. Cognitive interviewing was a good fit for this study, as it helped ensure that respondents from each group understood the questions the way that the researcher intended (Willis, 2005). Individuals who were recruited to be cognitive interviewees received information in an email with details about the interview and project purpose. The researcher coordinated with each of the four participants individually to determine dates, times, and locations of interviews. Informed verbal consent was collected at the beginning of each cognitive interview. The researcher used the information gathered in the four CIs to make changes to the final focus group guide. Answers provided to the questions by the cognitive interviewees were used to supplement the results.

FGDs

Setting

FGDs were conducted in person at the DeKalb County Juvenile Court. Dates and times for the focus groups were selected prior to recruitment. All FGDs were held from 2-4 pm and were completed in a two-week period between November and December 2018. All were held in private spaces within the Juvenile Court to ensure confidentiality.

Procedures

This project used focus groups to collect data, as focus groups are designed to facilitate group discussion on a particular issue or set of issues (Kitzinger, 1994). Three mixed focus groups were conducted. Enrolled participants who confirmed their attendance at a focus group date were sent personalized invitations through email. The invitation included the date and time of the focus group they chose, group location, and a detailed map with directions to the focus group. Two days before each focus group, the researcher emailed all enrolled participants to confirm their attendance at the chosen focus group date.

The PI served as the moderator for all three focus groups. A research assistant took notes at each focus group. A focus group assistant was responsible for creating a diagram displaying the room seating arrangements, and taking shorthand notes of the focus group. Assistants did not directly participate in the focus groups.

At the beginning of the focus group, the moderator read out a brief interview script. This included a brief oral summary of the purpose of the group and project, as well as established some ground rules for the focus group discussion (such as respect for others, etc). The moderator also ran through the risks and benefits and obtained oral informed consent. Each participant received a printed copy of the framework for reference during the discussion. Each focus group ran approximately two hours. Catered meals were provided to all FGD participants by one of the project partners.

IDIs

The sample for IDIs consisted solely of adult survivors of CSEC. Three IDIs were conducted either face-to-face or on Skype and were held in a private space to ensure confidentiality and were completed between January and February 2019. Dates and times were selected individually for each participant. The interviews were approximately 30-45 minutes.

IDI Procedures

Given the discomfort that many survivors have with conversing with law enforcement and other authorities, IDIs granted survivors the opportunity to share personal details and information with the researcher that could otherwise be traumatizing. Furthermore, there is limited research surrounding commercial sexual exploitation of children that has included survivors' perspectives and thoughts on services and resources. The purpose of the interviews

was to collect in-depth perspectives from survivors on the feasibility of the framework, as well as whether it would make the lives of survivors easier.

As a result of the iterative process of qualitative research, data collected during the initial phases of the research object were used to inform and refine the subsequent data collection stages (Hennink et al., 2011). Therefore, for the IDIs, the PI slightly modified the interview guide that was used for the FGDs. The revisions included minor changes in wording as well as an additional probe for some of the questions (See Appendix II).

Individuals who were recruited to be IDI participants received information in an email with details about the interview and project purpose. The researcher coordinated with each interviewee individually to determine dates, times, and locations of interviews. Informed verbal consent, which included permission to audiotape the interview, was collected prior to commencing the interview.

Data Management

All CIs, FGDs, and IDIs were audio recorded using a digital audio recorder. The audio files were uploaded to the personal password protected computers of the PI of this study and the two research assistants (RAs). The PI made sure that all names and other identifying information were removed from recordings/transcripts before downloading them onto the computer and commencing data analysis. IDI participants were given pseudonyms. The PI and RAs transcribed each recording verbatim into written English. Backup copies of all recordings and transcripts were stored in secure, password-protected electronic files on the computers of the PI and RAs. All audio recordings and transcripts were deleted from all devices upon completion of the project.

Data Analysis

After transcription was completed, FGDs and IDIs were qualitatively coded using MaxQDA 12 software, which permitted the PI and second coder (RA) to read through and code the text and identify pertinent components and themes. The two coders compared their codes and themes to generate inter-coder reliability. Codes were first organized into a coding tree (See Appendix III). All codes were given definitions, which were later used in the creation of the codebook (See Appendix IV). The notes taken during each focus group were used to inform the FGD transcripts. All transcripts were reviewed multiple times in order to develop a codebook consisting of 13 main codes and 39 subcodes. Deductive codes were developed based on concepts directly asked about in the interview guide, and included concepts such as feedback on the any of the components of the framework and proposed aesthetic changes. Inductive codes were developed based on topics that came up through one or more of the focus group discussions, but may not directly be related to questions asked (Fereday & Muir-Cochrane, 2006). Examples of inductive codes included “victim and risk identification,” “therapy for guardians,” and “survivor involvement in training.”

Thematic Analysis

This project employed Braun and Clark’s 6-phase approach for thematic data analysis. Due to its theoretical freedom, thematic analysis allows for a highly flexible approach that can be modified to meet the needs of many studies. It also allows researchers to capture a complex, rich, and detailed account of the data (Braun & Clarke, 2006). By utilizing this method, the PI delved into each transcript to highlight the nuanced perspectives and experiences of each participant.

The 6-phase approach to thematic analysis according to Braun and Clark (2006) is described below:

1. Familiarizing Yourself with the Data

Each CI, FGD, and IDI was transcribed with utmost attention in order to preserve accuracy. For each FGD, the speakers and timestamps were maintained, and written notes were incorporated to provide context to nonverbal cues (glances, nods, hesitation) or to noises from participants (murmurs of agreement, laughter). Upon completion of verbatim transcription, all lines were numbered. All transcripts were read multiple times to gain familiarity with the data.

2. Generating Initial Codes

Once interviews were transcribed, the PI and an RA used MaxQDA software to highlight and memo any interesting data points throughout the transcripts. Both the PI and one of the RAs then made note of initial codes throughout the transcript. Examples of codes included "trauma-informed focus" and "boundaries of reported data."

3. Searching for Themes

The PI and the RA reviewed all codes and subcodes and created a thematic map as well as a coding tree. The codes that were considered to be most relevant to the research question were combined and others were omitted. The combined codes were split into overarching themes and subthemes (Braun & Clark, 2006).

4. Reviewing Themes

Once themes were identified, the list of themes was refined. Some themes were omitted or combined due to insufficient data to support them. During this phase, the themes were reviewed

holistically to ensure that they reflect the data inside each theme as well as the data set as a whole. This step was critical in clearly defining the themes.

5. Defining and Naming Themes

Themes were clearly defined and named to enhance the story being told in the thematic analysis. For each defined theme, the PI and RA conducted a detailed analysis to relate them to the study's main research objectives. An example theme was "Elements of Survivor-Centered Care".

6. Producing the Report

This last phase was used to inform the results chapter of this manuscript. Once the thematic analysis process was complete, compelling themes and data were selected. A final analysis of these selected excerpts was completed to tie the results into the project's objectives and literature review.

RESULTS

Themes that arose from the three focus group discussions (FGDs) were analyzed to provide insight into stakeholder perspectives on various elements of the framework. Based on this project's preliminary assessment of the framework, stakeholders believe that the framework would improve the resources currently available and have a positive impact on their professions and the lives of survivors. Stakeholders spoke about including the option of family-wide mental health resources, as opposed to resources solely for survivors. Each stakeholder provided examples from cases that corresponded to their fields of work or experiences (law enforcement, social work, clinicians, survivors), and many provided insight on their interactions with other fields. Participants also shared their thoughts on whether implementation of the framework would reduce re-traumatization among survivors overall, and what changes would need to be made prior to piloting it.

Themes in the three in-depth interviews (IDIs) with survivors provide further context for the FGD results and illuminate additional survivor perspectives. IDIs were used to document survivors' personal insights on how the framework could be modified to better address survivor mental health needs.

Five themes emerged from the FGDs and IDIs: 1) Protocols for Interagency Data Sharing, 2) Training Priorities for Stakeholders, 3) Therapy for Survivors and their Families, 4) Potential Impact of Framework on Stakeholders, 5) Elements of Survivor-Centered Care.

Protocols for Interagency Data Sharing

Stakeholders in the three focus groups were supportive of the idea of collaboration and communication between agencies, but were concerned about the potential confidentiality and HIPAA issues that could arise. Participants argued that there were a few unique ways to share data between stakeholders without violating privacy and confidentiality laws across disciplines. An FGD participant from law enforcement explained that data sharing nationally would be helpful, “considering that we do have children that are crossing state lines a lot. So it’s easier for the parties and different agencies in different states to be able to access it.”

Stakeholders reported that it would be easier on everyone, especially on survivors, if there were more effective ways to collaborate. One social worker suggested having a forensic interview where all parties come together so that “we can gather up what we need and all questions can be answered, for your case and for ours” and a clinician explained that in the case of child abuse, it could be useful to share details between professionals about the level of trauma that survivors have experienced.

The feedback that stakeholders provided on the data-sharing mechanism of the framework provided insight on the types of data that need to be in the database, the integration of an alert and contact system, and how implementation of the data-sharing system could be structured.

Type of Data Reported

One of the FGD participants from law enforcement suggested determining the types of data that are most necessary within the database. A couple of clinicians and social workers expressed concern with the concept of having medical and therapeutic information searchable by

database users, and in response, one of the clinicians suggested using the database to house less-sensitive information. She proposed the following:

> Instead of building the database on the therapy that the survivors receive, can you build it on identifying marks or common places where they're found, or the names that they often use? Could you record whether they have tattoos on them? I have such concern about using light therapy notes and you know, what they say during a confidential session plus the fact that their stories will change based on, you know, how long they've been away from the person that's victimizing them. It would help if you can base what's in the database on more objective criteria.

A social worker in the same FGD added onto those comments, stating, "So at least if I can put it in her name and an identifier, for example, "Angel with the Blue Eyes"…you know, something might come up." During her interview, Laura explained there are simple ways to record information while not violating HIPAA or confidentiality:

> It can stay generalized. If we have someone coming in, all I need to know is their name, date of birth, drug history, and mental health history. That's all you need to know. I'm not violating any laws because I'm not telling you every single thing about this individual. I'm not sharing this individual's story with you.

Stakeholders suggested having guidelines and protocols for the types of data that they would be inputting into the database, and having a set of questions that each professional would complete to avoid the child being asked the same questions over and over again. One survivor, Laura, explained in her interview that interagency data sharing can still be effective with the sharing of solely general information, because survivors will still get the care they need. An FGD

participant from law enforcement provided a suggestion on how the data-sharing mechanism could function:

> If there were comment boxes and questions that all database users had to answer and check, it might make everybody's input a lot more streamlined. Perhaps each person who interacts with the survivor clicks the box and answers specific questions, and then it saves your centralized database and then the next person pulls it up. Some things are already filled in, but the survivor might have opened up even more to the next person, so that person can flesh it out even more.

There was consensus among stakeholders that having a verbatim transcript of interactions with survivors on the database would be a violation of survivors' confidentiality and privacy. As Elle expressed in her interview, streamlining the information that needs to be in the database is far more secure than letting highly personal and private information about survivors just "float around in a hard drive." Overall, stakeholders found that interagency data sharing could be a useful addition to the resources currently in place, but there would have to be specific measures in place to ensure that only pertinent, objective information was kept on record.

Alert and Contact System

Coupled with the streamlining of the data sharing system was the suggestion of an alert and contact system. This suggestion was proposed in all three of the FGDs and was described as a way for professionals to be aware of how at-risk a survivor is, whether or not they are receiving services, and whether or not those treatments are effective. An attorney added that "a documentation of if the survivor has tried services, which services worked, which services didn't work" would be useful. A social worker in one of the FGDs explained that such a system would "automatically connect so many people, because if an alert comes up, that automatically involves

everyone else." A clinician responded that she has had difficulty receiving timely responses from law enforcement, because most of the time, she has no idea who to call. The database would include contact information of the personnel that interacted with the survivor. A social worker described how this might function:

> If this person is the one who spoke with the survivor, then I would be able to call and speak with that person and be able to go connect. If I know who has talked to this survivor, then the [medical and therapeutic] content doesn't need to be in there because I could call them and talk to them and so then I don't have to necessarily ask the same questions.

A police officer at one of the FGDs expressed that there have been times that he could have missed a victim and would not have known. He explained that law enforcement officers come into contact with several juveniles on a daily basis and there has to be a better way to identify risk. Another social worker provided some feedback on how stakeholders could be alerted to specific cases and survivors:

> The database that we're looking to put in place, it would need to...I think it would probably need to have some type of alert saying that this is a survivor that we keep coming across. An alert for certain survivors. That way we're not using the therapeutic notes saying this child has a history… we're just pointing out these three characteristics over and over again. That's something we can all look at. But that way too, we're not re-traumatize interviewing.

The alert system would draw attention to tattoos, identifying marks, social media accounts, and nicknames that come up often. It would also allow stakeholders to assess the resources that

survivors need, including therapy and placements, by viewing which survivors are most at risk of dangerous behaviors, such as self-harm, going "on-run," or substance use.

Implementation

There was one key suggestion provided by a stakeholder of how the process of implementation could be simplified. In one of the FGDs, an attorney recommended rolling out the database in phases:

> The first phase is just giving resources, so they don't have input into it at first, they're just familiarizing themselves with it and they have something they can rely on. This way, you establish relationships with the users and they realize how beneficial the database is. And then slowly build it from there.

Other stakeholders in the room nodded during this recommendation. A couple others mentioned that buy-in would be a challenge, but the strategy of breaking the project into smaller pieces would increase buy-in.

Training Priorities for Stakeholders

Most FGD and IDI participants agreed that if the framework were to work, law enforcement, clinicians, and social workers would all have to undergo training. Stakeholders also mentioned that trainings must include consistent protocols and survivor involvement, and must be high quality and survivor-informed. As part of the trainings, there should be information on victim and risk identification, how to treat survivors, and how they can work with other stakeholders to collaborate and trust each other using the framework. Laura explained in her interview that trainings should be mandated for everyone:

> It should be mandated for all professionals before working in this field. You got to do it. I think it should be more than law enforcement. It should be doctors, social workers. And foster parents. I think also making sure that EMTs and other first responders get training, or even people who work in convenience stores. Anyone can be a first responder, so everyone should be trained.

Most stakeholders, whether they were clinicians, social workers, or law enforcement, agreed that clear and descriptive protocols are needed when working with CSEC victims. One prosecutor described what protocols for judges could look like:

> So when they are juvenile, in the juvenile justice system, I think there could be some more resources and maybe a better framework provided for the judges to educate the judges and educate the probation officers and the service providers about what services this child may need that's different from other children.

These trainings would be available to all first responders, from emergency medical staff to police officers to airline employees. Also indicated was the importance of trainings for foster parents, which would include steps foster parents can take to look out for survivors and provide them with a stable environment.

Stakeholders also suggested interprofessional trainings. One FGD participant stated:

> I agree with training folks together… we often work in our own silos and system. So I think as often as you can have people from other entities coming together and sharing experiences and learning from each other is really helpful. It gives consistent messaging to people so that we're all on the same page and speaking the same language.

Survivors in both FGDs and IDIs said that there were many people who could have helped them at different times and didn't - that is why training is so critical. It would be most useful, a few

survivors said, to have survivor-informed trainings, either led directly by them or guided by them. Survivors could either deliver them directly or could work with educators and social workers to do so.

Victim and Risk Factor Identification

Participants in every FGD reported that a majority of professionals do not have a clear understanding of CSEC, how to identify it, and how to determine when an individual is at risk of becoming a CSEC victim. During the FGDs, many stakeholders indicated a lack of clarity on victim and risk factor identification. An investigator explained this issue further:

> There needs to be better identification, because often, law enforcement doesn't even know they are working with CSEC. I mean they went through the whole process and never knew really what was going on with this person. And so I think there needs to be more training on that.

A police officer then explained that he too had not learned how to identify victims of CSEC or even sexual exploitation and provided a suggestion:

> If they're traumatized and they try to reach out, I don't know how I would identify them. I just learned so much in these last ten minutes. So I would recommend that [victim and risk identification] be taught in the [police] academies every year… they're hiring new officers every year, so you'd need to address that somehow. You have to go the academies directly.

FGD and IDI participants both named a multitude of risk factors and ways to identify victims, but there were a few that came up consistently. They included: tattoos and any form of branding (other identification marks), going "on run" repeatedly, appearing at school with new, expensive

clothes or jewelry, mood swings, and demeanor changes. At the end of one of the FGDs, a clinician described some of these identifiers in more detail:

> Often you'll see branding from tattoos. Sometimes you'll see something like 'property of K. Mack.' Other times a victim might show up with brand new hairstyle, brand new shoes, brand new backpack, items that are super fancy. Sometimes it might be clothing that is sort of provocative and expensive-looking. And when you ask them, they'll say 'a friend gave it to me.' Sometimes having multiple cell phones can be a red flag. Often, you might see the victim with a much older man, or woman. But it usually isn't just one of these factors, it would have to be a combination of them.

Stakeholders suggested a "targeted, tiered training" for individuals who are likely to interact with survivors. One stakeholder explained that not everyone needs the same training, because not everyone interacts with survivors in the same ways:

> First you have particular first responders, such as Uber drivers and airline folks, who are typically the first to see the problem. They're almost like our mandated reporters. They should be trained on how to recognize certain signs and how to report to law enforcement what they're seeing and the concerns that they have. Then you have a first responder type training for your uniformed officers and DFACS investigators who conduct first assessments. And then there is the more in-depth, intensive training for those who are interacting pretty regularly with possible victims.

Participants suggested that trainings would include an in-depth discussion about some behaviors that CSEC victims might exhibit and the reasons for why they do.

Consistent, Up-to-Date Protocols

In an FGD, a law enforcement officer explained her frustration with working with some police departments, because none of them had protocols. She reflected that many departments still have not added a CSEC portion to their sexual assault protocol. Many stakeholders indicated that having educational resources available would not only help identify victims faster, it would make their jobs as professionals easier. A clinician explained the need within her profession for protocols in each specific case:

> Like what are the protocols? We need the resources and education to know what to do in each scenario. If someone comes in and they have to be transported to an undisclosed location, who takes them there? Sometimes its the officer, sometimes a family member, who is it? Which location is it? If there's a urine sample for a particular person, who collects it, when do you collect it, how do you collect it? We can't lose the evidence. Education for that first clinician is so important. If all of us knew what our roles were, it would make our jobs so much easier.

Another clinician emphasized that it would be helpful to have protocols to follow for violent situations, or how to work with people who are in a posttraumatic stress state or who might be mentally unstable. Having protocols for a variety of possible cases is useful, because such information needs to be easily accessible in a crisis or emergency.

A social worker provided some recommendations for protocols to ensure victims and survivors would get their mental health needs assessed:

> LA County has implemented their first responder protocols. They trained their law enforcement and other first responders, including EMT, that are actively able to identify these kids and young adults that are out on the streets, or at a hotel, or gas station parking

> lot. The protocol includes steps that need to happen within 24 hours and 72 hours, as well as mandatory medical and mental health assessments for every victim.

Survivors in both FGDs and IDIs mentioned numerous times that different survivors need different types of resources, and a case-by-case approach is necessary. These protocols would additionally encourage collaboration between groups of people, emphasizing 'relationship building to help them be able to trust one another to work together.'

Protocols can also reduce the number of times a victim or survivor has to repeat what happened to them. In one of the FGDs, a social worker brought up a question to one of the clinicians:

> When the triage nurse asks the client 'why are you here?' and the client says, 'I was raped,' is there not something the nurse could write in their system so that the next person who sees this client knows that they were raped? As in, can there be a clear protocol to avoid the necessity of four different people having to ask the same questions?

The clinician explained that due to a lack of resources and a lack of ability to reduce procedural steps, the victim might still have to talk to a few people. With a clear protocol, however, there could be ways to reorganize existing resources to get the right resources to those who need it in a faster manner.

A social worker also explained that trainings must be ongoing and up-to-date:

> As the environment changes, the policies and processes change, and everyone working in the field needs to have up-to-date information. If we aren't aware, then we miss things and we won't be able to provide services and assistance to victims and survivors.

Stakeholders reported that adequate resource allocation depends on having a consistent and current understanding of what survivors need and how best to address those needs. The creation of Standard Operating Procedures (SOPs) was seen as promising for CSEC cases.

Survivor-Informed Trainings

Trainings for stakeholders will not be effective unless they are high quality and survivor-informed. Laura mentioned, "What I've been discovering quite a bit is that if you don't train someone how to treat a survivor, they won't know." A prosecutor further described how law enforcement officers currently address CSEC victims:

> They don't know how to talk to them. They don't know how to understand their experiences. They just treat them like they're there for stealing a car. They [victims] need different services and you also have to have different approaches for each person.

Trainings guided by elements of survivor-centered care, as mentioned previously, are key when working with CSEC victims. A social worker stated that training on sensitivity and knowing one's boundaries is important, because "if you overstep, you could cause a re-traumatization." A clinician added onto this, explaining that if people were trained on survivor-centered care, survivors would probably not be asked so many extra questions over and over again. In their interviews, Beth and Elle also noted that knowing that the personnel they were interacting with had been trained would have been very comforting for them. Sensitivity and trauma-informed trainings must be integrated into the protocols for stakeholders and responders.

Both Beth and Laura gave insight on how trainings could more actively involve survivors. Laura explained that these trainings *must* be survivor-led, as only survivors really know their experience:

> There's already so much training, but it needs to be survivor-led training because I've listened to people speak so much and I've read so many things and I'm just sitting here thinking, have you ever in your life experienced anything like this? So you have to find those people in communities who are leading survivor groups and you need to ask them 'What do we need to do differently? We want to hear your side. Not your story. Your side.'

Beth stated that there should be "survivors on hand that can actually be there. There should be more survivors who have actually gone into the line of work to help victims." If there are more survivors working in any of these fields, whether it is law enforcement, medicine, or social work, there will be more stakeholders who are trauma-informed. This could also mean that if survivors are willing, they work with the other stakeholders on a more regular basis to help make other survivors comfortable.

Trainings for Foster Parents

Training foster parents and guardians was brought up in focus groups and interviews as a way of ensuring that survivors received emotional and familial support. In an FGD, a survivor recounted significant abuse at the hands of her foster parents; they reported her to the police every time she ran away. One social worker explained that this story is unfortunately very common, and can partially be attributed to the lack of knowledge or understanding about the traumas that survivors endure in "the life." She suggested encouraging more training for foster parents to make for better placements. She shared how this could have a significant impact on the current lack of placements for survivors:

> We're working on training foster parents who are really prepared and 'in the know' about what to expect because what happens is we place kids with whoever's first on the list and

> who says, ‘yeah, I'll take that kid!’ And that kid is there for a week and then they go on run and maybe they come back home, maybe they don’t, maybe they get picked up. But then that foster parent says that they don't want that kid back. Then that kid is in the next placement and the cycle repeats. So caregivers aren't really prepared or trained on what to look for, what to expect. They're not trained to expect that these kids are going to go on run.

Many stakeholders agreed that “there were kids who, if their parents could get it together, that the children, they’d have a little bit of a better chance.” These resources would include ways for foster parents and guardians to recognize signs in their children and protect or support them accordingly. Stakeholders also suggested training foster parents and survivors on harm reduction techniques, considering that 96% of children in Georgia go on run at some point (Georgia Cares). They explained that there are many parents who want to be good parents, but just do not have the tools and resources.

Therapy for Survivors and Their Families

Many stakeholders brought up the logistics of therapy and foster placements for survivors, as well as resources to support guardians and foster parents. Stakeholders also agreed that a huge part of matching survivors and their families with the right kinds of services is the risk-evaluation process. Participants initially expressed distaste towards mandating survivors to therapy, but proposed a solution: compulsory attendance rather than forcing survivors to open up. Both FGD and IDI participants explained that a large part of addressing mental health needs of survivors is ensuring that their families are equipped both physically and emotionally to care for them.

Court-Mandated Attendance to Therapy

When the idea of court-mandated therapy was first brought up in the focus groups, a couple of participants expressed concern. One social worker described her discomfort with the idea of mandating therapy as follows:

> With someone who's been that traumatized, you cannot say you have to go to therapy because they're going to just sit there. First of all, you're ordering them around, which is something they just got out of. I think it should be when they're ready to open up.

A clinician described that stakeholders have to have open conversations with survivors about therapy and present it as an option:

> You have to show that person that they need to focus on their long-term mental health needs. Although it might not seem ideal right now, long-term it will be beneficial to you. You have to make them think that treatment is an option. And if they still don't want to do it, then I guess you get the courts involved. Because at the end of the day, they're still a child.

In response, a few clinicians brought up the elements of survivor-centered care; if survivors are going to receive therapy, it must be evidence-based and trauma-informed. There was consensus in the group that a solution could include collaboration between judges and therapists and an understanding that the survivor should not be forced to talk unless they are ready. The FGD participants drew a distinction between mandating therapy and mandating attendance. The former, they suggested, could take away control from survivors, but the latter might help them realize they deserve the help they need prior to them turning 18 (when they turn 18, courts would no longer be able to easily mandate them). A clinician gave some additional detail on how mandated attendance to therapy might work:

> You're not going to make [survivors] talk, you're not going to force them to do anything other than be in a setting for half an hour or 45 minutes, and hopefully that relationship involves just being together, getting together with a good therapist who knows where to back off. You can just play music or look at the fish tank. Whatever they want. You're just mandating them to be in a place. You're not mandating that they talk to you.

As highlighted by stakeholders, mandated attendance ensures that survivors begin the process of getting treatment for their trauma, but allows them to retain control over the process. In her interview, Laura talked about the benefits of mandating therapy: "if the court's going to mandate you to do these, which they should, that's helping you." She explained the need for more regulation along with court-mandated therapy:

> Let's say if I was mandated and I was told, 'for your first three months, I want you to start trauma-informed therapy, GED classes and anger management. And I want to see you back in three months.' So I go back in three months and I've started trauma-informed therapy. I have not started GED classes and have not started anger management. I have to go back and explain to the judge why I haven't done it and they ask me, 'You haven't done this, I want to know why.'

Laura mentioned that judges and therapists should work together to make sure that survivors are attending their therapy sessions and putting the effort into getting help. She reported that there are many survivors who might decide they do not want therapy and that "you can court mandate somebody all day long, but if they don't want it, there has to be another solution." She reflected that a survivor is still a minor and it falls back on the foster care system, on the foster parents, on the social worker, and then on the juvenile justice system to take care of survivors and make sure they get help. Both Beth and Elle similarly agreed that court-mandated therapy would be a

helpful resource for survivors, because “if the court mandates you to do something, you have to do it.”

Therapy for Guardians

In both FGDs and IDIs, participants talked about how therapy for survivors is incomplete without therapy for guardians and foster parents. A social worker in one focus group described that therapy can also be recommended, or even mandated, for caregivers:

> I think that maybe before the [survivor] is released from therapy, there should be some therapy with the caregiver or parent or foster parent, whoever it is for them. Even a support session to give them some ideas of how to best support the survivor and their rehabilitation from this lifestyle could help.

As explained by another social worker, “[Caregivers] also need support. They need to have a place to vent, too. They need to have a place to come to, talk about what their struggles, and get strategies from professionals.” Many other FGD participants nodded at this suggestion, and one from law enforcement recommended that courts should mandate therapy for both survivors and their parents. She reasoned that survivors would see the process differently if their caregivers were also involved and they would be more willing to attend sessions. A clinician then explained that court-mandated therapy is more likely to be effective if parents are also held accountable for following up. For survivors to have stable environments to grow up in, the entire family needs to have resources. Beth mentioned similar ideas in her interview:

> I know my family would have been willing to attend therapy and also hold me accountable if they were mandated to do so. This framework for court-mandated therapy is absolutely amazing because my mental health needs did not get taken care of. The entire process of getting an assessment, a psychological exam, and, you know, just seeing

> and being able to try to work through the problems that they're going through. I think that's fantastic because I mean, my family wouldn't listen to anybody except for, you know, the legal system. They kept just trying to get me to move on, but if the courts were involved, that would have helped.

Overall, stakeholders agreed that therapy for both survivors and their families comes down to survivor-centered care. The goal of therapy should be to make the family feel more confident in their ability to support the survivor mentally and emotionally.

Referrals and Risk Evaluation

Stakeholders reported that a major part of adequate therapy and resources for survivors included a strong referral system, also dependent on risk-evaluation measures. Law enforcement, clinicians, and social workers all mentioned the challenges they had faced and seen with finding foster placements or safe houses for survivors, mainly due to the referral system being very inefficient. As an FGD participant from law enforcement described, “a lot of places won't take the child without a referral from Georgia Cares. Even if that referral comes from law enforcement. Getting that referral completed by Georgia Cares can take two weeks, three weeks, sometimes more.” Other stakeholders nodded during this statement and another from law enforcement explained that “there is a single entry point for the assessment and we just don’t have that kind of time.” With only one entry point, the referral system is reliant on one agency. A lot of survivors end up going “on run,” because there is not enough time to match them with the appropriate services. Stakeholders suggested simplifying the referral process and using the framework to develop a network in order to ensure that more agencies could do assessments.

In addition to a more centralized referral system, stakeholders believed that it would be easier to place survivors if there were better ways of assessing the risk of them “going on-run,” or returning to coercive sex work. A social worker in one of the FGDs explained:

> It is important to determine risk. Some survivors are more at risk than others…the high risk ones should not be placed with the lower risk ones so that the ones who have been out there longer and who have been exposed to a lot more don’t influence the ones who are new into the process.

Stakeholders rationalized that if they determined and knew how at-risk a victim or survivor was, they could make sure that the individual received the type of therapy and placement they needed. A clinician in one of the FGDs explained how risk identification could be beneficial:

> The survivor could be transferred to an inpatient therapeutic program. It would be for more higher risk CSEC survivors, who would now have a group or community, sort of like an inpatient safe house. Possibly a locked facility.

Stakeholders agreed that a framework like this one could help ensure that those who are at risk are identified faster through specific risk factors and warning signs to look for.

Foster Placements for Survivors

While both short and long-term placements were initially proposed in the framework, a few social workers in the FGDs expressed that the only placements that work are long-term:

> Short-term placements don’t work for these kids. They need long-term stable placements, and I'm talking like a year or two or more. A three-month residential program isn't going to really do anything but barely touch the surface.

In her interview, Laura encouraged keeping both short and long-term placements as options. She described this in more detail:

> Having relocation in safe houses in different counties is very important. Maybe even different states. Survivors do not need to be in the same place where they experience their trauma, because it always makes them think about that trauma. Oftentimes due to trauma bonding, being in the same place makes them want to go back. So you could give the option of different states as well. And I would definitely leave short and long-term placements.

Beth explained that having the option of short and long-term is helpful, but long-term could be best because then "they don't have to keep moving around to other places. Stability and security are the things that I craved when I was going through this." Beth also agreed that the option of moving to either different counties or different states would be useful.

Potential Impact of Framework on Stakeholders

Benefits

Many stakeholders stated that the implementation of the framework would be very helpful, as long as everyone followed the steps. An FGD participant from law enforcement stated that the framework could make her job easier:

> I think it would help me to help me identify a CSEC victim. Once I identify the victim, I think your framework would be helpful. The framework would make my job easier. Problem is that it is a lot of steps. It really boils down to the same thing. If the victim sticks to the process, [the framework] might be able to help. But I don't see a deficiency in your process. I think if it's implemented well, it will work.

Many stakeholders nodded at this statement. A social worker agreed and added that a holistic approach and team effort to really help survivors is very much needed; the process would be

helpful to both her job and survivors if all the moving parts worked as planned. In her interview, Laura reflected that the framework would make the lives of survivors and the jobs of survivor advocates a lot easier, as long as people followed the step and rules. She explained that everything is hard at first, but things get easier once they get moving. A clinician in one of the FGDs explained that establishing the framework would be a challenge, but it could be beneficial:

> There would be a lot of resistance from the medical field. There would have to be more training and more collaboration with our mental health associates in the emergency department. But I think it would be easier if we knew exactly what we were doing. Hospitals love protocols, so if all of us knew exactly what our roles were, it would make our jobs so much easier.

A clinician in a different FGD also mentioned that there would be resistance from clinicians to get information onto the database, but the framework would make it so much easier for clinicians to provide care and treatment in the long run. Social workers, clinicians, and law enforcement agreed during the FGDs that having a database would help serve CSEC victims a lot faster because professionals would be able to share information and alert one another, and get confirmation on a victim's history. As one social worker said, "We would know exactly who to reach out to… it goes from searching 30 different professionals to four. I would know exactly where to start." There was consensus among participants that the framework would take a lot of work to implement at the beginning, but the end result would be worth it.

Survivors in both FGDs and IDIs had very positive things to say about how the framework might impact other victims and survivors of CSEC. A survivor in one of the FGDs stated that the framework would have helped her if it existed when she was victimized:

> I think that this is the great. This is something really good that can really help a lot of a lot of women, men, kids, boys and girls. I think that it will give us a better outlook. I've been raped, I've been molested. It was just all of that in the course of 23 years. I think being able to have somebody that you're willing to open up to and who you can talk to every now and again about what's going on. I think that seeing a survivor go through this program would open the door for other survivors to willingly come out and say, 'you know, hey, I need help. I see what you did for my friend.' I think this is going to be very life changing and very problem solving. It won't solve all the problems, but it will be help.

Survivors in other FGDs and IDIs had similar comments. They believed that there were specific exceptions that would need to be addressed, such as survivors that have children. Elle explained that it would not make the lives of survivors with children particularly easier, unless the placements were customized for their needs. Generally, stakeholders found that the framework would make the lives and jobs of participants easier and would streamline the process of assessing and treating the needs of CSEC victims and survivors.

Re-Traumatization

The majority of FGD and IDI participants stated that the framework would decrease the re-traumatization of survivors. In her interview, Laura stated:

> I think it would help lessen it. I think if people really started paying attention to some of these things and really put them into practice, it would greatly benefit survivors. The more people who learn how to treat us, no matter what age, the better. Because if you can reduce stigma, you can reduce re-traumatization. And if you can reduce re-traumatization, then you could save a survivor from many of the mental and emotional

> aspects that go along with being a CSEC survivor.

Both Beth and Elle responded similarly, stating that the framework would reduce re-traumatization because there would be a support system and direct resources in place for survivors of CSEC. A clinician in one of the FGDs also stated that having the contact system would help because she would not have to ask the same questions. Other stakeholders stated that there were specific elements of the framework that would help decrease re-traumatization. An attorney explains this further:

> I think that in essence this framework does kind of illustrate a ways to decrease the re-traumatization. But I feel like it's more so in the components of the database.

A social worker expressed that the court-mandated therapy programs would definitely reduce re-traumatization. Many stakeholders in the room nodded at this statement and once again stated that if everyone followed the steps and rules, the framework would be very effective.

Challenges

Stakeholders also mentioned challenges to implementing the framework. These challenges included an inability to reduce some procedural steps during cases, privacy issues, and buy-in. As an example of the first, a social worker explained that there is no way to get around the examinations that CSEC victims have to go through every time they go "on run." She reports the process:

> Any time a [victim] runs away and they are found again, they have to go through that medical again; they have to go through that psychological exam again. So that relates to that re-traumatization piece where every time they go back, they're getting asked the same questions.

Clinicians also mentioned that even though they can try to reduce the number of people who

need to ask the survivor questions, there are still three to four people who need to do their assessments. Prosecutors explained that there are always reasons that the questions are being asked and that in order to prepare a survivor for a case, they would need to be questioned a number of times. One FGD participant stated that for these steps that cannot be reduced, the framework serves as "best practices" for the stakeholders on how to do their jobs.

Stakeholders also expressed concern about the privacy of survivors, mainly due to the database. She talks about how information storage in the database could be uncomfortable for survivors:

> Like [survivors] have heard so much lies and nonsense and tricks that they just need the straight answers, even if it's ugly or hard to hear. And I think the idea that anything they say is somehow being collected or preserved, I can see that being very, very sticky and uncomfortable for them. I mean I understand and I see there are some competing interests that you're talking about and I do see that there's value that's in [the database]. But that's kind of where my mind went.

A survivor during the FGD responded to this and explained that everyone has a motive and she will always want to know the truth. The consensus was that the framework might work if there was complete transparency with survivors about the database and its purposes and there were other measures to keep the data secure, such as encrypted files and having to be in an office space to connect.

The last challenge that was brought up was buy-in. When asked what the main challenge would be to implementing the framework in each FGD and IDI, the response was buy-in:

> …it's all a great idea, but it's training and getting people on board, the buy-in, that is the most difficult. And then there's a couple of other obstacles that we're not thinking of. One

is the courts… are they going to want to participate? Because that's a huge hurdle.

Stakeholders stated that for people to want to participate in the framework and move it forward, they have to care. Not everyone will participate in elements of the framework at first, but "when people see the importance of it, they will start participating."

Elements of Survivor-Centered Care

Overall, we found that the development of survivor-centered care is based on an understanding of the traumas that survivors have faced, creation of an environment of trust where survivors can reclaim power and control, and inclusion of survivors in every part of the framework. There is a need for training on this model of care among all stakeholders. The findings of this project underscored the importance of any framework being informed by the community it aims to serve.

Trauma-Informed Focus

Of the many elements of survivor-centered care that project participants brought up, a central one was the role that being trauma-informed plays in working with survivors. Stakeholders described being trauma-informed as recognizing, understanding, and responding to survivors' past trauma. One FGD participant, a law enforcement officer, explained that, "survivors have trauma that stems back from their childhood that we uncovered throughout the court process. We often bring this up in court in order to just help people understand and know why is this happening to them and their circumstances." Focus group participants brought up that law enforcement, clinicians, and social workers must recognize that addressing re-traumatization starts with being informed with just how deeply childhood trauma affects survivors.

One participant, Beth, shared the sexual traumas she experienced as a child during an interview. She described this past trauma as follows:

> The things that I had went through as a child; I just thought that I wasn't going to be affected by them as an adult. I mean from an early age, I had always said that once the sexual abuse stopped in my household, I would be done. I wouldn't have to deal with it anymore. But I didn't realize that the abuse and trauma that I went through as a child affected every aspect of my life.

Multiple survivors described similar experiences of having not realized the extent to which they would be affected by past trauma and the degree to which it would impact their behavior and actions. FGD and IDI participants both explained just how important it is for professionals to know the ways that past trauma can color how survivors see the world and express themselves. Laura, who currently works with other survivors explained:

> Survivors usually suffer from some type of PTSD or complex PTSD. Time and time again, you experience the trauma. You smell something and it is literally like the trauma is happening in front of you. It's like you're re-experiencing it all over again and you're sensing it, all the receptors in your body, you're going haywire. You can visualize the very place that it happened…so it's really crucial for people to understand that most survivors have these PTSD problems, and severe anger issues. Most of them are very angry.

A trauma-informed focus requires comprehension of the psychological effects that survivors often experience. Stakeholders additionally proposed integrating a trauma-informed focus into all services, to account for survivors' trauma and resulting coping mechanisms. A FGD participant from law enforcement explained, "It's a specific type of way that you have to be able

to interact with [survivors] and it takes time, and people need to know how to do that. Anybody who comes into contact with this kid, they need to be trained." Stakeholders mentioned that they had witnessed the unwillingness of probation officers and clinicians to recognize the unchecked trauma behind victims' anger and decision-making.

During one of the FGDs, a social worker described the concept of trauma-informed care in the context of therapy:

> I think any therapeutic intervention that is recommended has to be evidence-based and trauma informed… I wouldn't consider anything else for this population, so there's a ton of different options out there, but you need highly trained therapists who are ready to focus on trauma and who are trauma informed. They have to be evidence-based.

Stakeholders provided a couple of different suggestions for ensuring that the needs for quality therapy were met. One explained that at their center, all therapists are trained in "trauma-focused, cognitive behavioral therapy," where they "actually provide education to youth about what exploitation really is."

An Environment of Trust: Reclaiming Power and Control

A trauma-informed focus usually goes along with ensuring that survivors feel comfortable speaking freely, so another element of survivor-centered care is the creation of an environment where survivors can reclaim the power and control they lost as a victim of CSEC. A survivor in one FGD stated that she "kept running away because I…I wanted the help. Nobody helped me, not even the police." The way that survivors are treated in each interaction with stakeholders can have a significant bearing on whether they go "on run," or relive the trauma they have experienced. A social worker in an FGD explained this further:

> If the first person that survivors interact with act appropriately, that first meeting, 9 times out of 10, changes the way the remainder of the process goes. So if you have someone in the forefront that treats the case as it should be treated, it lessens the trauma. The survivor must be treated with respect. If they are, they are less likely to go back. There needs to be consistency. When that first person treats the survivor badly, they lose hope in the process.

As stakeholders explained in almost every FGD, a positive and appropriate interaction could make a difference: survivors would be less likely to go "on run" and more likely to participate in the court and therapy process. One stakeholder even mentioned that survivors often go "on run" to gain control over their lives. Laura expounded, "trust is monumental for a survivor."

A survivor in an FGD described a communication style that therapists could use to help survivors feel in control:

> All right let's just debrief…we can talk about whatever you want to talk about. Get that person feeling like they're human again. Because when you put them back in that spot, they feel like a victim.

Many other stakeholders agreed with this and additionally stated the importance of "control, because it's something that they have not had." Another FGD participant detailed her experience working as a therapist with survivors as follows:

> You're starting where that kid is. And if that kid doesn't want to talk about it, you're not going to push them and you're just going to be there every week. And eventually they'll start to build that relationship and they'll begin to open up.

Other stakeholders nodded during this statement. In her interview, Elle also stressed the importance of giving survivors control when choosing their therapy. She recommended providing options to survivors:

> I would also recommend different options of therapy based on the survivor's religious preferences or just to choose the gender preference of her therapist.

There was agreement that stakeholders have to meet survivors where they currently are. Pushing them to engage before they are ready can potentially cause severe damage.

Survivor Involvement in the Framework

A third theme was the importance of survivor involvement throughout the process. In a survivor interview, Elle explained that survivors have a unique experience that is hard to understand, no matter how talented or compassionate a professional is:

> Conversations with other professionals can be kind of hard, because even with professionals with the best intentions, I think there's a tendency of some survivors to feel, still feel kind of like 'Othered.' So if she has another survivor that she can talk to and the other survivor can say, 'I understand how you feeling,' that can go a long way. It would be important to have a survivor mentor in the framework.

Many stakeholders' comments during FGDs echoed this sentiment, stating the importance of "asking them what they want and just making sure that their voices are embedded into this process whenever possible." A prosecutor at one of the groups suggested gathering feedback from survivors who have either been through the framework or who have experienced different parts of it:

> I would want to see would be feedback from survivors, maybe like an exit interview type of strategy for ongoing improvement. I would want to know, was this effective? Was it

> not? Did you appreciate your court-mandated therapy or would you have liked to have come to that on your own? Were law enforcement professionals trained properly? Did they speak to you with respect?

In their interviews, both Laura and Beth explained how beneficial survivor mentorship and peer support could be for other survivors. Beth suggested using a model similar to AA for the framework, so that survivors would have ongoing support throughout the court and therapy process:

> If you get someone, if they can at least speak to somebody… I know this is a long shot, but finding a survivor that would actually match the victim. Finding another survivor who has been through it, that had been there, done that and gotten through it.

It would be a motivator for victims and survivors to get the help they need if there were survivors they could speak with that could "sponsor" them.

Conclusion

Participants in both FGDs and IDIs shared their perceptions, opinions, and feedback on the framework and its feasibility. There was consensus among participants that there needs to be more survivor involvement in the legal process and in meeting survivors' mental health needs. Participants described some of the inadequacies with the current resources available for survivors and provided insight on how the framework could more effectively meet the gaps in mental health resources. The majority of stakeholders believed that the framework would reduce re-traumatization among survivors, as long as agencies followed the steps. A revised framework was created to represent the FGD and IDI findings (See Appendices VI and VII).

DISCUSSION

The aim of this project were to assess stakeholder perceptions of the framework's feasibility, identify the components that should be modified, and describe potential solutions to concerns with feasibility. A thorough analysis of the three focus group discussions (FGDs) and three in-depth interviews (IDIs) conducted with stakeholders, who have worked with CSEC victims (law enforcement, social work, clinicians, survivors), identified several important themes. Critical elements of these themes are described in detail in this section. A summary of the key components of these themes and how they relate to one another are displayed in the revised frameworks in Appendices VI and VII. This qualitative project found that re-traumatization of survivors of CSEC is a problem worth studying further, and that the proposed framework may be likely to reduce re-traumatization among survivors. Finally, the project showed that Diffusions of Innovations (DOI) theory can be helpful in understanding the factors that influence adoption of frameworks targeting mental health needs of vulnerable groups, such as CSEC victims and survivors.

Stakeholders believed that a data sharing mechanism would be useful, considering the lack of collaboration between different agencies. Research conducted in California on multidisciplinary approaches to addressing CSEC found that there are no national interagency data-sharing mechanisms in the country that emphasize collaboration between clinicians, law enforcement, and social workers (Walker, 2013). Such mechanisms have not been implemented due to some stakeholder concerns about privacy and confidentiality (Walker, 2013). Initially, many stakeholders brought up logistical concerns about the feasibility of the data-sharing mechanism of the framework. Throughout the groups, they provided some suggestions for implementing it without violating privacy and confidentiality. Data-sharing mechanisms

mentioned in the focus groups are currently used by stakeholders in the United States: National Crime Information Center (NCIC) and Georgia Crime Information Center (GCIC), which law enforcement agencies and case managers use to enter information on missing or abducted youth who are at-risk of being CSEC victims; and Collaborate, a customizable case management data system used by clinicians and social workers to track information about CSEC victims' needs. Clinicians do not have access to the crime information centers and law enforcement agencies do not typically use Collaborate. Both of these data systems are only used by certain professionals, as opposed to all three of the stakeholder groups that interact with CSEC. Stakeholders did agree that the database should be national, as many victims cross state lines. CSEC is by definition interstate. Traffickers frequently move their victims from state to state, making it difficult for authorities to track individual victims (Barnitz, 2001). Prior research has indicated that addressing CSEC requires coordinated local and national responses; our findings show that resource allocation for victims might also benefit from coordinated responses, as agencies would be able to track victims' locations and meet their needs.

The data-sharing component of the initial framework suggested that the first stakeholder interacting with the victim would upload a transcript of their interaction with the victim and relevant portions of the transcript would be viewable by the respective stakeholders. In other words, the data sharing mechanism would act as a protective factor against the CSEC victim having to repeat what had happened to them numerous times to multiple individuals from different agencies. One of the concerns regarding interagency data sharing that stakeholders brought up during the focus groups and interviews was that of confidentiality and HIPAA issues. They agreed that re-traumatization was a relevant concern, but stated that uploading full

transcripts would not only be complicated for stakeholders, it would make survivors uncomfortable and would violate their privacy.

Stakeholders proposed some alternative strategies to minimize those concerns. One suggestion was a standardized questionnaire for database users to ask survivors. This would serve as a way to streamline stakeholder responses, ensuring that only the most relevant case information would be entered into the database. The questionnaire would be composed of the questions that each agency needs answers to and could be asked to CSEC victims in person. Each stakeholder that interacts with the victim would flesh out the answers to these questions more until they have all been answered. This method would have two impacts: 1) It would simplify the questioning process for stakeholders through a clear list of the questions they need answered in a given case, and 2) It would limit the number of times that victims and survivors have to answer the same questions from different individuals and agencies.

In addition to the streamlined questioning process, stakeholders suggested sticking to only having generalized information on the database, and not confidential medical and therapeutic information. Generalized information could include nicknames, tattoos, or social media accounts; the presence of these could also be used to track victims and survivors. For example, if a survivor has a very specific nickname or tattoo, the screening tool on the database would be able to register this. Gang signs/affiliations, unexplained bruises, cigarette burns, and tattoos of names, nicknames, and symbols have all been described as signs of CSEC in the literature (McKeen, 2015). Recognizing these signs is also a part of trainings for professionals. Some stakeholders might not notice or identify these signs, so documenting them on the database is a way of ensuring that victims in need are noticed.

Survivors expressed concern with medical information being readily available to any stakeholder who has access to the database. Some victims and survivors of CSEC believe that authorities will not protect them if they reached out for help, or that stakeholders despise them (Marcus et al., 2014; Helfferich et al., 2011). This distrust was evident for some of the participants in this project, who felt that therapists might judge them, take advantage of personal information on the database and leak it, or use it against them in legal or other proceedings. Their concerns stemmed from negative experiences with seeking help from healthcare providers, and they explained that they would be less concerned if all therapists were well trained. This finding was in line with research showing that a major barrier to CSE youth seeking healthcare of any type is the fear of a judgmental environment (Ijadi-Maghsoodi et al., 2018).

The alert and contact system was posed as an additional solution to the privacy and confidentiality concerns. It would include a place on the database to notify other stakeholders through the usage of alerts in the case that a CSEC victim was mentally unstable, at risk of going "on run," or at risk of returning to "the life." Each stakeholder would be able to add their contact information to the database, so that if another stakeholder interacted with the same survivor and needed to know more about their medical or mental health history, they could get in contact with the corresponding provider.

Stakeholders brought up potential challenges with getting individuals and agencies to use the database, stating that it would be valuable to introduce the database in smaller pieces, starting first with resources and training on database usage, and encouraging some agencies to use the database before others. There was consensus that buy-in and active participation in the database would be a challenge, however certain groups and agencies would be far more willing to play an active role at first than others.

Literature has documented that curricula are being developed frequently for training professionals on CSEC victim identification and trauma-informed practices (Wernham, 2005). Stakeholders in the FGDs and IDIs explained that although trainings do exist, there is a lack of knowledge in law enforcement about how to identify victims, a lack of clear protocols for clinicians, and a lack of consistent training altogether between stakeholder groups. A few focus group and interview participants shared that high-quality trainings should be mandated for everyone who interacts with a survivor in any capacity, including those who work as first responders or at convenience stores. Participants similarly believed that there should be specific frameworks created for stakeholders to differentiate each CSEC case, as each case is different from the next. The case-by-case nature of CSEC would be reflected in the development of consistent protocols for stakeholders across agencies.

Stakeholders provided some examples of effective first responder protocols, specifically those in Los Angeles County. LA County's protocols include a system where law enforcement officers identify victims and work with other County agencies and community-based organizations to keep victims safe and provide them with services (Ackerman-Brimberg et al., 2018). The protocol focuses on meeting the immediate and short-term needs of CSE youth, using youth-centered, trauma-informed services. The protocol outlines roles and responsibilities of every partner agency and includes follow-ups to ensure that victims are getting their needs met (Ackerman-Brimberg et al., 2018). A system like this does not exist in Georgia, but it could be a key step in deepening the understanding of this problem, encouraging collaboration between Georgia stakeholders, and creating unique solutions for addressing the mental health needs of victims.

Stakeholders proposed interprofessional trainings to encourage groups of professionals to step out of their silos, learn how the database works, and work together more actively. Survivors brought up survivor-led trainings on victim identification and risk factors, as only survivors are aware of the details that professionals often miss. Survivor-led trainings do exist, but most professionals are unaware of them and where to find them. It is absolutely vital to more actively bring survivor perspectives to the table when equipping other stakeholders with knowledge about working with and caring for survivors. This finding was supported by research evaluating the CSEC Community Intervention Project (CCIP) that took place in five U.S. cities. The research emphasized that cross-disciplinary collaboration and the integration of trainings and resources from survivor-led NGOs positively influenced participants' knowledge, skills, and attitudes regarding CSEC (Ferguson et al., 2009). Furthermore, leading trainings can put the power and control back in the hands of survivors. Prioritizing survivor-led change is a form of survivor empowerment (Brantley, 2015). Survivors could train stakeholders on the risk factors and "red flags" of CSEC. As mentioned in the previous section, it is vital that all stakeholders recognize how to identify each of these risk factors and have protocols on how to proceed in the event that any of them are present. Prior research has documented an exhaustive list of "red flags" of CSEC, yet our findings indicate that although there is a significant body of research about these signs, stakeholders are not well trained on recognizing and identifying them (McMahon-Howard & Reimers, 2013).

Trainings must also be survivor-informed and provide guidance on trauma-informed practices. As mentioned in the literature, victims and survivors do not typically trust authorities, so when professionals treat victims with respect and understanding, it can prevent re-traumatization (Lloyd, 2011). Stakeholders in the focus groups alluded to the importance of

mandated sensitivity trainings for the same reason: knowing survivors' boundaries and not crossing them can develop trust and prevent further negative mental health consequences.

A novel suggestion brought up by a few social workers in the focus groups was that of training foster parents in order to create stronger and more consistent long-term placements for survivors. Literature has noted the likelihood of CSEC victims going "on run," or returning to "the life," due to stigma or a lack of social support (Lloyd, 2011; Walker, 2013). Training foster parents to recognize risk factors and training them for what to expect can enable them to create better environments for the youth they serve. The first social worker that proposed this idea in the focus groups explained that her organization has already begun training foster parents. Through the process, she has realized that there are so many foster parents who genuinely want to learn more and support their foster kids, but they do not understand the trauma that some of the kids in the system have experienced. Resources for foster parents could help them become better parents and learn to more effectively protect and support their kids in the process.

Depending on county and state, there are a few types of therapy options available to survivors of CSEC, including Cognitive-Behavioral Therapy (CBT), art therapy, and psychotherapy (Abu-Ali, 2011; Goździak, 2008). Some of these are offered in outpatient clinics and many are offered inpatient or as services within safe houses during the recovery process. Alongside participants' emphases on the importance of trauma-informed, evidence-based therapy, they also provided several unique suggestions that could restructure the current mental health services available to survivors and their families.

Many focus group participants were initially opposed to the idea of court-mandated therapy for CSEC survivors. They expressed concern about encouraging a practice that could make a vulnerable group undergo treatment, as forcing them to do so might mimic the

powerlessness they faced at the hands of their trafficker. Court-mandated therapy has been most commonly used in Drug Treatment Court and within the Criminal Justice System. It is a court-sanctioned intervention in which convicted individuals have to undergo mandatory treatment conditions during their probation. Court-mandated therapy is usually proposed as an alternative to jail time for legally involved individuals, in other words, individuals who have been convicted of a crime (Hamel & Nicholls, 2006). While many CSEC victims and survivors are also within the juvenile justice system, there are others who are not legally involved (Liles et al., 2016). The main challenge in implementing court-mandated therapy for CSEC victims is that in some of their cases, the court is not already directly involved. This framework proposes that all CSEC victims, regardless of whether or not they are directly involved in the juvenile justice system, can still benefit from court participation in their treatment.

They became more open to the idea when a distinction was made between court-mandated attendance and court-mandated therapy itself. The primary difference between the two is that in the former, therapy is prescribed in a trauma-informed manner to allow survivors control over their therapy sessions. As long as they are attending sessions, even if they are not actively talking or sharing, they are still meeting the court-mandated attendance to therapy requirement. The purpose of this change in the framework is to ensure that survivors do begin the process of seeking out help before they turn 18, when they would no longer be able to take advantage of resources within the child welfare system.

As proposed in the first version of the framework, psychologists and social workers would assess survivors' mental health needs prior to taking their cases to the court. Each case would be addressed separately, and once treatment was determined, courts and judges would be able to mandate that survivors attend sessions. The active involvement of the courts in survivors'

treatment programs can include judges holding survivors accountable for their progress in treatment. CSEC victims and survivors are minors and wards of the state. They might not have anyone that can hold them accountable, especially if they are within the child welfare or juvenile justice systems. Courts could set up a check-in process where they would schedule brief meetings with survivors every few months to survivors' therapy and recovery process was going. CSEC victims and survivors might not initially realize that starting therapy is in their best interest, but our findings indicated that many adult survivors realized that they could have benefited from seeking out help sooner.

Focus group participants suggested that court-mandated therapy should first be offered as an option rather than a requirement. Victims and survivors should be informed about the long-term benefits of treatment services. Mandating a survivor to therapy attendance does not necessarily mean that the alternative is jail, as a few stakeholders explained. For systems-impacted youth or CSEC victims within the juvenile justice system, mandated therapy could be an alternative to jail, but for others, it could simply be an alternative to a more intensive inpatient facility. Research has shown that for legally involved juveniles, high-quality court-ordered therapy can be effective; the more juveniles' treatment needs were met, the lower their odds were of recidivating (Vieira et al., 2009). Even with these resources, there will still be some victims that are very resistant to following through on treatment plans, which might require more court involvement. Our findings indicated that for victims who are not legally involved, mandating therapy might not always be the right fit. Some might benefit from being provided with the option and others might be very resistant at first. Court-mandated therapy has been shown to have tremendous long-term benefit on those who do follow through, however, so for victims who need help, therapy can have a very positive impact (Liles, 2016). The greatest challenge with

implementing the court-mandated therapy program now is that courts are not yet trauma-informed, nor are judges equipped to work closely with psychologists and social workers. With evidence-based, trauma-informed therapy options and the willingness of the courts, this therapy model could serve both legally and non-legally involved youth.

Alongside the proposal of more rigorous trainings for foster parents, participants also suggested therapy for guardians, foster parents, and families. Research has shown that trainings for foster parents are used within the foster care and child welfare systems, but there is need for more trauma-informed care within the system (Beyerlein & Bloch, 2014). Most child welfare agencies nationally offer preservice and foster parent inservice trainings, but the trainings are not always required (Child Welfare Information Gateway). There are also guides published by independent parties for individuals fostering potential CSEC victims, however these are not affiliated with foster care agencies and are not required (Human Trafficking Search). Some stakeholders believed that affordable therapy options should simply be offered to families, while others believed that it should be mandated for all families of CSEC victims and survivors. Many believed that this would ensure that survivors were fully supported and were held accountable for following through in their recovery process. As Beth mentioned in her interview, the legal system holds a lot of power over many families. Families would be more willing to go to therapy and hold their children accountable if the courts were involved. If therapy and other mental health services are not mandated for guardians and families, then support sessions on how best to support survivors should be offered and encouraged to families. A stable environment for survivors hinges on caregivers having a support system and resources as well.

Therapy for survivors is incomplete without the option of relocation services. Research has shown that CSEC survivors can face stigma from their families and communities, which

renders them more vulnerable (Holger-Ambrose et al., 2013). This vulnerability often makes it easier for their exploiters to find them again and might cause them to return to coercive sex work (Jülich, 2008). Laura cited stigma and vulnerability as reasons why safe houses and relocation foster placements are crucial. Participants mentioned the shortage of safe houses for survivors as well as the spottiness in quality, as most safe houses are funded by state and federal grants (Barnert et al., 2016; Rand, 2010). Participants therefore were in favor of increasing the availability of both short and long-term placements, offering the opportunity for survivors to be placed both within and out of state, depending on their needs and preferences.

Two challenges to finding placements for survivors were brought up in the focus groups: lack of a risk evaluation system and lack of an efficient and centralized referral system. Determination of how at-risk survivors are of returning to "the life" is important in evaluating their mental health and placement needs. Focus group participants frequently alluded to the difference between "high-risk" and "low-risk" survivors, stating that it would negatively impact both of them if they were placed in the same placement. Participants offered an alternative: using a risk evaluation system to determine the unique placement needs of survivors. Focus group participants additionally explained some of the issues they had experienced with finding a placement for a survivor due to there only being one agency that processes safe house referrals. The inefficiencies posed by having a single entry point for all referrals also leads to survivors going "on run." Allowing more agencies to process referrals for placements is a concrete solution to this logistical issue. Simplifying this process would ultimately speed up the process of assessing survivors' placement needs and the placement referral process at large.

Just as survivors needs would be assessed prior to their being mandated to therapy, needs would also be assessed prior to determining their placements. Coupled with the court-mandated

therapy program, these parts of the framework would address one of the gaps in the current system, the lack of emphasis on the unique needs of victims (Aberdein & Zimmerman, 2015). Relocation services offer space and distance to survivors, providing them with the tools they need to reflect and begin their healing and recovery process. They also provide access to a fresh start and a completely new social network (Murphy, 2010). Relocation services would give survivors an opportunity to step away from their trauma and location-based triggers, and therefore away from the possibility of stigma and re-traumatization.

There is a strong body of research on the components of trauma-informed care and its usefulness as a model when working with victims and survivors of CSEC (Greenbaum & Crawford-Jakubiak, 2015; Seita & Brendtro, 2005). The results of this project confirmed the importance of a trauma-informed care model while working with survivors, as well as an understanding that many victims and survivors have past trauma leading back to their childhood. A few survivors explained that it would be helpful for professionals to be knowledgeable about complex PTSD and how it manifests. This ties into the importance of survivor-centered trainings. Survivor-centered care ensures that the resources that the model provides will positively impact survivors. Research on involving survivors in the legal and therapy process shows that survivor-centered care means getting to know the whole survivor, not just their trauma. Survivors should be included at all points of decision-making as this will help gain their trust (Brantley, 2015).

Participants also repeatedly brought up the importance of survivors having a voice in their legal and therapy process. Many survivors repeatedly have their power and control taken away from them even after they are out of "the life." As mentioned in the therapy section, the hallmark of quality services includes the development of trust between professionals and

survivors. Establishing trust might also mean not labeling victims' and survivors' experiences. Multiple stakeholders mentioned that many CSEC victims do not identify as victims initially and might not know what exploitation is. Some survivors explained that when they were being exploited, they did not recognize themselves as victims or survivors of trafficking. Sometimes the label of "trafficking victim" can turn some victims away because it is a label that implies certain contexts. She suggested some broader terms such as "working in the sex industry," which might be more relatable to girls who are mainly exploited at strip clubs as opposed to "on the streets." A few focus group participants provided similar suggestions, highlighting the importance of giving survivors' control over their own experiences by allowing them to choose when and how they want to tell their story.

Another innovative suggestion was that of survivor involvement in the framework coupled with peer mentorship. Having survivor presence would facilitate the progression of the entire framework. Survivor feedback would be integrated into the framework. Elle, Laura, and Beth all highlighted how isolating it can be for survivors to go through the process of seeking help and resources alone. They suggested integrating a support network for survivors into the framework itself. In other words, at every step of the process, they would have a fellow survivor they could speak with for advice, support, and guidance. This could also take the form of a network of survivor advocates that get matched directly with victims. Just as Alcoholics Anonymous matches those in recovery with a sponsor who has made it through the recovery process, participants suggested having a survivor-matching system. As a couple FGD participants alluded to, knowing that some survivors have gone through the steps proposed by the framework and received help would help other survivors feel confident that they could do the same.

Stakeholders expressed concern about their ability to reduce procedural steps due to inevitable routine medical and mental health examinations. The protocols that would be developed as part of the trainings component of the framework would provide “best practices” on how stakeholders could do their jobs and might also help determine which are the most necessary steps and what could be reduced. Additionally, stakeholders explained that buy-in, funding, and initial resistance with learning new processes would be challenges. These were cited as common challenges with the implementation of a new innovation and stakeholders stated that if certain agencies put in the work upfront, the framework would make their lives and jobs easier in the long term.

Effects on Re-Traumatization

As documented in the literature, the repetition of distressing experiences to multiple professionals can be very traumatizing for survivors (Green & Tomkins, 2014). As of yet, very little has been done to limit this. Although not all stakeholders recognized the term “re-traumatization” immediately, they were very familiar with the concept. This project illuminated the importance of continued research on the factors causing re-traumatization and how it affects survivors. Re-traumatization of survivors is exacerbated by a lack of collaboration and consistency between professionals (Bounds et al., 2015; Green & Tomkins, 2014). Participants believed that the framework provides many practices that may reduce re-traumatization among survivors of CSEC. Participants explained that the framework provides steps to reduce stigma and that reducing stigma is a key step in reducing re-traumatization. The framework emphasizes the direct involvement and participation of survivors in the process, consistency and communication between professionals, and unique mental health services and resources tailored directly for survivors’ needs.

Stakeholders also emphasized that reducing re-traumatization would not necessarily hinge on rolling out the entire framework all at once. As DOI states, the main factors that have an impact on whether or not stakeholders will adopt the innovation include whether or not the framework is better than the old system, whether the framework is simple and easy to understand, whether it is compatible with their views, and whether it can be tested and observed. Findings indicated that stakeholders do believe this framework, upon testing it, would bring about much-needed changes to the system serving CSEC survivors. It was compatible with what they believed survivors' needs were and as shown in the results, their feedback and perspectives did simplify the framework. Many stakeholders stated addressing re-traumatization could begin with professionals paying attention to survivors and treating them with more respect. The court-mandated therapy program was considered by participants to be a useful tool in addressing re-traumatization as well.

Limitations and Strengths

This project was subject to several limitations. As a qualitative project, the findings are not considered generalizable. Very few survivors attended focus groups, so the discussion in 2/3 of the focus groups was primarily between law enforcement, clinicians, and social workers. Additionally, the numbers of each type of stakeholder differed from one focus group to another, which introduced the possibility of hearing more feedback from one stakeholder group in one focus group than another. An additional limitation was selection bias due to participants already being somewhat knowledgeable about the topic and already caring about it. One FGD participant mentioned that focus group participants attended because they recognized flaws in the system and wanted to brainstorm ways to make a difference. Because of the case-by-case nature of CSEC, the perspectives gathered in this project are not generalizable to other individuals,

counties, or states. Finally, as the creator of the initial framework, I naturally introduced my own biases onto the project. Although I did not tell the participants that I created the framework, it is possible that my own beliefs about it might have subconsciously affected the way I introduced it.

A strength of this project was my passion for addressing the mental health needs of survivors of CSEC. I have spent years developing the framework, know it very well, and therefore was able to answer every question that stakeholders had about it. The project also employed a rigorous qualitative design, with CIs, FGDs and IDIs and reached thematic saturation. The project utilized an innovative approach to assess stakeholder perceptions and incorporated public health theory to understand these perceptions. This is the first-known project in Georgia to employ mixed focus groups to look into CSEC-related issues, and the first project to propose a multidisciplinary approach to addressing the re-traumatization of survivors of CSEC. Finally, this project had the sponsorship and support of various well-known Atlanta agencies, which served as an asset throughout the recruitment process. The results, although not generalizable, may be transferable to other counties and states. This project provides best practices for the implementation of these individual components. Because stakeholder job responsibilities are very similar from state to state, the findings of this project can be transferred and potentially pilot implemented outside of Georgia.

Conclusion and Implications

Considering that the professions of law enforcement, clinicians, and social workers do not differ significantly by county or state, the findings could provide insight on how elements of the framework could be applied and implemented in other metropolitan cities across the United States. This project also provided some insight on the factors that would influence stakeholders' decisions to adopt the framework and begin using it. It was compatible with what they believed

survivors' needs were and as shown in the results, their feedback and perspectives did simplify the framework.

As described earlier, stakeholders expressed that implementation of part of the framework may be beneficial. The results of this project provided implementation strategies for the various components of the framework. Stakeholders suggested rolling out the database part of the framework in stages as opposed to all at once. One stakeholder proposed first providing trainings on how the database would work, perhaps in the form of a simulation, then providing access to certain agencies at first. Allowing the most interested agencies to use the database first would provide pilot data on the effectiveness of this part of the framework and also establish credibility. Another implementation strategy included inter-professional trainings and meetings to target CSEC related-topics and gain further understanding of stakeholder needs and values. Results also indicated that putting together detailed frameworks for educating judges on the mental health needs of survivors, as well as resource booklets for police academies and both governmental and non-governmental agencies, would be useful.

The rich information provided by participants in this project indicates the usefulness of focus groups and in-depth interviews in assessing stakeholder perceptions. To develop more implementation strategies, future research can be done on each component of the framework individually using the same research methods. It would also be interesting to gather stakeholder perspectives from other agencies in Georgia, including Georgia Cares, Georgia police departments, and other medical or healthcare organizations working in this space. Future research should also aim to understand the re-traumatization of survivors of CSEC: what its causes are and the systematic changes that can be made to reduce it. Finally, research should continue to illuminate risk factors for CSEC, countrywide mental health services currently

available, and ways that we can continue to create consistent, survivor-centered services for survivors.

REFERENCES

A Foster Parent's Guide: Commercial Sexual Exploitation of Children (CSEC) or Human Trafficking. Human Trafficking Search. (n.d.). Retrieved from https://humantraffickingsearch.org/resource/foster-parents-guide-commercial-sexual-exploitation-children-csec-human-trafficking/

Aberdein, C., & Zimmerman, C. (2015). Access to mental health and psychosocial services in Cambodia by survivors of trafficking and exploitation: A qualitative project. *International Journal of Mental Health Systems, 9*(1). doi:10.1186/s13033-015-0008-8

Abu-Ali, A., & Al-Bahar, M. (2011). Understanding Child Survivors of Human Trafficking: A Micro and Macro Level Analysis. *Procedia - Social and Behavioral Sciences, 30*, 791-796. doi:10.1016/j.sbspro.2011.10.154

Ackerman-Brimberg, M., Walker Brown, K., Newcombe, A. (2018) Los Angeles Law Enforcement First Responder Protocol for Commercially Sexually Exploited Children What We've Learned: A Four Year Look, National Center for Youth Law & Los Angeles County Probation Department.

Albanese, J. (2013). Commercial sexual exploitation of children: What do we know and what do we do about it? Retrieved from http://www.ncjrs.gov/pdffiles1/ nij/215733.pdf

Alisic, E., Zalta, A. K., Wesel, F. V., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: Meta-analysis. *British Journal of Psychiatry,204*(05), 335-340. doi:10.1192/bjp.bp.113.131227

Alvord, M. K., & Grados, J. J. (2005). Enhancing resilience in children: A protective approach. *Professional Psychology*, 36, 238-245.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5 (5th ed.). Arlington, VA: American Psychiatric Association.

American Psychological Association. *What is Cognitive Behavioral Therapy?* [PDF file]. Retrieved from https://www.apa.org/ptsd-guideline/patients-and-families/cognitive behavioral.pdf

ARC Reflections Training Program. (n.d.). Retrieved from https://www.childwelfare.gov/topics/management/training/curricula/foster/

Aron, L.Y., Zweig, J.M, Newmark, L.S. (2006). Comprehensive Services for Survivors of Human Trafficking: Findings from Clients in Three Communities. *Urban Institute*.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Qualitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller, The heart and soul

of change: What works in therapy (pp. 33-56). Washington, DC: American Psychological Association.

Baldwin et al. (2011). Identification of human trafficking victims in health care settings. *Health & Human Rights. International Journal*, 13(1), 36–49.

Banks, D., & Kyckelhahn, T. (2011). Characteristics of suspected human trafficking incidents, 2008-2010. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Baráth et al. (2004). The mental health aspects of trafficking in human beings: a set of minimum standards. *International Organization for Migration.*

Barnert, E. S., Abrams, S., Azzi, V. F., Ryan, G., Brook, R., & Chung, P. J. (2016). Identifying best practices for "Safe Harbor" legislation to protect child sex trafficking victims: Decriminalization alone is not sufficient. *Child Abuse & Neglect,51*, 249-262. doi:10.1016/j.chiabu.2015.10.002

Barnitz, L. (2001). Effectively Responding to the Commercial Sexual Exploitation of Children: A Comprehensive Approach to Prevention, Protection, and Reintegration Services. *Child Welfare,80*(5), 597-610.

Bath, H. (2008). The Three Pillars of Trauma-Informed Care. *Reclaiming Children and Youth,17*(3), 17-21.

Benard, B. (2004). Resiliency: What have we learned? San Francisco: West Ed.

Benoit, C., Jansson, M., Millar, A., & Phillips, R. (2005). Community-Academic Research on Hard-to-Reach Populations: Benefits and Challenges. *Qualitative Health Research,15*(2), 263-282. doi:10.1177/1049732304267752

Beyerlein, B. A., & Bloch, E. (2014). Need for Trauma-Informed Care Within the Foster Care System: A Policy Issue. *Child Welfare,93*(3), 7-21.

Bigelsen, J. (2013). Homelessness, Survival Sex and Human Trafficking: As Experienced by the Youth of Covenant House, New York.

Bolger, K. E., & Patterson, C. J. (2001). Developmental pathways from child maltreatment to peer rejection. *Child Development*, 72, 549–568

Borland, R., Zimmerman, C. (2009). Caring for Trafficked Persons: Guidance for Health Providers. *International Organization for Migration.*

Bounds, D., Julion, W. A., & Delaney, K. R. (2015). Commercial Sexual Exploitation of Children and State Child Welfare Systems. *Policy, Politics, & Nursing Practice,16*(1-2), 17-26. doi:10.1177/1527154415583124

Boxill, N., & Richardson, D. (2007). Ending sex trafficking of children in Atlanta. Affilia: Journal of Women & Social Work, 22(2), 138-149. doi: 10.1177/0886109907299054

Brantley, N. K. (2015). Tips for Working with CSEC Survivors. *Child Law Practice,34*(10), 154-154.

Braun, Virginia & Clarke, Victoria. (2006). Using Thematic Analysis in Psychology. Qualitative research in psychology. 3. 77-101. 10.1191/1478088706qp063oa.

Carnes, P. J. (1997). The betrayal bond: Breaking free of exploitive relationships. Deerfield Beach, FL: Health Communications.

Child Victims' and Child Witnesses' Rights Act (18 U.S.C. §3509). Retrieved from https://www.law.cornell.edu/ uscode/text/18/3509

Choi, H., Klein, C., Shin, M.S., & Lee, H.J. (2009). Posttraumatic stress disorder (PTSD) and disorders of extreme stress (DESNOS) symptoms following prostitution and childhood abuse. *Violence Against Women, 15(8).*

Cochran, B. N., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges Faced by Homeless Sexual Minorities: Comparison of Gay, Lesbian, Bisexual, and Transgender Homeless Adolescents With Their Heterosexual Counterparts. *American Journal of Public Health,92*(5), 773-777. doi:10.2105/ajph.92.5.773

Coy, M. (2008). Young Women, Local Authority Care and Selling Sex: Findings from Research. *British Journal of Social Work, 38*(7), 1408-1424. doi:10.1093/bjsw/bcm049

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and Conducting Mixed Methods Research*. Thousand Oaks, CA: Sage Publications.

Dalla, R. L. (2006). Exposing the" pretty woman" myth: a qualitative investigation of street-level prostituted women. Lexington Books.

Department of Health and Human Services. (2017). Sex Trafficking Fact Sheet [PDF]. National Human Trafficking Resource Center.

Deutsch, S., & Fortin, K. (2015). Physical Health Problems and Barriers to Optimal Health Care Among Children in Foster Care. *Current Problems in Pediatric and Adolescent Health Care, 45*(10), 286-291. doi:10.1016/j.cppeds.2015.08.002

Dottridge, M. (2006). Reference Guide on protecting the rights of child victims of trafficking in Europe. *UNICEF.*

Estes, R.J., & Weiner, N. A. (2001). The commercial sexual exploitation of children in the U.S., Canada and Mexico. Philadelphia: University of Pennsylvania, School of Social Work, Center for the Study of Youth Policy.

Family Violence Prevention Fund. (2005). Turning Pain into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies. World Childhood Foundation, San Francisco: World Childhood Foundation.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods,5*(1), 80-92. Retrieved June 2, 2018.

Ferguson, K. M., Soydan, H., Lee, S., Yamanaka, A., Freer, A. S., & Xie, B. (2009). Evaluation of the CSEC Community Intervention Project (CCIP) in Five U.S. Cities. *Evaluation Review,33*(6), 568-597. doi:10.1177/0193841x09346132

Flory, J. D., & Yehuda, R. (2015). Comorbidity between post-traumatic stress disorder and major depressive disorder: Alternative explanations and treatment considerations. *Dialogues in Clinical Neuroscience,17*(2), 141-150.

Fong, R., & Cardoso, J. B. (2010). Child human trafficking victims: Challenges for the child welfare system. *Evaluation and Program Planning,33*(3), 311-316. doi:10.1016/j.evalprogplan.2009.06.018

Ford, N. J. (2003). Tourism and sex: Culture, commerce and coercion. *Tourism Management, 24*(2), 228-231. doi:10.1016/s0261-5177(02)00054-7

Fowler, J., Che, N., & Fowler, L. (2010). Innocence lost: The rights of human trafficking victims. Procedia-Social and Behavioral Sciences, 2(2), 1345-1349. doi: 10.1016/j.sbspro.2010.03.198

Friedman, S. A. (2005). Who is there to help us? How the system fails sexually exploited girls in the United States: Examples from four American cities. ECPAT-USA, Incorporated.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *The Lancet,373*(9657), 68-81. doi:10.1016/s0140-6736(08)61706-7

Goździak, E. M. (2008). On Challenges, Dilemmas, and Opportunities in Studying Trafficked Children. *Anthropological Quarterly, 81*(4), 903-924. doi:10.1353/anq.0.0033

Greenbaum, J., & Crawford-Jakubiak, J. E. (2015). Child Sex Trafficking and Commercial Sexual Exploitation: Health Care Needs of Victims. *Pediatrics, 135*(3), 566-574. doi:10.1542/peds.2014-4138.

Green, A., & Tomkins, S. (2014). Advocacy outside the Life: A Guide to Using Legal Services to Build a Public Systems Safety Net for Child Survivors of Commercial Sexual Exploitation. *Children's Legal Rights,34*(2).

Helfferich, C., Kavemann, B., & Rabe, H. (2011). Determinants of the willingness to make a statement of victims of human trafficking for the purpose of sexual exploitation in the triangle offender–police–victim. Trends in Organized Crime, 14(2-3), 125-147. doi: 10.1007/s12117-011-9125-1

Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L. M., Stanley, N., . . . Oram, S. (2016). Responding to the health needs of survivors of human trafficking: A systematic review. *BMC Health Services Research,16*(1). doi:10.1186/s12913-016-1538-8

Hennink, Monique & Hutter, I & Bailey, Ajay. (2011). Qualitative Research Methods.

Herman, J. L. (1997). Trauma and recovery (Rev. ed.). New York: BasicBooks.

HM Government, (2007). Working together to safeguard children - safeguarding children who may have been trafficked. *Department for Children Schools and Families.*

Holger-Ambrose, B., Langmade, C., Edinburgh, L. D., & Saewyc, E. (2013). The Illusions and Juxtapositions of Commercial Sexual Exploitation among Youth: Identifying Effective Street-Outreach Strategies. *Journal of Child Sexual Abuse,22*(3), 326-340. doi:10.1080/10538712.2013.737443

Hom, K. A., & Woods, S. J. (2013). Trauma and its aftermath for commercially sexually exploited women as told by front-line service providers. Issues in Mental Health Nursing, 34(2), 75-81. doi:10.3109/01612840.2012.723300

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-Informed Care in Homelessness Services. *The Open Health Services and Policy Journal,3*(2), 80-100. doi:10.2174/1874924001003020080

Hotaling, N., Miller, K., & Trudeau, E. (2006). Commercial sexual exploitation of women and girls: A survivor service provider's perspective. Yale JL & Feminism, 18, 181.

Hovens, J. G., Giltay, E. J., Wiersma, J. E., Spinhoven, P., Penninx, B. W., & Zitman, F. G. (2012). Impact of childhood life events and trauma on the course of depressive and anxiety disorders. *Acta Psychiatrica Scandinavica,126*(3), 198-207. doi:10.1111/j.1600-0447.2011.01828.x

Hughes, D. (2007). Enslaved in the USA. Retrieved from http://article.nationalreview.com/?q= ZDU0OGNlMDcwM2JmYjk0N2M0OTU4 NGVlMTBlMmEyMjI.

Human Rights Campaign. Glossary of Terms. Retrieved on March 31, 2019 from https://www.hrc.org/resources/glossary-of-terms.

Ijadi-Maghsoodi, R., Bath, E., Cook, M., Textor, L., & Barnert, E. (2018). Commercially sexually exploited youths' health care experiences, barriers, and recommendations: A qualitative analysis. *Child Abuse & Neglect,76*, 334-341. Doi: 10.1016/j.chiabu.2017.11.002

Isaac, R., Solak, J., Giardino, A.P. (2011). Health Care Providers' Training Needs Related to Human Trafficking: Maximizing the Opportunity to Effectively Screen and Intervene. *Journal of Applied Research on Children: Informing Policy for Children at Risk,* 2(1), 1–32.

Jülich, Shirley. "Stockholm Syndrome and Child Sexual Abuse." *WCSA J. of Child Sexual Abuse Journal of Child Sexual Abuse* 14.3 (2005): 107-29. Web.

Kardiner, A. (1941). *The Traumatic Neuroses of War*. Washington: National Research Council.

Kitzinger, J. (1994). The methodology of Focus Groups: The importance of interaction between research participants. *Sociology of Health & Illness,16*(1). Retrieved June 2, 2018.

Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America,12*(2), 293-317. doi:10.1016/s1056-4993(03)00003-8

Konstantopoulos, W. M., Ahn, R., Alpert, E. J., Cafferty, E., Mcgahan, A., Williams, T. P., . . . Burke, T. F. (2013). An International Comparative Public Health Analysis of Sex Trafficking of Women and Girls in Eight Cities: Achieving a More Effective Health Sector Response. *Journal of Urban Health,90*(6), 1194-1204. doi:10.1007/s11524-013-9837-4

Krueger, R. A. (1998). *Developing Questions for Focus Groups*. Thousand Oaks, CA: Sage Publications.

Kung, J. (2014). Sex trafficking: an exploration of clinician perspectives of the type and efficacy of treatment interventions. *Smith College School for Social Work*.

Lederer, L., & Wetzel, C. (2014). The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. Annals of Health Law, 23, 61–91.

Liles, B. D., Blacker, D. M., Landini, J. L., & Urquiza, A. J. (2016). A California Multidisciplinary Juvenile Court: Serving Sexually Exploited and At-Risk Youth. *Behavioral Sciences & the Law,34*(1), 234-245. doi:10.1002/bsl.2230

Link, B. G., & Phelan, J. C. (2006). Stigma and its public health implications. *The Lancet,367*(9509), 528-529. doi:10.1016/s0140-6736(06)68184-1

Lloyd, R. (2011). Girls like us. New York: HarperCollins Publishers.

Macy, R.J., Johns, N. (2011). Aftercare Services for International Sex Trafficking Survivors: Informing U.S. Service and Program Development in an Emerging Practice Area. *Trauma, Violence & Abuse*, 12(2), 87–98.

Marcus, A., Horning, A., Curtis, R., Sanson, J., & Thompson, E. (2014). Conflict and agency among sex workers and pimps: A closer look at domestic minor sex trafficking. Annals of the

American Academy of Political and Social Science, 653(1), 225-246. doi: 10.1177/0002716214521993

McKeen, Amber, "Exploring the Realities of Child Sex Trafficking in Georgia" (2015). National Youth-At-Risk Conference Savannah. 66. https://digitalcommons.georgiasouthern.edu/nyar_savannah/2015/2015/66

McMahon-Howard, J., & Reimer, B. (2013). An evaluation of a child welfare training program on the commercial sexual exploitation of children (CSEC). *Evaluation and Program Planning,40*, 1-9. doi:10.1016/j.evalprogplan.2013.04.002

Mitchell, K. J., Finkelhor, D., & Wolak, J. (2009). Conceptualizing Juvenile Prostitution as Child Maltreatment: Findings from the National Juvenile Prostitution Study. *Child Maltreatment, 15*(1), 18-36. doi:10.1177/1077559509349443

Mitchell, K. J., Jones, L. M., Finkelhor, D., & Wolak, J. (2010). Internet-Facilitated Commercial Sexual Exploitation of Children: Findings From a Nationally Representative Sample of Law Enforcement Agencies in the United States. *Sexual Abuse: A Journal of Research and Treatment,23*(1), 43-71. doi:10.1177/1079063210374347.

Muftic, L. R., & Finn, M. A. (2013). Health Outcomes Among Women Trafficked for Sex in the United States: A Closer Look. *Journal of Interpersonal Violence, 28*(9), 1859-1885. doi:10.1177/0886260512469102

Murphy, L. (2010). Understanding the social and economic contexts surrounding women engaged in street-level prostitution. Issues in Mental Health Nursing, 31(12), 775- 784 10p. doi:10.3109/01612840.2010.524345

Nicholls, T. L., & Hamel, J. (2007). *Family Interventions in Domestic Violence: A Handbook of Gender-inclusive Theory and Treatment*. Springer Publishing Company.

Oosterbaan, A. (2008, September). Keynote address. Delivered at the National Training Conference on the Sex Trafficking of America's Youth, Dallas.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.

Pheterson, G. (1990). The category “prostitute” in scientific inquiry. *The Journal of Sex Research: Feminist Perspectives on Sexuality, Part 2,27*(3), 397-407.

Pierce, A.S. (2012). American Indian adolescent girls: Vulnerability to sex trafficking, intervention strategies. American Indian and Alaska Native Mental Health Research, 19(1), 37-56. doi: 10.5820/aian.1901.2012.37

Polaris Project. (2018). Georgia. Retrieved from https://humantraffickinghotline.org/state/georgia

Priebe, A. S., & Suhr, C. (2005). Hidden in plain view: The commercial sexual exploitation of girls in Atlanta. Atlanta, GA: The Atlanta Women's Agenda. Retrieved on October 14, 2009, from http://www.womensagenda.com/Child_Prostitution.pdf

Rand, A. (2010). It Can't Happen in My Backyard: The Commercial Sexual Exploitation of Girls in the United States. *Child & Youth Services,31*(3-4), 138-156. doi:10.1080/0145935x.2009.524480.

Raymond, J. G., & Hughes, D. M. (2003). International and Domestic Trends in Sex Trafficking of Women in the United States, 1999-2000. *ICPSR Data Holdings*. doi:10.3886/icpsr03438

Reid, J. A., & Jones, S. (2011). Exploited vulnerability: Legal and psychological perspectives on child sex trafficking victims. Victims & Offenders, 6(2), 207-231. doi:10.1080/15564886.2011.557327

R, J, L & V. (n.d.). Retrieved from https://www.equalitynow.org/r_j_l_v

Roe-Sepowitz, D. E. (2012). Juvenile entry into prostitution: The role of emotional abuse. *Violence against Women, 18*(5), 562–579. doi:10.1177/1077801212453140

Rogers, E. (2002). Diffusion of Preventative Innovations. *Addictive Behaviors*, 27, 989- 993.

Rothman, E. F., & Bair-Merritt, M. H. (2018). Commercial Sexual Exploitation of Children in the United States. In *Violence and Trauma in the Lives of Children*(pp. 227-246). Santa Barbara, CA: ABC-CLIO.

Rowan, A. B., Foy, D. W., Rodriguez, N., & Ryan, S. (1994). Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse & Neglect,18*(1), 51-61. doi:10.1016/0145-2134(94)90095-7

Saewyc, E. M., Miller, B. B., Rivers, R., Matthews, J., Hilario, C., & Hirakata, P. (2013). Competing discourses about youth sexual exploitation in Canadian news media. *The Canadian Journal of Human Sexuality,22*(2), 95-105. doi:10.3138/cjhs.2013.2041

Seita, J., & Brendtro, L. (2005). Kids who outwit adults. Bloomington, IN: Solution Tree.

Shared Hope International. (2007). Demand: A comparative examination of sex tourism and trafficking in Jamaica, Japan, the Netherlands and the United States. Retrieved from http://sharedhope.org/wp-content/uploads/2012/09/DEMAND.pdf

Shared Hope International. (n.d.-d). Domestic minor sex trafficking, the United States: The assessments. Retrieved from http://www.sharedhope.org/dmst/documents/ FINAL_FactSheet_National_000.pdf

Shared Hope International. (n.d.) Retrieved from http://sharedhope.org/

Shared Hope International. (2013). Protected innocence challenge: State report cards on the legal framework of protection for the nation's children. Retrieved from http://sharedhope.org/wp-content/uploads/2014/02/2013-Protected-Innocence-Challenge-Report.pdf.

Smith, L. (2008, July). Keynote address. Delivered at Catholic Charities Anti-Human Trafficking Training, San Antonio, TX

Smith L.A., Vardaman S.H., & Snow M.A. (2009). The national report on domestic minor sex trafficking: America's prostituted children. Shared Hope International. 2009. Retrieved from http://sharedhope.org/wp-content/uploads/2012/09/SHI_National_Report_on_DMST_2009.pdf.

Stoltz, J. M., Shannon, K., Kerr, T., Zhang, R., Montaner, J. S., & Wood, E. (2007). Associations between childhood maltreatment and sex work in a cohort of drug-using youth. *Social Science & Medicine, 65*(6), 1214-1221. doi:10.1016/j.socscimed.2007.05.005

Stransky, M. & Finkelhor, D. (2008) How many juveniles are involved in prostitution in the U.S.? Factsheet published by the Crimes Against Children Research Center at the University of New Hampshire.

Swaner, R., Labriola, M., Rempel, M., Walker, A., & Spadafore, J. (2016). Youth Involvement in the Sex Trade: A National project. *Center for Court Innovation.*

Todres, J., & Clayton, E. W. (2014). Responding to the Sexual Exploitation of Minors. *New England Journal of Medicine N Engl J Med, 370*(14), 1282-1283. doi:10.1056/nejmp1314927

Twill, S. E., Green, D. M., & Traylor, A. (2010). A descriptive study on sexually exploited children in residential treatment. *Child & Youth Care Forum, 39*(3), 187–199. doi:10.1007/s10566-010-9098-2

United States Census Bureau. (2017). State and county quick facts. Retrieved from https://www.census.gov/quickfacts/ga

United States Department of State. (2013). Trafficking in persons report 2013. *US Department of State.* Retrieved from www.state.gov/j/tip/rls/tiprpt/2013/

U.S. Department of Health and Human Services. (n.d.). Fact sheet on sex trafficking. Retrieved October 11, 2009, from http://www.acf.hhs.gov/trafficking/ about/fact_sex.html

Varma, S., Gillespie, S., Mccracken, C., & Greenbaum, V. J. (2015). Characteristics of child commercial sexual exploitation and sex trafficking victims presenting for medical care in the United States. *Child Abuse & Neglect, 44*, 98-105. doi:10.1016/j.chiabu.2015.04.004

VERBI Software. (2012). MAXQDA 12: The art of text analysis. Berlin: Germany: VERBI.

Vieira, T. A., Skilling, T. A., & Peterson-Badali, M. (2009). Matching Court-Ordered Services with Treatment Needs: Predicting Treatment Success with Young Offenders. *Criminal Justice and Behavior,36*(4), 385-401. doi:10.1177/0093854808331249

Walker, K. (2013). *California Child Welfare Council, ending the Commercial Sexual exploitation of Children: a Call for multi-System Collaboration in California*.

Walls, N. E., & Bell, S. (2011). Correlates of Engaging in Survival Sex among Homeless Youth and Young Adults. *Journal of Sex Research, 48*(5), 423-436. doi:10.1080/00224499.2010.501916

Wells, M., & Mitchell, K. J. (2007). Youth Sexual Exploitation on the Internet: DSM-IV Diagnoses and Gender Differences in Co-occurring Mental Health Issues. *Child and Adolescent Social Work Journal,24*(3), 235-260. doi:10.1007/s10560-007-0083-z

Wernham, M. (2005). *Police Training on Child Rights & Child Protection: Lessons Learned & Manual*. London, UK: Consortium for Street Children.

WestCoast Children's Clinic: Research to Action: Sexually Exploited Minors (SEM) Needs and Strengths. Oakland, CA, *WestCoast Children's Clinic,* 2012

What is a women's safe house, and what do they do? (2018, August 24). Retrieved from https://iwda.org.au/what-is-a-safe-house-and-what-do-they-do/.

What is Sex Trafficking? (n.d.). Retrieved from https://sharedhope.org/the-problem/what-is-sex-trafficking/

Williamson, E., Dutch, N., & Clawson, H. (2017, February 21). Medical Treatment of Victims of Sexual Assault and Domestic Violence and Its Applicability to Victims of Human Trafficking. Retrieved from https://aspe.hhs.gov/report/medical-treatment-victims-sexual-assault-and-domestic-violence-and-its-applicability-victims-human-trafficking

Williamson, C., & Prior, M. (2009). Domestic minor sex trafficking: A network of underground players in the Midwest. Journal of Child & Adolescent Trauma, 2(1), 46-61. doi: 10.1080/19361520802702191

Willis, G. B. (2005). *Cognitive Interviewing-A Tool for Improving Questionnaire Design*. Thousand Oaks, CA: Sage Publications.

Zimmerman, C., Hossain, M., Yun, K., Roche, B., Morison, L., & Watts, C. (2006) Stolen Smiles: The physical and psychological health consequences of women and adolescents trafficked in Europe. *London School of Hygiene & Tropical Medicine*, London.

Appendix I: Final Focus Group Discussion (FGD) Question Guide

Introduction:
Hello! Thank you all for taking the time to attend today's focus group. My name is Maya Lakshman *(introduce two focus group assistants)* and we are students at Rollins School of Public Health and Emory College at Emory University. The purpose of this project is to assess the proposed "Framework for Addressing Re-Traumatization of Survivors of Commercial Sexual Exploitation of Children". Before we begin, I will briefly go over the risks and benefits of the project.

In this room, there are some clinicians, members of law enforcement, social workers/psychologists, and survivors *(edit depending on who is in the room).* During this focus group, I would like to gain your insights on whether the proposed model would reduce re-traumatization of survivors. The focus group will range from 1 hour to 2 hours. This focus group discussion will be recorded and transcribed. I will be moderating this discussion, and notes will also be taken by _____.

The project does not directly inquire about past trauma. However, it might be difficult to talk about your own traumas or the traumas of survivors you have interacted with. Aside from discomfort discussing this issue there are no substantial risks to participating in this project.

There are no direct benefits to participating in this project, however you will have the opportunity to learn about a new intervention that could be implemented, and how it could potentially change your duties and line of work. It is possible that if implemented this model may, in the future, benefit survivors and the service providers who work with them.
This project is voluntary and you are welcome to stop at any point. Do not hesitate to ask me if you have any questions or comments during the interview.

I will now turn on the recorder and ask for individual oral consent from everyone in the room.

[Turn on audio recorder]

Do I have your consent to begin? (*Wait for oral consent of each individual in the room)*. Please do not hesitate to ask me any questions at any point.

Before we begin, there are a couple important rules for today's discussion I would like to bring up.

- Please remember that we have individuals from many different backgrounds in this room today. Everyone's experience is valid, so please be respectful and aware of that as you formulate your responses.
- To protect confidentiality, please do not refer to other individuals in the room by name, or share or refer to any information that could reveal yours or anyone else's identity.

Thank you.

Interview Questions

Opening Questions

- Can you tell me a little bit about how you work with survivors?
    - Probe: What is the nature of your relationship with the survivors whom you work with?
- What do you believe are the main mental health needs of survivors?
    - Probe: What is your role in attending to those needs?

Thank you for this brief background information. I will now introduce you to the model that was created to address survivors' mental health needs.

One graduate assistant will hand out the printed copy of the model to each focus group participant

Script: Survivors of Commercial Sexual Exploitation of Children (CSEC) are asked to re-explain their experiences several times to different professionals. The three main groups are members of law enforcement, health care professionals and social work workers. The repetition of distressing experiences can be very traumatizing for survivors (Green and Tomkins, 2014). The proposed model attempts to reduce the trauma that CSEC survivors face from re-telling their stories. The model includes four parts:

- **A secure database** where law enforcement, clinicians, and social workers will record their interactions with survivors to capture and store survivor stories.
- **A court mandated therapy program** for CSEC survivors
    - Social workers determine whether or not therapy is necessary for each case.
- **Relocation** services for survivors
    - Safe short and long-term placements
    - Social workers determine whether or not relocation is necessary, as well as placement timeframe.
- **Required trainings** for all professionals
    - Trauma-informed practices

Before we get into the specifics of each part of the model, does anyone have any questions about the model itself?

Specific Questions on Model

- The database serves as a data-sharing platform between professionals, where survivor information can be recorded in a secure and reliable manner. Regarding the national, central database part of the model (red), what can be changed to make it more feasible?
    - Probe: Is it feasible? What would improve it?

- Social workers would provide survivors with the option of short and long-term placements in alternate locations to lessen stigma. Regarding the relocation services for survivors part of the model (orange), what can be changed to make it more feasible?
    - Probe: Is it feasible? What would improve it?

- Courts would have responsibility to mandate case-by-case therapy for survivors who need it, as determined by social workers and psychologists. Regarding the court-mandated therapy part of the model (teal), what can be changed to make it more feasible?
    - Probe: Is it feasible? What would improve it?

- All personnel working with survivors should be required to participate in trauma-informed trainings, as well as trainings on the database. Regarding the appropriate training of personnel part of the model (gray), what can be changed to make it more feasible?
    - Probe: Is it feasible? What would improve it?

Overarching Questions on Model

- What is your reaction to the model?

- What effect would this model have on the re-traumatization of survivors?

- Would this model have an impact on the high numbers of children that return to coercive sex work after being rescued?
    - Probe: If yes, why? If no, why not?

- What would you see to be the greatest challenge(s) in implementing such a model?

- In what ways could this model be improved to better help survivors?
    - Probe: Are there unaddressed elements of the model?
    - Probe: For what type of cases would this model apply?
    - Probe: When would this model not work?
    - Probe: Are there any cases it would not be able to be applied to?

- For each of you, how might this model make your job or the job of others in your profession easier or more difficult?

- How might this model make the lives of survivors easier or more difficult?

Closing Questions

- What are other questions/concerns/feedback you might have regarding the model and its feasibility?
- Is there anything else you would like to share?

Thank you for your time today.

Appendix II: In-Depth Interview (IDI) Question Guide

Introduction:
Hello! Thank you for meeting with me today. My name is Maya Lakshman and I am a student at Rollins School of Public Health and Emory College at Emory University. The purpose of this project is to assess the proposed "Framework for Addressing Re-Traumatization of Survivors of Commercial Sexual Exploitation of Children". Before we begin, I will briefly go over the risks and benefits of the project.

During this interview, I would like to gain your insights on whether the proposed model would reduce re-traumatization of survivors. The interview will range from 30 to 45 minutes. This discussion will be recorded and transcribed.

The project does not directly inquire about past trauma. However, it might be difficult to talk about your own traumas or the traumas of survivors you have interacted with. Aside from discomfort discussing this issue there are no substantial risks to participating in this project.

There are no direct benefits to participating in this project, however you will have the opportunity to learn about a new intervention that could be implemented, and how it could potentially change your duties and line of work. It is possible that if implemented this model may, in the future, benefit survivors and the service providers who work with them.
This project is voluntary and you are welcome to stop at any point. Do not hesitate to ask me if you have any questions or comments during the interview.

Do I have your consent to record this interview?

[Turn on audio recorder]

Do I have your consent to begin? *(wait for verbal consent).* Please do not hesitate to ask me any questions at any point.

Interview Questions

Opening Questions

- What do you believe are the main mental health needs of survivors?
    - Probe: What is your role in attending to those needs?

Thank you for this brief background information. I will now introduce you to the model that was created to address survivors' mental health needs.

Script: Survivors of Commercial Sexual Exploitation of Children (CSEC) are asked to re-explain their experiences several times to different professionals. The three main groups are members of law enforcement, health care professionals and social work workers. The repetition of distressing experiences can be very traumatizing for survivors (Green and Tomkins, 2014).

The proposed model attempts to reduce the trauma that CSEC survivors face from re-telling their stories. The model includes four parts:

- **A secure database** where law enforcement, clinicians, and social workers will record their interactions with survivors to capture and store survivor stories.
- **A court mandated therapy program** for CSEC survivors
  - Social workers determine whether or not therapy is necessary for each case.
- **Relocation** services for survivors
  - Safe short and long-term placements
  - Social workers determine whether or not relocation is necessary, as well as placement timeframe.
- **Required trainings** for all professionals
  - Trauma-informed practices

Before we get into the specifics of each part of the model, do you have any questions about the model itself?

Specific Questions on Model

- What elements would be useful or not useful in a database?
  - Probe: The database serves as a data-sharing platform between professionals, where survivor information can be recorded in a secure and reliable manner. Regarding the national, central database part of the model (red), what can be changed to make it more feasible?
  - Probe: Is it feasible? What would improve it?

- What elements would be useful or not useful for relocation placements?
  - Probe: Social workers would provide survivors with the option of short and long-term placements in alternate locations to lessen stigma. Regarding the relocation services for survivors part of the model (orange), what can be changed to make it more feasible?
  - Probe: Is it feasible? What would improve it?

- What elements would be useful or not useful for court-mandated therapy for survivors?
  - Probe: Courts would have responsibility to mandate case-by-case therapy for survivors who need it, as determined by social workers and psychologists. Regarding the court-mandated therapy part of the model (teal), what can be changed to make it more feasible?
  - Probe: What are some factors we should consider?
  - Probe: Is it feasible? What would improve it?

- What elements would be useful or not useful for trainings for personnel?
  - Probe: All personnel working with survivors should be required to participate in trauma-informed trainings, as well as trainings on the database. Regarding the appropriate training of personnel part of the model (gray), what can be changed to make it more feasible?
  - Probe: Is it feasible? What would improve it?

Overarching Questions on Model

- What is your reaction to the model?

- What effect would this model have on the re-traumatization of survivors?

- Would this model have an impact on the high numbers of children that return to coercive sex work after being rescued?
    - Probe: If yes, why? If no, why not?

- What would you see to be the greatest challenge(s) in implementing such a model?

- In what ways could this model be improved to better help survivors?
    - Probe: Are there unaddressed elements of the model?
    - Probe: For what type of cases would this model apply?
    - Probe: When would this model not work?
    - Probe: Are there any cases it would not be able to be applied to?

- For each of you, how might this model make your job or the job of others in your profession easier or more difficult?

- How might this model make the lives of survivors easier or more difficult?

Closing Questions

- What are other questions/concerns/feedback you might have regarding the model and its feasibility?
- Is there anything else you would like to share?

Thank you for your time today.

Appendix III: FGD and IDI Combined Coding Tree

1. **Mental Health Needs of Survivors**
    a) Past/Childhood Trauma
    b) Trauma-Informed Focus
    c) Trust in Environment
2. **Issues with Current System**
    a) Survivors' distrust of professionals
    b) Going "on run"
    c) Abuse and neglect in foster care
    d) Lack of collaboration
3. **Stakeholder Recommendations for Adoption**
    a) Establishing trust
4. **Feasibility Issues**
    a) Privacy
    b) Inability to reduce procedural steps
    c) Timeliness
    d) Lack of placements
5. **Feedback on Database**
    a) Boundaries of reported data
    b) Collaboration during data collection
    c) Type of data
    d) Alert and Contact System
6. **Feedback on Relocation Services**
    a) Centralizing referral process
    b) Modify risk evaluation process
    c) Resources for fosters and guardians
    d) Long-term placements
7. **Feedback on Court-Mandated Therapy**
    a) Therapy for guardians
    b) Compulsory attendance to therapy
    c) Giving survivors control
    d) Quality of therapy
8. **Feedback on Trainings**
    a) Victim and risk identification
    b) Up-to-date protocols
    c) Consistency and Collaboration
    d) Case-by-case basis
    e) Sensitivity Training
    f) Quality of Training
    g) Survivor Involvement in Training
9. **Aesthetic changes**
10. **Retraumatization**
    a) Success in reducing retraumatization
    b) Follow-through on all steps
11. **Challenges to Implementation**

a) Buy-in
b) Accountability

12. Survivors' Perspectives

a) Ongoing survivor feedback
b) Potential impact

13. Impact on Stakeholders

a) Simplification of responsibilities
b) Resistance from clinicians

Appendix IV: FGD and IDI Combined Codebook

Code #	Code	Subcode	Definition	Inclusion/Exclusion Criteria	Example Quotes
1	Mental Health Needs of Survivors		The services and type of care that survivors need, based on the research, knowledge, and experience of stakeholders.	***Include*** mentions by any stakeholder of the needs of survivors, specifically mentally and/or emotionally.	"If there was a way to have services be more child-friendly and less clinical, I guess that's the bottom line. They would be more receptive to the information and opening up".
1a		Awareness of past trauma	Need for therapeutic care that accounts for survivors' past and childhood trauma.	***Include*** mentions of survivors' past or childhood during conversations about therapy options.	"They have trauma that stems back from their childhood that we have uncovered through the court process".
1b		Trauma-Informed Focus	Need for services and care that account for survivors' trauma and their resulting coping mechanisms. Relevant to all stakeholders.	***Include*** mentions of trauma-informed or trauma-sensitive care, especially for law enforcement and clinicians.	"Trauma focus is definitely the main mental health need… we work with a whole holistic approach".
1c		Trust and Power in Environment	Need for the development of a stable, trusting environment for survivors during questioning and throughout services. This environment must give survivors power.	***Include*** mentions of creating an environment where survivors feel safe.	"The environment that goes along with the [trauma-informed care] is also important, because with some victims and survivors that we worked with…we didn't get a lot of information out about them until three/four to six months down the line".
2	Issues with Current System		The reasons why the system and resources currently		"Well and I think that kind of points to some sort of existing system

			in place to aid survivors are not effective.		failures. Because there really be [a way to identify victims] when law enforcement is encountering a victim… they should be contacting the detectives that have experience with these kids….”
2a		Survivors distrust of professionals	References to survivors’ distrust of professionals, and the reasons for this.	***Include*** mentions of distrust as potential reasons why survivors do not open up to responders, or seek out and receive services.	“I've been in that situation, even family therapy with it and you have the therapist telling my parents, you know, what's happening and it's no confidentiality. There is no trust. And for me personally, it's just, I just want to feel like I can trust you.”.
2b		Going “on run”	References to survivors running away from placements or during services.	***Include*** mentions of survivors running away and inadequate systemic responses.	“We indirectly find out that it is CSEC because we could get a young lady that’s on run from either guardian’s home or her parents home and is constantly running… the police ended up arresting her and finding out she had been a runaway”.
2c		Abuse and neglect in foster care	References to negative survivor experiences in foster care that are inadequately addressed.	***Include*** mentions of poor treatment of survivors within foster care.	“The reason why it doesn’t work is because I was being physically abused by my adopted mother…[she] physically abused me and once she busted my lip and she cut my hair off…”
2d		Lack of collaboration	Mentions of a problem with the system in place	***Include*** comments expressing distaste of professionals	“I think what you were talking about though is like exactly what this is

			being people working alone as opposed to together on CSEC cases.	working in their silos.	though. Like everyone kind of has their role and they sit in their chair and so I feel like that space to be like I'll sit over here and then figure out what I'm supposed to do, but until I'm, until I'm sure, I'm not, I'm not gonna do it".
3	Stakeholder Recommendations for Adoption		Refers to parts of the model that stakeholders thought would be beneficial as written. Recommendations for successful implementation.	***Include*** positive comments on model. ***Exclude*** negative and/or constructive feedback.	"That training is absolutely like hands down one of the best things… But these are kids. It's someone's responsibility to take care of them, you know? And I think that they need to really know what goes on behind it. Like, yes, they may have found themselves in this situation, but why?"
3a		Establishing trust	Defined as attempts by stakeholders to establish a trusting, stable relationship with the survivors that they work with.	***Include*** attempts made both during and after the case.	"But I keep in touch with all of my victims in the cases that have gone to trial because it's a completely different experience when you're going through trial and actually touch base with them. You know, a couple of times a year and make sure they're all right".
4	Feasibility Issues		Technical challenges that stakeholders did not have specific solutions for, and which might make implementation	***Include*** technical barriers to implementing specific parts of the model. ***Exclude*** mentions of buy-in or	" Because the more information we as prosecutors get our hands on, the more information that is potentially going to be turned over to the other side. Then we

			difficult.	funding.	obviously have a lot of confidentiality issues, HIPAA issues…”
4a		Privacy	References to the need to keep information about trauma and survivor experiences private.	***Include*** mentions of privacy. ***Exclude*** mentions of confidentiality.	“And I think the idea that there… anything they say is somehow being collected and preserved… I can see that being very, very sticky and uncomfortable for them”.
4b		Inability to reduce procedural steps	Mentions of specific steps in the current process of prosecuting survivors’ cases and providing care that cannot be avoided.	***Include*** mentions of rigid procedures during questioning, assessment of survivor needs, etc.	“I can understand why you don't want like 10 different DFACS workers asking the child the same question and that's just a matter of them reviewing the file. But when the child comes to court, there is no way, no way. And I would ever put a child on the stand without having talked to them once, twice, maybe three times”.
4c		Timeliness of Submissions	Mentions of difficulty monitoring if professionals enter information into the database on time, and consequences if they do not.	***Include*** references to time-sensitive nature of data entry. Must pertain to database. ***Exclude*** timeliness as it relates to any other part of the model.	“Um, it's just making sure that people, um, uh, are timely in their submission because if, say the case manager wants to look at a person in order for them to make a determination, everybody has to enter information”.
4d		Lack of placements	This refers to a lack of long or short-term placement availability for	***Include*** mentions of challenges with physical placement space or	“The problem that I've encountered with survivors is locations for placements … they need

			survivors.	availability.	a safe, secure location with maybe uh, more intense services. They also need doctors who are set up for that”.
5	Feedback on Database		Defined as constructive feedback from any stakeholder about components of the database and its potential implementation.	***Include*** feedback for implementation of components of database part of the model. ***Exclude*** comments that do not propose changes or tweaks.	“So with that being said, I think the coordinator, the first responder, might be more effective in getting a lot of the information out because you have a traumatized child, who first of all is shocked by the situation itself…if another adult comes in and says I'm here to help you... how much trust is that child going to have?”
5a		Boundaries of reported data	Comments proposing methods of protecting data and ensuring that only necessary information is reported.	***Include*** mentions of confidentiality and boundaries in reference to data sharing.	“And so, what would be the kind of boundaries around what information is reported? Because I think if we figure this out, it could be part of how we are making sure that everyone's needs, for lack of better words, are getting met in terms of communicating and sharing information that is appropriate and effective”.
5b		Collaboration during data collection	Comments proposing more collaboration between professionals during data collection to simplify process.	***Include*** mentions of collaboration as it relates to the database.	“Maybe having the forensic interview being in place where all parties kind of come together to make sure that all the questions get answered, but by a person who is skilled to be able to do it in a way that does not retraumatize”.

5c		Type of data	Suggestions about the type of data that would go into the database (i.e. how streamlined, amount of detail, subjectivity, etc).	***Include*** mentions of type of data, data classifications, or information that would be helpful for people to have about MH/CSEC.	"and like a documentation to have if they have had tried to limit services, which services worked, which services didn't work, did the child respond or did they not respond? did they even get an assessment done? Like all those records will be very helpful…"
5d		Alert and contact system	Suggestions for marking signifiers or signaling at-risk survivors on the database, and providing contact info for corresponding personnel.	***Include*** mentions of alerts, patterns or indicators on the database for the purpose of quick identification and provision of care.	"We couldn't get to the hospital because we don't have any information. Whereas if we did have a database that at least alerts us that yes, this child has a history… that could be very helpful".
6	Feedback on Relocation Services		Defined as constructive feedback from any stakeholder about components of relocation services.	***Include*** feedback for implementation of components of database part of the model. ***Exclude*** comments that do not propose changes or tweaks.	"I know for the division we don't really have access to those, so if we're doing relocation services, it would be something that we'd like to have that access to through service providers for that specific placement".
6a		Centralizing referral process	Need for streamlining the process of referring to survivors treatment facilities or placements.	***Include*** references to Georgia Cares and complexities and challenges of referrals.	"Perhaps there could be a more simplified way of making referrals and having those referrals reviewed to appropriate those relocation services... like a more of a centralized even way of doing it, it would be much easier".
6b		Risk evaluation	Need for better	***Include*** mentions	"And I will say some

		process	process of evaluating how at risk a kid is (high or low). Risk is defined as likelihood of running away or by presence of self-harming behaviors.	of risk in regard to placements or otherwise.	girls are more at risk than others…the high risk girls, you know, make sure you keep them away from the low risk girls, you know…So that the ones who have been out there longer and who have been exposed to a lot more don't influence the ones who are new into the process and you know have a better chance of being rehabilitated".
6c		Resources for fosters and guardians	Defined as need for providing trauma-informed trainings to foster parents to prepare them for caring for survivors.	***Include*** mentions of training foster parents.	"One of the things that we're working on is umm to your point is training up a couple foster parents who are really prepared and in the know about what to expect…"
6d		Long-term placements	Defined as the need for long-term over short-term placements (greater effectiveness of long-term placements).	***Include*** any comments or feedback from stakeholders about preference of long-term placements.	"They need long-term stable placements, and I'm talking like a year or two or more... Like a three month residential program isn't gonna really do anything but barely touched the surface".
7	Feedback on court-mandated therapy		Defined as constructive feedback from any stakeholder about components of the court-mandated therapy portion.	***Include*** feedback for implementation of components of the court-mandated therapy part of the model. ***Exclude*** comments that do not propose changes or tweaks.	"So to expand it to every jurisdiction, you know, so that courts will require the treatment, but also so that it is being enforced because I've had CSEC survivors who were actually participating in court mandated treatment, but they weren't attending and no

					one was enforcing it".
7a		Therapy for guardians	Defined as references to importance or benefit of mandating therapy for guardians or foster parents.	***Include*** mentions of therapy or therapeutic services for guardians.	"It would be good to court-mandate the therapy for the parents to deal with because then the child is going to see it a little differently as well".
7b		Compulsory therapy attendance	This is defined as the need to ensure that only survivor attendance at therapy sessions is mandated, not necessarily opening up.	***Include*** comments about ways to define "court-mandated therapy" and what it includes, attendance vs. opening up.	"If you're mandating putting this child in a place, with hopefully a well-prepared person who can help them, if the child is ready. You're not going to make them talk, you're not going to force them to do anything other than be in a setting for half an hour or 45 minutes, and hopefully that relationship involves your being together, getting together with a good therapist who knows where to back off'.
7c		Giving survivors control	Defined as the importance of giving survivors power over their therapy, and taking into account their input through all parts of the process.	***Include*** comments about survivor input in the process, ensuring that they have power and control.	"The timing of those interviews is dependent on that child's situation and whether they're stable, whether they're appropriately housed, or whether they're willing to talk at that time".
7d		Quality of therapy	Defined as the need for therapy to be evidence-based and trauma-informed, ensuring that therapists and psychologists are	***Include*** references to therapy quality. Specific to therapy curriculum and training for therapists.	"I think any therapeutic intervention that is recommended has to be evidence-based and trauma informed… Like I wouldn't consider anything else for this

			well-trained.		population”.
8	Feedback on trainings		Defined as constructive feedback from any stakeholder about components of the trainings.	***Include*** feedback for implementation of components of trainings. ***Exclude*** comments that do not propose changes or tweaks.	“Like I think everybody needs to be trained at this point. Anybody who has to come in contact with this kid, they need to be trained”.
8a		Victim and risk identification	Defined as the need for inclusion of main risk factors, patterns, and indicators of victims of CSEC in all trainings for all professionals.	***Include*** any mentions of identification or risk factors, triggers, especially in relation to trainings.	“There needs to be better identification, because often, law enforcement doesn’t even know they are working with CSEC. I mean they went through the whole process and never knew really what was going on. You look at it and say, ‘Oh yeah, we have a CSEC victim’. And so I think there needs to more training on that”.
8b		Up-to-date protocols	Defined as the need for the presence of detailed protocols for all professionals, importance of making sure these protocols are current.	***Include*** any reference to protocols.	“Well hospitals and nurses love protocols. We need to know how to collect, where to collect, etc”.
8c		Consistency and collaboration	Defined as the need for collaborating consistently to ensure trainings are up-to-date and detailed, and that elements of the protocols are same for everyone.	***Include*** any references to collaboration between people or groups.	“I think it's less about law enforcement and social workers being trained on how to work together and it's more about the opportunity for stability for them and relationship building to help them be able to trust one another to work together”.
8d		Case-by-case	Defined as the need	***Include*** any	“So it is all unfortunately

		basis	for taking into account the unique nature of each CSEC case; importance of adapting protocol slightly for each case.	mention of case-by-case or unique circumstances or situations.	on a case by case basis. So we'd have the triage nurse and the triage nurse, how it works with the client is that you tell the triage nurse, I'm here because xyz happened to me and from there, there is very little monitoring of the patient".
8e		Sensitivity Training	Defined as the need for trainings to incorporate sensitivity and compassion, as well as a trauma-informed curriculum.	***Include*** mentions of a need for sensitivity, boundaries and understanding of unchecked trauma, specifically in relation to trainings.	"It's one thing if I'm trying to explain to a judge why this 40 year old has made the decisions that they have because of unchecked trauma that has gone on for however long. But these are kids".
8f		Quality of Training	Defined as the need for trainings that are more extensive, up to date, led by better trained individuals and that have better resources.	***Include*** mentions of a need for better training.	"I also kind of wonder what training for them would look like-for example how maybe that training would need to be structured differently or taught by individuals where they either have very open lines of communication or feel like the information that they're giving is top notch."
8g		Survivor Involvement in Trainings	Defined as survivor-led training, survivor input on trainings or survivor involvement in framework.	***Include*** any mention of survivor involvement in training.	"So there's so much training and it needs to be survivor led training because I've, I've, I've listened to people speak so much and I've read so many things and I'm just sitting here thinking, have you ever in your life

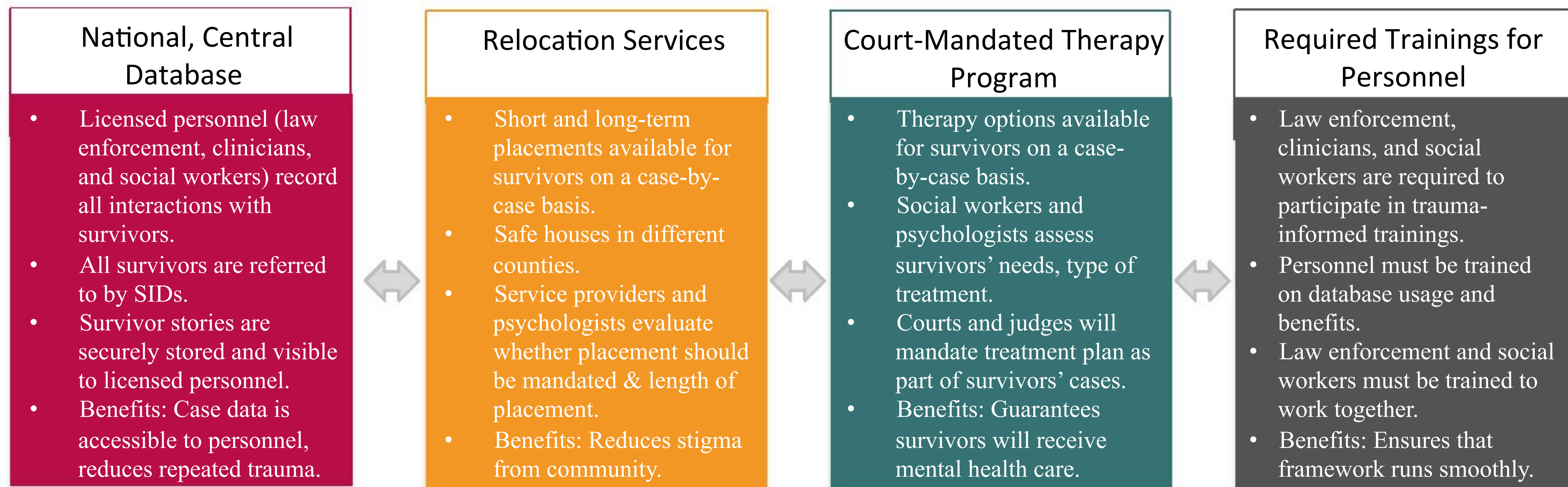
					experienced anything?”
9	Aesthetic changes		This is defined as comments that service providers made about how the model as a whole looked.	***Include*** any constructive feedback on the appearance of the model.	“Yeah, like a, like a tree with different branches. Know that's very specific, but that's kind how I see...Like these are different branches. They're all part of the same thing, but maybe it doesn't all work at the same time”.
10	Retraumatization		This is defined as what retraumatization is according to stakeholders	***Include*** mentions of retraumatization.	“So training on sensitivity and knowing your boundaries so that we don’t overstep them and then cause a retraumatization. I think sensitivity and what the next step is a very good idea”.
10a		Follow-through on procedures	Defined as importance of follow-through from all groups on their respective protocols.	***Include*** mention of follow-through or following steps. ***Exclude*** references to buy-in.	“I agree. I think it can, it can definitely decrease the amount of traumatization, but the steps need to be followed”.
11	Challenges to implementation		Defined as what stakeholders consider to be the main overarching obstacles or challenges to implementing the model.	***Exclude. Use*** codes 11a-11b to describe the main challenges or obstacles.	“Because if this cannot be applied to the current system like the officer was saying, like we put it in GCIC or something of that nature. This is a separate entity, another task in the end. Although it's worth it, we have to have that buy-in”.
11a		Buy-in	Challenges that might come up as a result of some	***Include*** when barriers regarding individuals are	“Process implementation is very difficult, it's all a great idea, but it's

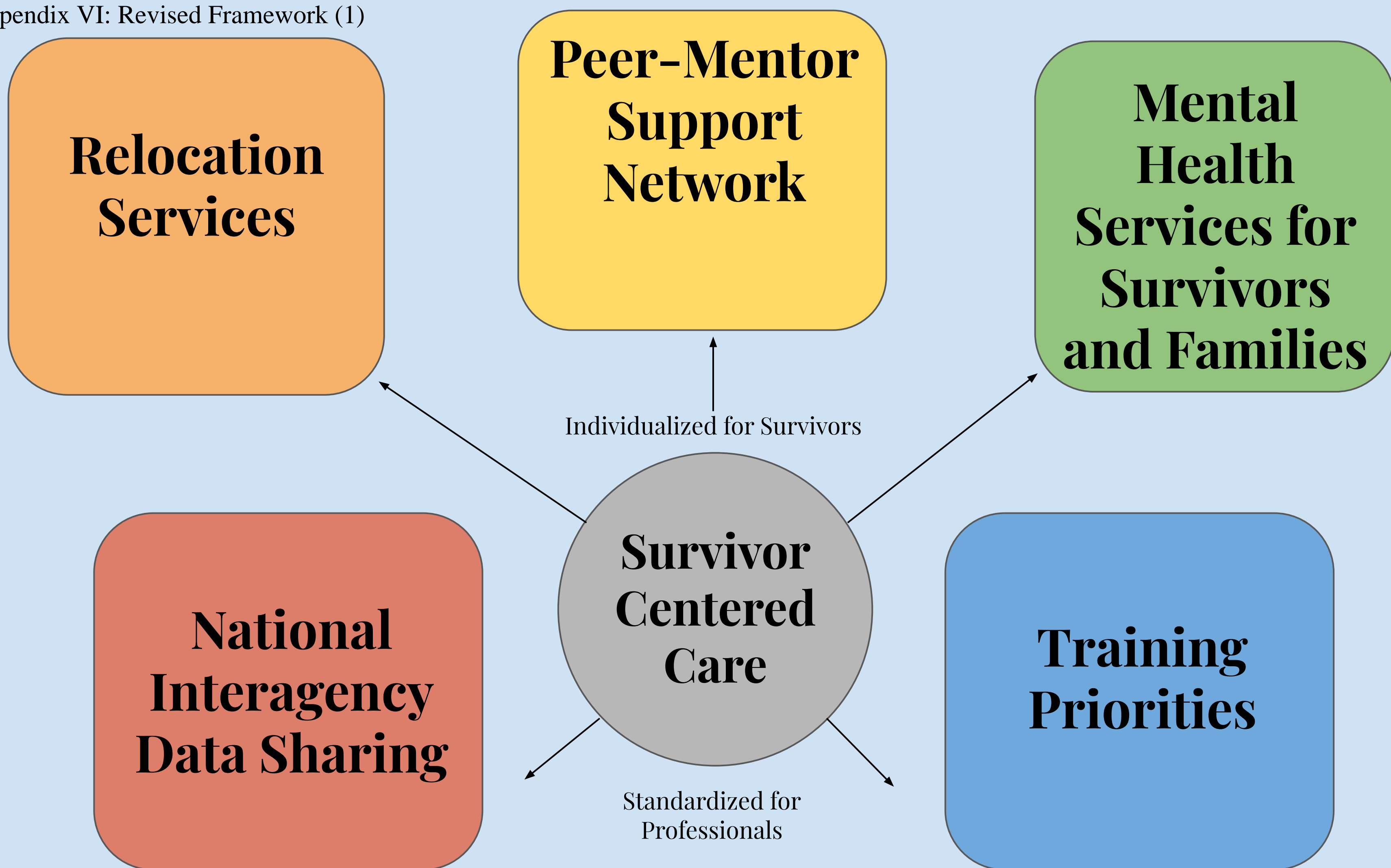
			CSEC personnel being unwilling or unable to participate in the model/framework.	mentioned; or the word buy-in.	training and getting people onboard the buy in that is most difficult".
11b		Funding	Defined as challenges with implementing the model due to a lack of funding or limitations posed due to caps on funding.	***Include*** when the funding or financial side of such projects is brought up.	"Apparently there's a shortage of funding because when I tried to get girls into housing programs, that's been the explanation given to me as to why there's a shortage of this … and why they can't accept as many [kids]".
12	Survivors' perspectives		Defined by either survivors' perspectives on the model or the importance of their perspectives.	***Include*** survivors' comments, or comments that indicate importance of survivor input on the model and during its implementation.	"If they work the process, then they'll come out more successful as adults. We can focus on a holistic approach and a team effort to really help survivors. So I think that the process might be helpful if we can make all the moving parts work".
12a		Ongoing survivor feedback	Defined as inclusion of survivor feedback throughout the model's implementation.	***Include*** comments about survivor feedback.	"I would want to see would be feedback from survivors who have been through the framework or have experienced different parts of the framework of maybe like an exit interview type of strategy for ongoing improvement. I would want to know like actual, was this effective?"
12b		Potential positive impact	Any positive comments or constructive feedback that	***Include*** direct feedback or comments from survivors.	"I think that this is the great. This is something really good that can really help a lot of a lot of

			survivors provided on model. Also relevant is the impact this model would have on survivors.	***Exclude*** comments not made by survivors.	women, men, kids, boys and girls. Um, I think that it'll give us a better outlook honestly because I think that me personally, I can only speak for myself, so me personally, I think that having something like this a long time ago would, it helped me because I would've been able to open up more…"
13	Impact on stakeholders		This is defined as the impact that the model would ultimately have on all stakeholders and their professions.	***Include*** mentions of how the model might change or modify stakeholders' professions/whether it would make jobs easier or more difficult.	"I think it would help me to help me identify a CSEC child. Once I identify the child, I think your model would be helpful. But because we've worked with child abuse, physical abuse of children in other sexual trauma, it would help a lot to know the differences and the unique cases of CSEC victims".
13a		Simplification of responsibilities	Defined as the potential for the model to simplify and streamline stakeholder responsibilities.	***Include*** comments or feedback on how the model could potentially streamline job descriptions.	"It would definitely make my job easier because a lot of times once we recover a runaway girl who we identify as being CSEC, um, like I said, housing is an issue most of the time. Um, so if we didn't have that issue will definitely make it easier".
13b		Resistance from clinicians	Defined as the precise issues that medical providers and clinicians might have in implementing the	***Include*** mentions of resistance or issues that clinicians might have with the implementation in	"There would be a lot of resistance from the medical field, but there would have to be more training and more collaboration with our

			model and how to address these issues.	the short-term.	mental health associates in the emergency department. But I think it will be easier if we knew exactly what we are doing”.

Framework for Addressing Re-Traumatization Among Survivors of Commercial Sexual Exploitation of Children (CSEC)




Relocation Services
Peer-Mentor Support Network
Mental Health Services for Survivors and Families
Individualized for Survivors
Survivor Centered Care
National Interagency Data Sharing
Training Priorities
Standardized for Professionals

Appendix VII: Revised Framework (2)