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The Commercial Sexual Exploitation and Sex Trafficking of Minors in the Boston Metropolitan Area: Experiences and Challenges Faced by Front-Line Providers and Other Stakeholders

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Introduction

The commercial sexual exploitation of children (CSEC) in the United States has garnered much attention in recent years. Though reliable prevalence data are hampered by the hidden nature of these crimes and probably underestimate the true scope of the problem, an estimated 100,000 to 300,000 children are at risk of commercial sexual exploitation in the US each year.[1] UNICEF estimates that 1.9 million children worldwide are exploited in the commercial sex industry each year.[2]

The 1996 World Congress against Commercial Sexual Exploitation of Children defined CSEC as "sexual abuse of a child by another person in return for remuneration, in cash or kind, paid to the child or to a third person or persons."[3] The term commercial sexual exploitation of children is a broad term that captures a range of sexually exploitative criminal practices "committed against juvenile victims for financial or other economic reasons".[4] Included among the various forms of CSEC are sex trafficking, prostitution of children, child sex tourism, pornography, stripping or performing in sexual venues, survival sex, forced child marriage, mail-order brides, and other forms of transactional child sex in which benefits are derived by the household from the perpetrator.[3-6]

Sex trafficking of minors is one of the primary forms of CSEC.[4] The US *Victims of Trafficking and Violence Protection Act of 2000* (TVPA) defines "severe forms of trafficking in persons" as "sex trafficking in which a commercial sex act is induced by force, fraud or coercion, or in which the person induced to perform such act has not attained 18 years of age."[7] A "commercial sex act" is further defined as "any sex act on account of which anything of value is given to or received by any person."[7] Under US federal law, the need to establish the use of force, fraud, or coercion as a means of inducing a person to perform a commercial sex act is obviated in cases involving minors who have not attained the age of 18 years.[7]

In all its forms, the commercial sexual exploitation of children is a fundamental violation of human rights and children's rights with myriad short- and long-term negative effects on the physical health, mental health, and psychosocial well-being of victimized children and adolescents.[8-10] Furthermore, the aftermath of the violence and trauma endured is deep-rooted—affecting all aspects of a survivor's life, challenging his or her resilience, and threatening recovery years after the exploitation.[11]

From a public health perspective, the imperative to prevent the commercial sexual exploitation (CSE) and sex trafficking of minors is no less an imperative than that held by health care providers regarding more traditional forms of child maltreatment. Certainly, the far-reaching impacts

of these crimes necessitate a multipronged and multidisciplinary approach that should include partnerships with the health care sector. Recognizing the profound impact of commercial sexual exploitation on children's health and well-being, the present study sought to answer the following questions:

- How does the context and process of exploitation affect minors' health?
- What is the current state of health care services for exploited minors?
- What health care-related opportunities exist for improving minors' health?

Our study examines the perceptions of experienced frontline providers and antitrafficking stakeholders regarding the following domains: the scope of CSEC, the social determinants of CSEC, the process by which traffickers recruit and control minors, barriers to health care, and gaps in services for exploited minors in the Boston metropolitan area. Specifically, in using a public health lens, our study examines concepts within the aforementioned domains as they relate to the health and well-being of this vulnerable population, identifies gaps in health care services and public health policy, and suggests potential strategies for intervention and prevention. Our research also explores gaps and opportunities for improved cross-sector coordination and collaboration.

In keeping with the World Congress against Commercial Sexual Exploitation of Children and the US federal legal definitions, minors who engage in survival sex (i.e., perform sex acts in order to meet needs such as food and shelter), and are thus sexually exploited, are included for the purpose of this study.

Methods

Study Design

Case study methodology was used to allow for an inductive, context-specific approach to examining commercial sexual exploitation and sex trafficking in the Boston, Massachusetts, metropolitan area (city population: 644,710) from a public health perspective.[12] Using a public health lens, the present study sought to answer the following questions: (a) How does the context and process of exploitation affect minors' health? (b) What is the current state of health care services for exploited minors? and (c) What health care-related opportunities exist for improving minors' health? This study builds upon an 8-city, 5-country comparative case study analysis of sex trafficking and local health systems—including 2 US cities (Los Angeles and New York). The methods of the multicountry

research, described elsewhere,[13] focus on the use of semistructured, in-depth interviews with key anti-CSE/trafficking stakeholders in each city. In brief, our study defined cities as the primary unit of analysis and employed the following inclusion criteria for city selection: recognition of sex trafficking as occurring locally, access to local social scientists, sufficient security and safety for the research team, demonstrated national government commitment to combat this practice, and adequate public health infrastructure to study sex trafficking and its intersection with health. This study was reviewed and approved by the Institutional Review Board of Partners Healthcare (Boston, MA) and exempted from further review.

Participants and Informed Consent

We conducted a total of 22 semistructured interviews with 25 key informants (19 interviews with single key informants and 3 interviews with paired key informants). Verbal informed consent was obtained from all participants. Key informants included 21 female, 1 transgender female, and 3 male researchers, social service providers, health care providers, law enforcement agents, and legal advocates (see Table 1). Participants were identified using a snowball sampling method. An initial cohort of key informants was selected following an extensive search of agencies and organizations within the greater Boston area and a review of the literature on CSEC/sex trafficking originating from the area. These individuals received email requests for their participation in the study, as well as requests for additional contacts whose participation in the study would benefit the field. Snowball sampling allowed for identification of key frontline providers and antitrafficking stakeholders from various sectors, representing a wide range of occupations and organization types. Snowball sampling continued until theoretical saturation was attained.

Of note, Boston as a city has been quite active in the field of CSEC/sex trafficking for more than a decade, with many agencies and organizations receiving national recognition for their anti-CSEC and antitrafficking work. The initial cohort of key informants from which the snowball sampling originated included individuals with 10+ years of experience who had achieved high-ranking leadership positions within their respective agencies, organizations, and specialized law enforcement units (e.g., Program or Service Directors, Executive Directors, Department of Public Health Leaders, Federal Special Agent, Police Department Unit Supervisor, Medical Directors). Subsequent snowball sampling allowed us to reach additional key informants with unique experiences and insights through their daily interactions with victims and survivors of CSEC/trafficking.

Interviews

Two health researchers trained in case study methodology conducted the interviews together. Paired interviewing was employed in order to minimize potential single-investigator bias. The interviews were conducted using a semistructured interview guide. Anchored by the Victims of Trafficking and Violence Protection Act of 2000 definition of sex trafficking, the interviews consisted of open-ended questions used to elicit respondents' perceptions of the occurrence of sex trafficking in the greater Boston area, including the prevalence, mechanisms, and key determinants of sex trafficking, as well as the local response to sex trafficking across various sectors such as education, law enforcement, policy, and health. Interviews were open ended and semistructured by design to allow for exploration of emerging concepts in order to facilitate the iterative development of a conceptual framework.

Interviews were conducted during a 3-month period between June 2011 and August 2011. All interviews were conducted in person and lasted 60 minutes on average, but length times varied depending on the direction of the interview. Researchers took notes during the interviews and, with only one exception (at the request of the participant), audio recorded all interviews for transcribing purposes. All audio files were downloaded to a secured, encrypted laptop computer and deleted from the portable recording device. The audio files were transcribed verbatim by members of the research team. All transcripts were reviewed for accuracy with the audio files by at least one other team member before being finalized.

Data Analysis

Qualitative research software (NVivo 8 and NVivo 10, QSR International) was used to organize data for the case study. The researchers used an "integrated approach" (part deductive, part inductive) to develop a thematic code structure for analyzing and organizing the data.[14] Codes were developed based on the interview guide questions that were designed based on *a priori* knowledge (deductive), as well as new key concepts that were iteratively developed and explored in the course of the open-ended interviews (inductive). Two research team members independently coded all of the transcripts and subsequently reviewed the codes, reconciling any coding differences, and through an iterative process, identified key themes/results.

Results

Prevalence and Demographics of CSEC

None of our key informants felt that they could estimate the prevalence of CSEC or sex trafficking of minors in the Boston metropolitan area. However, based on their experiences, respondents noted that victimization of boys and girls generally occurred between the ages of 13 and 19 years with almost equal numbers of African American and Hispanic youth being affected, with these 2 groups comprising the larger subset of the population they served. While respondents generally said that victims were minority youth from economically disadvantaged areas, three respondents with access to more citywide data reported that "it crosses all races and all classes," noting that families living in the more upscale suburbs of Boston are also affected but less likely to access public services.

Social Determinants of CSEC

Child maltreatment, in its various forms, resonated across the interviews as one of the most salient social determinants of CSE and sex trafficking of minors. Child sexual abuse was felt to be particularly damaging to the self-esteem of children who then have difficulty forming healthy relationships and developing healthy relationship boundaries. Described by a respondent as "pretty egregious sexual assaults that have happened starting at a pretty early age in their lives" (social worker 1), child sexual abuse was collectively identified as a common factor among CSEC survivors. The association between child sexual abuse and CSEC was summarized as follows by another respondent:

> History of sexual abuse...I would say it's fair to say between 80 and 90 percent of the girls we've served over the last 2 years have been sexually abused as children..., which in the eyes of these pimps, they're primed for this work. And quite often, when they endure trauma like that, [they have] poor boundaries. (social worker 2)

Family dysfunction was also cited by a majority of the participants as a significant social determinant of CSE and sex trafficking of minors. Respondents explained that family dysfunction—mediated through numerous factors such as lack of parental involvement, negative behavior modeling (e.g., parental prostitution or substance use), and domestic violence—can result in a lack of support for the involved children and a skewed perception of normality. Many respondents commented on the link

between family dysfunction and CSEC/sex trafficking as mediated through domicile instability (e.g., "couch surfing"), out-of-home residential placements, and homelessness. Following is a representative sample of respondents' perceptions:

> A lot of removals from homes and being bounced around also is another risk factor because I feel [for] kids in those situations, there are fewer people…. I just feel like people in their lives are more used to them being somewhere, but not really knowing exactly where. So I think it's easier for them to get caught up in stuff like this and not having someone say "well, why weren't you home at this time?" (social worker 1)

Family dysfunction severe enough to result in out-of-home residential placements within the Department of Children and Families (DCF) foster care system can change the perception of a minor from a child experiencing abuse and neglect in the home to one requiring discipline and containment in the system. One respondent pointed out:

> These girls that are having a history—and again her history prior to being placed in a DCF program is abused at home, running away from home, trying to get away from a terrible situation—[to] being placed in a DCF program where she's the bad kid, she's the trouble-maker, she's got a CHINS* because she can't follow rules in the house. Well, the house wasn't so healthy for her to be in. The house was an absolute mess. It was chaos, and she was being abused in there. (mental health 1)

Youth homelessness clearly surfaced as a salient social determinant of CSEC. Whether due to running away from home or being thrown out of the home—the latter having been identified as particularly relevant to LGBTQ youth—homelessness demands a whole new set of survival skills. It is in this context that past trauma and current survival needs collide to create an exploitable situation from which unscrupulous

*CHINS = Child in Need of Services, a law in Massachusetts that gave parents and schools the right to ask the court for help when a child repeatedly runs away from home, skips school, breaks school rules, or "refuses to obey the lawful and reasonable command of a parent or legal guardian." Under this law, police officers had the right to arrest children and place them under custody. New legislation in 2012 made significant changes to this law, now known as CRA (CRA = Child Requiring Assistance). http://www.mass.gov/eopss/docs/mptc/juvenile-law-chins.pdf.

adults benefit. One respondent reflected: “A disproportionate amount of homeless female and male, but particularly female, youth are previous victims of sexual abuse and have been taught by their offenders that their currency is sexuality” (social service provider 1).

In addition to the role of parental substance abuse, many respondents also pointed out the role a minor’s personal history of substance use may play. One respondent explained:

> We see a lot of males, but we do see some females, where there is an addiction to a substance. And homelessness, I didn’t mention that, but that’s a big deal. You get kicked out. Where are you going to stay? Well, this person says, “Hey, I’ve got a place for you to stay for tonight or a couple nights. Let’s do some X, Y, and Z.” If you’ve never done any drugs before, that can lead to more chronic use. Maybe the young woman has already been using, and that’s how she’s going to get her heroin or her meth. We don’t see that as much with the females as we do with the males. Heroin, cocaine, you know…alcohol. And often that leads to hanging out with people where you can score these drugs, you know. And if you don’t have money to pay for them, how are you going to pay for them? And what we see here is sex in exchange for a place to sleep or drugs. (mental health 1)

Financial insecurity was felt to be an indirect social determinant of CSEC. Respondents noted that, rather than poverty itself, it is the deleterious effects of chronic financial stress on family dynamics and the exposure to violence in poverty-stricken communities that accounts for a minor’s increased risk for exploitation/trafficking. A representative explanation of poverty offered by one respondent was: “Substance abuse in the home, poverty, just having really huge strains on the family system. And again I think most of it is stemming from limited resources and/or just some form of abuse going on in the home” (mental health 1).

The following is a powerful summary of the social determinants of CSE and sex trafficking of minors in the US:

> Many, many of the people that I spoke with generally came from families that were highly unstable. And by that, I mean that there was a lot of child abuse or neglect in the home. There was quite a significant number of people that reported their mothers, or grandmothers, having been in prostitution or using substances, and it usually went hand in hand, substance use and prostitution. Many

> primarily entered into heavy drug use at a young age. Many talked about being runaways at like age 13 or 15, hooking up with drugs and then... once you're addicted, needing to find whatever way you could to get your next fix. So a lot of folks were, um, exchanged sex for drugs...and that then became part and parcel of the way to survive on the street. Sex, many people had...were a part of generations of this type of dysfunction and so were sometimes even prostituted by their parents or by the adults in the home as children, even by mothers to get their next fix. And that was not an uncommon story. (advocate 1)

Mechanisms of Recruitment and Control

Exploiters capitalize on the vulnerabilities of minors in order to recruit or lure them for CSE and sex trafficking. All respondents highlighted at least one of the following conditions as facilitating recruitment by perpetrators: (a) attraction to material goods, (b) desire to escape an oppressive home life, (c) innate longing for affection, and (d) instinct to survive after leaving their homes (see Table 2). One especially worrisome observation made by 6 respondents referred to exploiters' keen ability to manipulate and exploit various situations in order to recruit minors into CSE. The following quote captures this sentiment: "Manipulation is of key component to the pimps, to what the pimps are doing. They know how to handle a situation, to turn a situation to their advantage, while making the victim think, 'I'm here because I want to be, this is my choice'" (law enforcement 1).

Multiple respondents identified peer recruitment as a major mechanism used by exploiters. One highly experienced respondent's perspective was particularly poignant and representative of how and why peer recruitment might occur:

> Sure, yeah, there's definitely peer recruitment. Often it's, you know, there's a pimp and he has his bottom girl and her job is to recruit…. It happens a lot in the group care setting. So a girl who works for a pimp gets placed in a program. She is going to go on the run to go back to him, and she brings—you know, she knows that it's going to be better for her relationship, she'll get more love, money, support, all of that—so she brings somebody with her. And so it's often that most vulnerable kid, most naïve kid in the group home that she takes with her on the run, and we hear that all the time. I mean...can tell you a story of a kid who actually sold a girl to a pimp to get money to go see her pimp, you know? I mean—but more frequently, what we hear is, "Come with me. My boyfriend's

> awesome. He's going to be having a party tonight. It's going to be great." Then that girl comes, she gets drunk, she gets high, she gets raped, and he's making money off of whoever's raping her. And then we do hear of the stories of um… the girls, you know, who are 17...maybe she was exploited when she was 12 to 15…and now she's saying, "Hell with this, I'm going to do it my way, under my terms, and I'm going to have my own stable of girls," you know? Um…that classic thing of when you've been abused so badly and you either stay victim or you can become offender, and they become offenders sometimes, for sure. (social worker 3)

One emerging theme explored in a large number of the interviews was peer recruitment within the DCF foster care system. Respondents pointed out that minors who end up in foster or group homes are likely to be coming from unstable home situations that increase their vulnerability. While none of the respondents ventured to discuss causality, a majority of respondents touched upon their observed correlation between experiencing CSE and growing up in the foster care system. As one respondent stated:

> A lot of times if they end up in DCF custody—if they're going from foster home to foster home or institution to institution—then what will happen is they will meet other girls that have been doing it in those places and they'll say "Hey, you should try it. It's not that bad. You will make some good money." So then the girls recruit other girls from within the foster care system or the institutions that they go to. (law enforcement 1)

Collectively, respondents identified 2 major venues for peer recruitment of minors into CSE— out-of-home residential placements, as already discussed, and schools. The majority of the respondents identified schools as being a potential place of recruitment, and one key respondent within the public school system reported:

> I've sat in on many of the workshops over the past 4 years, and there isn't one middle school girl who doesn't nod her head and say, "Yes, I know someone that is involved in trafficking or trying to get somebody out with them or working for a boyfriend." So there is middle school, definitely—younger and younger. (school nurse 1)

> Only 2 respondents had provided services to survivors who had

been abducted (as opposed to coerced) into CSE or sex trafficking, but all agreed that abduction was a rare occurrence and by no means a common mechanism of recruitment.

Health Consequences and Needs

Our interviews revealed a wide range of physical and mental health consequences of CSE/trafficking. Respondents described that CSEC victims experience injuries inflicted by their exploiters as a means of punishing and controlling them (e.g., cuts, bruises, cigarette burns). Multiple respondents pointed out that exploited/trafficked minors also sustain physical injuries dealt by the clients that pay for their services. Two respondents noted that traffickers may even force victims to inflict violence upon one another. One respondent remarked: "It seems like the different pimps have different tactics of humiliating the girls and making them sometimes beat each other up and pinning them against each other" (law enforcement 1).

Many respondents flagged sexual and reproductive health problems as major health concerns for exploited/trafficked minors: sexually transmitted infections, unwanted pregnancies, unsafe abortions, and pelvic inflammatory disease. Furthermore, a majority of respondents described that CSEC victims experience significant mental health problems before, during, and after their exploitation, including depression, anxiety, and posttraumatic stress disorder (PTSD). LGBTQ youth affected by CSE also carry with them any trauma suffered as a result of their sexual orientation and gender identification, making the process of healing and recovery particularly onerous. One respondent had the following to say with regard to mental health outcomes specific to the transgender female population:

> The mental health issues that we experience here are depression. They don't have a sense of belonging. There is no family support. Their families rejected them. Depression. We also see a few girls that are bipolar. We also see girls who are HIV positive—then there is that side of depression that the illness brings to them. So it's mainly depression, a few bipolar and then some girls with substance abuse issues.... (social service provider 2)

Two respondents directly noted that CSEC victims may exhibit self-harming behaviors such as suicide attempts, and both were specifically referring to LGBTQ youth. However, the direction of causality may not always be clear.

Barriers to Health Care Access

Multiple respondents noted that CSEC victims face barriers to obtaining health care services due to a number of factors. First, victims may not be allowed to seek health care by their exploiter, at least not until their medical situation becomes more dire. Second, even if victims are free to access health care as needed, they may be restricted to a particular health care facility due to geography. One respondent noted that victims may be forbidden from crossing certain gang lines in various parts of the city. This was felt to be an important barrier to care, because the CSE or trafficked youth may refrain from obtaining certain types of medical services or from disclosing the exploitation to a health care provider in a health care facility located in a familial neighborhood. Additionally, minors may have difficulty navigating the health care system on their own. These difficulties may range from their lack of basic understanding of which health clinic to go to, how to schedule a medical appointment, and how to arrange their transportation to the clinic.

Multiple respondents specifically noted the difficulty that undocumented CSE/trafficked victims have in obtaining health care when they lack legal documentation, such as a green card or proof of US citizenship. These victims may incorrectly perceive that they cannot receive health care services without this documentation. Furthermore, multiple respondents, such as the one below, suggested that victims may view health care providers as untrustworthy authority figures:

> They just don't understand the concept of going to the doctor and the doctor helping them. They don't look at the medical profession as someone that can help them. A lot of times they look at the medical profession as someone who will file for 51A and then send them to the Department of Children and Families. So the medical profession is the bad guys. (social worker 4)

Other barriers to health care access relate to the awareness and attitudes of health care providers. Many respondents described low awareness of CSEC among health care providers—and a decided lack of training opportunities for health care providers on how to identify and treat CSEC victims.

Gaps in Services

Even if minors are able to access health care, there remain a number of institutional gaps that prevent them from obtaining the full spectrum of

services they require. Coupled with the competing demands of a busy urban hospital or clinic setting, respondents suggested that health care providers may be hindered in their ability to recognize and appropriately address the full spectrum of health needs of CSE and trafficked youth. For instance, because victims of CSE may not regard themselves as victims, they would be unlikely to disclose their situation to a health care provider, and the untrained provider would fail to recognize the signs and symptoms of CSE/sex trafficking.

Furthermore, the complex trauma experienced by victims may present a challenge for the untrained health care provider. One respondent said:

> People think they can just handle trauma work. We deal with trauma all the time in our work, but if you really want to get into somebody's trauma, that is a very delicate, specialized sort of, kid gloves kind of slow process, and really [you need] people that are skilled in knowing the nuance of that kind of treatment. (mental health 1)

The need for more health care providers trained in trauma-sensitive care for CSEC victims was a related theme in our interviews. Two respondents identified the difficulty of adhering to trauma-sensitive care in fast-paced clinical settings like traditional primary care practices and hospital emergency departments and the negative effect this has on building a trusting provider-patient relationship. One provider commented: "I mean it becomes really difficult because the reality of a 15-minute appointment of 'Do you feel safe at home, do you…, do you....' It becomes almost like a checklist. And well, is somebody really going to disclose to the checklist?" (social worker 1).

Similarly, the need for "empathic health care" was highlighted as a means of positive rapport with an entire group of affected minors who are well connected to each other. One respondent said: "People talk. If you have one bad experience at a place, the rest of the group is going to know about it. I think that's another thing for medical providers to note: just your interaction, your kind, thoughtful, empathic, nonjudgmental interaction" (mental health 1). Another respondent articulated the importance of patience and a nonjudgmental tone in the patient encounter: "So, had somebody asked the right questions in the right way in the nonjudgmental approach, she probably would have talked to them. Maybe not the first time, maybe not the second, maybe the third..." (social worker 3).

A majority of respondents also described a lack of availability of mental health services for CSEC victims in the Boston area as a major gap in the field. Respondents especially noted the need for longitudinal mental health care for victims—and questioned the effectiveness of shorter-duration services for this population. As one respondent explained:

> If you figure that they've been abused for 15 years, it's not gonna be 12 visits. And we can sort of suck it up and pay the 5 or 7 years of good psychotherapy and have a productive adult, or we can keep throwing meds at them and have them in and out and have them self-medicated and then have somebody who is struggling with chronic depression, has their own issues, and now has kids of their own, and we are repeating that cycle. So maybe we saved money on the short run, but we haven't on the long haul. (clinic nurse 1)

In addition, the lack of short-term housing was noted as a major concern for this population. Without emergency housing, respondents expressed concern that these youth could end up back in the same environments that had facilitated their original CSEC situation. For example, one respondent decried the lack of "a place that youth can choose to go for a short-term period—you know, it varies, could be 72 hours, could be 2 weeks." Another respondent expressed the need for multiple shelters for different groups of CSEC victims:

> At least one shelter for domestic youth, maybe there'd be another shelter for male domestic youth, which we hardly ever see, but you know it's a need. There would be shelters for, you know, different types of international trafficking with linguistic, cultural competence, and then there would be integrated services at those shelters. (advocate 2)

Another gap in the field mentioned by multiple respondents was not so much a lack of stakeholders working to combat CSEC/sex trafficking but rather a lack of coordination across the various players to ensure expeditious provision of wraparound services. Respondents remarked that this coordination needs to extend not just between the health services but also to the social service sector. As one respondent explained:

> There's been a good amount going on in Boston in terms of trafficking. There's lots of different groups working on it. I think one

> of the problems has been the cohesion piece and who's coordinating with who and who knows about what else is happening. I think that's a, a challenge for the community. (mental health 2)

Discussion

This paper describes CSEC as an active and pressing issue in the Boston metropolitan area. Our results underscore the complex, polylithic nature of CSEC in the area. CSEC affects boys, girls, and transgendered youth, can occur in the city or its suburbs, and can also entrap victims from a wide range of socioeconomic backgrounds (although many victims serviced by the respondents appear to be from minority groups). CSEC victims may be local, from other states, or may have immigrated to the US from South America and other parts of the world. While there is no classic profile of a CSEC victim in Boston, there appear to be a number of important trafficking determinants—child sexual abuse, poverty domicile instability, and financial insecurity, among others—that they may have in common. The fact that no interview respondents could provide an accurate estimate of the prevalence of CSEC underscores the difficulty in finding/identifying victims, who may either be hidden from view by their exploiters or unable/unwilling to disclose their victimization to law enforcement, health care providers, or other authority figures. The hidden aspect of this crime presents a major challenge to anti-CSEC stakeholders, including health care provides, seeking to identify, assist, and prevent CSEC from occurring.

Overall, our findings regarding key social determinants of CSEC in metropolitan Boston—e.g., childhood history of maltreatment, especially sexual abuse, youth homelessness, substance abuse by the child and/or the parent—all mirror findings from the extant literature. Our study suggests that there is considerable interplay between individual, family, and societal level factors that place minors at risk for CSEC and that it is difficult to decouple an individual-level risk factor (e.g., childhood sexual abuse) from other levels (e.g., family dysfunction) in terms of its cumulative effect on risk for trafficking. This finding is consistent with a recent committee report from the US Institute of Medicine and the National Research Council on CSEC. This report specifically notes:

> Community and societal norms and expectations about sexual behavior and coercion, as well as societal and cultural standards and expectations regarding minors, gender, sexual orientation, race/ethnicity, and power, also contribute to commercial sexual

exploitation and sex trafficking of minors. Adding to this complexity, each of these factors interacts within and across levels to increase risk or protection.[6]

Consistent with extant global literature, our findings strongly suggest that the physical health and mental well-being of CSE/trafficked minors suffer as a result of the complex traumatic experiences they endure.[6,8-10,13,15,16] Interview respondents offered a cascade of acute as well as chronic physical ailments ranging from injuries (due to assaults) and sexually transmitted infections to unwanted pregnancies and complications from unsafe abortions. Many interview respondents also identified various mental health disorders (e.g., depression, anxiety, and PTSD) affecting CSEC victims. These deleterious health consequences are often interactive and, as described earlier, suggest that the health needs of this population are both numerous and complex. This point may be especially salient for certain subpopulations, such as LGBTQ youth. Interestingly, the context in which CSEC occurs (determinants) and the process by which it occurs (mechanisms of recruitment and control) both have their own independent negative implications on the health and well-being of exploited/trafficked minors.

Yet in spite of these complex health needs, our study found significant gaps in the health sector response to CSEC: low awareness among health care providers in Boston; patchy physical and mental health care access for CSE/trafficked victims with only pockets of health care providers who had greater levels of awareness and experience caring for this population; and the apparent lack of a citywide coordinated system of health care for this population.

Greater attention to training health care providers and trainees is needed. Low levels of awareness, education, and training in trauma-sensitive care of exploited/trafficked minors resonated as a gap among Boston area health care providers. Though there has been a concerted call for education and training of health care providers, more local efforts are needed to implement this in a sustainable manner.[17-20] Formal curricula can be incorporated into the existing curricula in health professional schools, and existing CSEC and sex trafficking training programs for health care providers could be scaled in the Boston metropolitan area. More systematic and comprehensive educational training efforts could lead to more identifications of CSEC cases and ensure a greater supply of health care providers capable of providing trauma-sensitive care for this vulnerable population.

The paucity of available mental health services was specifically highlighted by respondents as an unmet need for CSEC victims. This gap can potentially be addressed via 3 approaches: (a) increase the number of mental health professionals who complete specialized training in complex trauma and polyvictimization, (b) infuse the public mental health system with financial resources to match the demand for services, and (c) implement health policies that remove budget-based limitations on service eligibility. One-size-fits-all mental health service programs cannot possibly be expected to care for all mental health patients efficiently. Survivors of CSEC and trafficking accrue multilayered dimensions of complex trauma (i.e., polyvictimization) that may require years of therapy to fully expose and disarm. Premature cessation of psychotherapy due to service quotas that are not tailored to patient-specific needs may leave survivors feeling more vulnerable and, perhaps worse, may lead to a regression in behavior and increased risk for re-polyvictimization.

The mismatch between the complex health needs of CSEC victims and a correspondingly high number of barriers to health care access makes for a worrisome situation in Boston. Coupled with a lack of emergency shelter/housing for identified victims, our findings suggest an urgent need to mobilize and coordinate resources to provide better wraparound services—i.e., health and non-health services. This lack of emergency shelter for CSE/trafficked minors may function to deter victim identification by health care providers for fear of not having the needed resources to subsequently keep these minors safe. Unfortunately, this circuitous logic becomes a negative feedback loop in that without the identifications as evidence of an unmet need, public policy cannot be informed and financial resources are unlikely to be released. Resources should be deployed and public policies implemented to alleviate this discrepancy in need and services.

Our results also specifically highlight the need for better coordination between health and social service providers throughout the city in order to identify and serve CSEC victims. Interview respondents described a system of health and social services that provided adequate episodic care for CSEC victims, but few if any respondents described a well-functioning, comprehensive, coordinated, longitudinal system of care that addresses the full spectrum of needs of CSEC victims in Boston. Interview respondents strongly suggested the need for mechanisms to foster collaboration between health and social service providers in the city for CSEC/trafficking. Such collaboration—one idea being the formation of multidisciplinary CSEC teams—could inform the development of a streamlined referral mechanism for health care for CSEC victims in the

Boston metropolitan area. While salient barriers exist, such as lack of dedicated funding and the fact that many providers are already overloaded with competing work responsibilities, working together across institutions and professional disciplines may be especially beneficial to commercially sexually exploited and sex trafficked minors.

This study has several limitations. First, the study was cross-sectional; we interviewed key experts during a single time window. Thus it is not clear whether the phenomena described by our interview respondents changed over time. Second, with the exception of one highly experienced respondent who was also a survivor, the study did not interview victims of CSEC in Boston and thus does not incorporate the direct perceptions of our target study population. We elected not to interview victims or survivors out of concern for retraumatization.

Limitations aside, this qualitative research study describes for the first time the landscape of CSEC in 1 major metropolitan area in the northeastern US (Boston) through a public health lens. Our current study corroborates the findings of our prior research in 8 cities around the world, including New York and Los Angeles (13). This study also sheds light on the myriad opportunities for intervention, principally through better cross-sector coordination and collaboration. Certain gaps—e.g., low awareness of CSEC and sex trafficking of minors among health care providers, emergency housing, and mental health services for CSEC victims—need to be addressed urgently.

Furthermore, the findings of this study suggest that health care providers play an important role in the prevention of CSE of minors by continuing to emphasize the prevention and identification of child maltreatment, writ large, since child maltreatment in the early years of life is a significant risk factor for subsequent CSE and sex trafficking. Special attention should be focused on more vulnerable LGBTQ minors.

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Table 1. Interview Respondents/Key Informants by Occupation

Occupation	# participants (title/role)‡
Mental health provider	2 (PD, SD)
Public school nurse	2 (DPH-L)
Child protection team physician	2 (MD, MD)
Social worker, hospital-based	1
Social worker, CSEC social service organization	3 (DC, PD)
Social worker, CSEC group home	1 (PD)
Adolescent clinic nurse	1
Attorney	1
Crime victim advocate	1
Law enforcement officer	2 (FSA, PD-US)
Academic researcher	1
Social service provider, CSE peer mentor	1 (SD)
Advocacy/policy analyst	2 (ED, ED)
Social service provider for homeless youth	3 (SD, PD)
Social service provider for LGBTQ population	2 (PD)
Total interview respondents	25

‡Title/role abbreviations: PD, Program Director; SD, Service Director; DPH-L, Department of Public Health Leader; MD, Medical Director; DC, Director and Cofounder; FSA, Federal Special Agent; PD-US, Police Department Unit Supervisor; ED, Executive Director.

Table 2. Four Conditions Most Commonly Exploited in CSE/Sex Trafficking Recruitment

Condition	Quote
Attraction to material goods	And, when these girls might see other girls who might be in "the life," and these girls have on these nice things, these things that they fantasize about, and someone's saying, "Oh, there's a—we could do this really quick! It's not as hard as you think it may be!" And that stuff looks attractive—we always look at the outside….
Desire to escape an oppressive home life	She came from a home that was a really difficult home to grow up in where her parents were very abusive towards one another. She was kind of in and out of foster homes, went from one of dad's home to mom's home to family home. You know, so she was everywhere. And this was a way out of some of that.
Innate longing for affection	I think that's where you see a lot of it. Where kids are kicked out of their homes, kids run away from their homes, they run away from their state…commanded or remanded sort of placement. And they get mixed up with people. Often young men who are trying to show them that things can be different. They can give them some gifts. They can give them some loving. And that turns into, unfortunately for some of these girls…into a life that they didn't expect they were going to have and being taken advantage of sexually.
Instinct to survive after leaving their home	Sometimes if the person is struggling with the habit, the pimp may exploit that, by saying "Well, I can get you the good stuff" or, "I can, you know, if you do X then I'll split X with you...." I think also housing is a huge one. Right, so if you see the girl who doesn't have a place to stay and you have a place to stay, it's an easy, it's an easy resource to offer.