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Using a Clinic-based Screening Tool for Primary Care Providers to Identify Commercially Sexually Exploited Children

Kimberly S. G. Chang

Asian Health Services, kimberly_chang@hms.harvard.edu

Kevin Lee

Asian Health Services, kevinlee@ahschc.org

Terrence Park

Asian Health Services, jop512@mail.harvard.edu

Elizabeth Sy

Banteay Srei, elizsy@gmail.com

Thu Quach

Asian Health Services, tquach@ahschc.org

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Introduction

It has been estimated that as many as 300,000 children under the age of 18 are at risk of becoming sexually exploited victims within the United States.¹ However, there are no reliable national estimates of the incidence or prevalence of commercial sexual exploitation and sex trafficking of minors in the United States.² Due to the underground nature of sexual exploitation, the lack of understanding among service providers and law enforcement, and the complex psychological factors involved with exploitation, identifying the commercial sexual exploitation of children (CSEC) has been a tremendous challenge. Despite government efforts and initiatives by numerous community-based organizations to expose human trafficking as a major problem in the United States, CSEC is the most hidden form of child abuse and has reached epidemic proportions.³ Many victims of CSEC or domestic minor sex trafficking (DMST) have a history of physical and sexual abuse, home violence, and homelessness. Children who were abused in earlier childhood are four times more likely to be sexually exploited, with 95% of teens engaging in commercial sexual activity having been sexually abused during earlier childhood.^{1,4}

While child abuse, domestic violence, intimate partner violence, and physical and sexual assaults are often treated as separate categories of violence, child victims of commercial sexual exploitation are often subjected to many of these overlapping forms of violence and trauma. These significant childhood traumas are associated with numerous adult psychiatric disorders (depression, suicide attempts, somatization, dissociation), increased health risk behaviors (smoking, alcoholism, illicit drug use), increased high-risk sexual behaviors (greater than 50 sexual partners, teen pregnancy), and medical disease (hepatic disease, chronic obstructive pulmonary disorder, coronary artery disease, autoimmune disorders).⁵ Given the severe long-term health impacts, it is essential to approach the issue of CSEC from a health perspective.

Commercial sexual exploitation has become particularly rampant in urban areas,² such as Oakland, California. Located in Alameda County, the city of Oakland is noted by law enforcement to have a robust underage sex market and is the center of a sex trafficking triangle between adjacent San Francisco and Contra Costa counties in the San Francisco Bay Area. However, it is difficult to accurately measure the number of CSEC or DMST victims within the region. It is estimated that most victims are youth between the ages of 13 and 15 with some as young as 11 years. The majority of these youth were born in the United States. From 2006 to 2011, the Oakland Police Department reported 1,782 cases of sex trafficking where children were often the victims in these cases. The police

department was able to rescue 191 children during this time period, breaking the cycle of exploitation experienced by these adolescents.⁶ In the vast majority of cases, trafficking was initiated through the use of digital technology such as the Internet, which has become a common source of trafficker engagement with vulnerable youth.⁷

An increasing number of Asian teens, particularly Southeast Asians (SEA), are at risk for commercial sexual exploitation. SEAs include refugees and immigrants from Cambodia, Laos, and Vietnam. Many Asian and Pacific Islander (API) and SEA youth are at greater risk of sexual exploitation due to a myriad of factors, including high rates of poverty and cultural and intergenerational conflicts as they attempt to adjust to a US lifestyle vastly different from that of their parents. A large proportion of first-generation SEA immigrants and refugees suffer the effects of Post-Traumatic Stress Disorder (PTSD): depression, addiction, and domestic violence.⁸ The effects of PTSD can greatly impact children, creating dysfunctional households that make children more vulnerable to the risk of commercial sexual exploitation,⁴ among other things. Other risk factors can also impact CSEC vulnerability, including but not limited to migration, poverty, and previous experiences of political and other forms of violence and persecution. SEA teens have disproportionately high birth rates compared to East Asian teens.⁹ Many SEA families are still coping with the tragedies of persecution and genocide that occurred in their homeland. In fact, studies indicate that 40% of SEA refugees suffer from depression.⁸ The high rates of poverty among SEA families—37.8% for Hmong, 29.3% for Cambodians, 18.5% for Laotians, and 16.6% for Vietnamese¹⁰—further exacerbate the problems at home and increase the risk for delinquency and risky sexual behavior among SEA teens. With the struggles that home life poses, many SEA teens turn to an escape, often recreating themselves on the streets with their peers.

Recently, numerous studies have shown that victims of human trafficking often come into contact with health care providers while in captivity.^{11,12} In one qualitative study of 98 victims surveyed, 87.8% of the sex trafficking victims had a medical visit.¹² More studies and policy recommendations are being made to increase training for health care professionals to recognize when a patient may be a victim of human trafficking.¹³⁻¹⁶ As such, our study comes at a critical time when the momentum to combat human trafficking and commercial sexual exploitation of children is growing in the medical and public health sector.

Background

In 1974, Asian Health Services (AHS)—a community health center located in Oakland, California, and serving Alameda County—was founded to address the unmet health care needs of APIs and to advocate on their behalf for improved health care. As the API population grew rapidly and diversity increased, AHS mirrored that growth to meet the community needs. Today, AHS provides over 110,000 medical and dental visits to over 24,000 patients annually and is a nationally recognized, comprehensive community health center model for serving a primarily low-income, limited English-speaking population. AHS provides services in 11 Asian languages.¹⁷

AHS recognizes that the API youth population has a unique set of health needs and has tailored specific programs to serve and advocate for the health care needs of this population. The Youth Program at AHS (AHSYP), established in 1996 in response to an increase in teenage pregnancies among Asian youth in Alameda County, provides a continuum of services to high-risk youth in Alameda County (including Oakland) and includes comprehensive sexual health education, reproductive health counseling, reproductive health care services, and youth leadership development activities. The Teen Clinic at AHS opened in 2000 after a Youth Program needs assessment indicated the desire for free and confidential clinical and support services.

From 2001 to 2003, the AHSYP community health workers and Teen Clinic providers began noticing disturbing trends among their patients, predominantly those of Southeast Asian American descent, as well as a few African American, Latino, and non-Hispanic white patients. During the course of frequent medical and reproductive health counseling visits, it was uncovered that many of these patients were being commercially sexually exploited.¹⁸

In 2004, in response to the rising number of sexually exploited SEA youth in the local area, and the lack of community-based services available to exploited youth who were not engaged in the criminal justice system, AHS staff and community organizers cofounded Banteay Srei, a youth development, asset-building program that works with young SEA women who are at risk of or experiencing sexual exploitation. Banteay Srei provides social support, healing arts, reproductive health education, life skills building, and leadership development for young SEA women impacted by sexual exploitation.¹⁹

In 2008, AHS and Banteay Srei conducted focus groups with CSEC patients, service providers, domestic violence experts, and community health advocates to inform the development of a CSEC screening protocol

that could be used as an identification tool within clinical settings (see Appendix). The goal of this CSEC screening protocol is to assist providers so that they can recognize children at risk of commercial sexual exploitation, take an appropriate history, and provide resources to children in the community setting. The tool helps guide providers in identifying when a youth patient may be at risk of commercial sexual exploitation by recognizing the presence of high-risk indicators of commercial sexual exploitation. This allows providers to intervene by inquiring about sexual exploitation, which offers the opportunity for patients to disclose their sexual victimization.

The purpose of this study is to determine the proportion of AHS Teen Clinic patients who are screened for CSEC based on the use of a CSEC screening protocol, assess the prevalence of CSEC among patients who are screened, and understand how the protocol can serve as a useful tool for detecting CSEC within a clinical setting with the ultimate goal of connecting young patients to appropriate services and support. Findings from the study are intended to inform medical and service providers about the potential importance of screening for commercial sexual exploitation in at-risk patients.

Methods

Study Design

This study used a retrospective cohort design to assess the prevalence of CSEC within a clinical setting such as Asian Health Services. We identified patients who received services at Asian Health Services Teen Clinic between 2008 and 2011. Information on patients and whether they received CSEC screening was obtained from patient medical charts. Chart abstractions helped to inform our study, as we were able to gather information collected through clinical visits; chart abstractions also provided insight about the number of CSEC patients who were identified by providers through the use of our CSEC screening tool. The screening tool included potential predictors for sexual exploitation, such as frequent requests for sexually transmitted infection (STI) screenings, frequent diagnoses of STIs, minors who are sexually active with multiple partners, chronic truancy issues, history of sexual abuse, and reporting greater than 10 lifetime sexual partners.

This study was reviewed and approved by the Association of Asian Pacific Community Health Organizations (AAPCHO) institutional review board.

Study Population

We reviewed 621 medical charts of female youth and young adult patients aged 13 to 23 who received sexual and reproductive health services in our Teen Clinic between 2008 through 2011.

Patients who did not receive sexual and reproductive health services during the study period were excluded. We also excluded subsequent clinical visits that were solely for the purposes of birth control refill or prenatal care if the initial visit had been abstracted and no additional services were sought. Patient charts were excluded from the study if they did not have the clinical visit within the study period. Although male patients access our Teen Clinic, they were excluded from this study because our providers focused more on screening female patients, who were believed to be more at risk.

Of the 626 patients who were eligible for the study, 621 patient medical charts were abstracted. Five patient medical charts were not abstracted because the charts were either missing or unavailable at the time of the chart abstraction.

Chart Abstraction

Research Department staff developed a chart abstraction training manual to provide instruction on how to conduct the chart abstractions to ensure consistency and reliability across chart abstractors. The manual highlighted the procedures for accessing patient medical charts, the protocols for reviewing and interpreting provider notes, and the process for documenting patient medical chart data. Abstractors were trained to review each patient medical chart and document information as defined by the categories listed below. The patient medical charts were specifically abstracted from chart notes, progress reports, and Teen Clinic intake forms, which were completed by medical providers, triage nurses, and Youth Program staff, respectively. A secondary abstractor reviewed the abstracted data in order to detect outlier data points and errors in data entry.

Four trained staff members and interns conducted the chart abstractions between September 2011 and February 2014. The data were collected and managed using Microsoft Access, with information abstracted in the following categories: (1) patient demographics, (2) patterns of clinical testing requests, (3) home environment and safety, (4) school enrollment and performance, (5) sexuality and birth control, and (6) history of CSEC.

Analysis

We analyzed the chart abstraction data using descriptive statistics to determine the demographic characteristics, prevalence of CSEC among those screened, and the distribution of risk factors for the patient population we were studying. We conducted univariate logistic regression with self-reporting CSEC victimization as the outcome. We tested different explanatory variables (i.e., variables that were included in the regression models that predict our outcome of interest—CSEC victimization). These variables were selected because they are suspected high-risk indicators for CSEC, which includes requests for pregnancy test, requests for STI test, history of STI, requests for multiple STI tests, history of truancy, living accommodations, current sexual partners, lifetime sexual partners, and multiple risk factors. We also tested multivariate logistic regression, although we were limited by the small sample size.

We conducted our analyses using Stata, version 13, and open source programming software, R.^{20,21}

Results

Table 1 illustrates the characteristics of 621 female patients between the ages of 13 and 23. More than half—357 patients (57.5%)—identified themselves as Asian. There were 70 Chinese (11.3%), 34 Filipino (5.5%), 30 Vietnamese (4.8%), 27 Cambodian (4.3%), 19 Mien (3.1%), and 10 Laotian (1.6%) patients. Also, there were 136 African American (22%), 47 Hispanic (7.6%), 5 Native American (0.8%), and 7 non-Hispanic white patients (1.1%). Patients who did not specify their ethnicity and any Asian ethnic group with less than 5 patients were categorized as Other and Other Asian, respectively.

Table 1. Demographic Characteristics of Study Population by Age and Race/Ethnicity

Characteristic	n (%)
<i>Age</i>	
13-15	101 (16.3%)
16-17	273 (44.0%)
18-23	247 (39.8%)
<i>Race/Ethnicity</i>	
Asian	357 (57.5%)
Cambodian	27 (4.3%)
Chinese	70 (11.3%)
Filipino	34 (5.5%)
Laotian	10 (1.6%)
Mien	19 (3.1%)
Vietnamese	30 (4.8%)
Other Asian	167 (34.6%)
African American	136 (22.0%)

Hispanic	47 (7.6%)
Native American	5 (0.8%)
Non-Hispanic White	7 (1.1%)
Other	56 (9.0%)
Unknown	13 (2.1%)

Table 2 shows that of the 621 patients whose charts were abstracted, 177 were screened for commercial sexual exploitation. Among 177 screened patients, we discovered that 13 patients (7.3%) confirmed having experienced commercial sexual exploitation.

Table 2. Number of Patients at Asian Health Services Teen Clinic 2008-2011 Screened for Commercial Sexual Exploitation of Children (CSEC)

History of CSEC	n (%)
Self-reported experience of CSEC	13 (7.3%)
No self-report of CSEC	164 (92.7%)

Table 3 shows the results for our univariate logistic regression. To predict the odds of commercially sexually exploited children among the 177 individuals screened, we set CSEC as the outcome variable and carried out univariate logistic regression against predictor variables shown in Table 3. We discovered the following: patients with a history of STI were nearly 7 times more likely to have experienced sexual exploitation than those without a history of STI; patients who had more than 2 sexual partners at the time of the screening were 15 times more likely to have experienced sexual exploitation than patients who had 2 or less partners at the time of the screening; patients with a history of more than 10 lifetime sexual partners were 19 times more likely to have experienced sexual exploitation than patients with 10 or less partners; and patients with 2 or more risk factors were 6 times more likely to have experienced sexual exploitation than patients with less than 2 risk factors.

Table 3. Univariate Logistic Regression Model Assessing Independent Predictors of Commercial Sexual Exploitation of Children (CSEC)

Variable	Odds ratio	95% CI
Request for pregnancy test	4.8	0.9-89.0
Request for STI test	—	—
Requested ≥ 2 STI tests	0.8	0.2-3.6
History of STI	6.8	2.0-31.2
Sexually active with >2 partners	15.3	3.3-70.0
>10 lifetime sexual partners	19.1	4.8-85.0
Lived away from family ^a	5.9	0.3-53.9
History of truancy ^b	6.8	0.7-63.3
≥ 2 combined CSEC risk factors	6.1	1.8-28.0

Note: Risk factor variables showing statistical significance are bolded. Dashes indicate that sample sizes were too small to report.

^aPatients less than 18 years of age and living away from family at the time of the visit.

^bPatients less than or equal to 16 years of age at the time of appointment and therefore legally required to be enrolled in school.

Table 4 illustrates the patient distribution of risk factors for commercial sexual exploitation among those who were screened compared to those who were not screened. A larger proportion of patients exhibiting risk factors was screened for CSEC compared to those not screened.

Table 4. Distribution of Risk Factors Comparing the Use of the Screening Tools

Variable	Screened for CSEC n (%)	Not screened for CSEC n (%)
Request for pregnancy test	129 (72.9%)	364 (82.0%)
Request for STI test	172 (97.2%)	370 (83.3%)
Requested ≥2 STI tests (n=542)	139 (80.8%)	226 (61.1%)
History of STI	64 (36.2%)	82 (18.5%)
Sexually active with >2 partners (n=540)	9 (5.3%)	—
>10 lifetime sexual partners (n=513)	17 (10.6%)	10 (2.8%)
History of sexual abuse (n=22)	—	11 (73.3%)
Lived away from family ^a (n=299)	5 (4.9%)	9 (4.6%)
History of truancy ^b (n=189)	10 (15.2%)	10 (8.1%)
≥2 combined CSEC risk factors	68 (38.4%)	78 (17.6%)

Note: While 177 patients were screened for CSEC and 444 patients were not screened for CSEC (n=621), the number of patients for each risk factor variable differs depending on whether a particular variable applied to the patient. Risk factor variables showing statistical significance are bolded. Dashes indicate that sample size were too small to report.

^aPatients less than 18 years of age and living away from family at the time of the visit.

^bPatients less than or equal to 16 years of age at the time of appointment and therefore legally required to be enrolled in school.

Discussion

The main findings of this exploratory study focused on understanding the rate of CSEC screening among providers and determining the prevalence

of CSEC among Teen Clinic patients. Our study found that of the female patients who sought clinical services between 2008 and 2011, only a little over a quarter of patients were screened for CSEC. Among those screened, 7.3% had experienced some form of commercial sexual exploitation. Given the outcome, this prevalence is of concern.

We also found that certain risk factors were more likely to be associated with commercial sexual exploitation. In other words, individuals demonstrating certain sets of characteristics are at greater risk of being sexually exploited. Adolescent female patients who have had positive diagnoses for STIs, who were sexually active with more than 2 partners, or who had more than 10 lifetime partners demonstrated higher possibilities of being CSEC victims than those not exhibiting the specified risk factors. Additionally, patients who exhibited 2 or more concurrent risk factors showed more chances of being sexually exploited than those having less than 2 risk factors. The strong associations signify the need to increase CSEC screening, especially when adolescent patients demonstrate these particular sexual behavior characteristics, elicited by a clinician taking a standard sexual history from a patient.

To date, there have been few studies in the literature that assess the prevalence of CSEC victims within a clinical setting or that identify specific risk factors associated with being a CSEC victim using an empirical approach. Rather, sexually exploited children usually interface with the juvenile justice system upon apprehension or run-in with the legal system. As a result, this study attempts to promote screening for CSEC in clinics in order to assist CSEC victims before they are subjected to further harm by traffickers or faced with the juvenile justice system. While there have been several initiatives to develop screening tools for use by other sectors, these tools are lengthy and impractical to use in a primary care outpatient clinical setting where the standard appointment is 15 minutes.^{22,23} There continues to be a lack of evidence-based policies that guide CSEC screening and assess the utility of a clinical screening tool.² Therefore, this study offers an opportunity to facilitate screenings for CSEC in clinic-based settings, providing a novel approach to identifying sexually exploited children. The risk factors leading to commercial sexual exploitation and trafficking that we identified in our screening protocol support previous studies (e.g., studies on sexual abuse), but we additionally focused on clinical indicators of sexual health (e.g., requests for testing, history of STIs, and number of sexual partners).⁴

Our study contained several limitations. Two of these limitations include underscreening and underreporting of CSEC among teen patients. Based on our sample, we had a much larger proportion of patients who

had not been screened for CSEC despite the presence of risk factors. Since we only screened a small sample (n=177), our prevalence is based on a small group of patients who may have had a higher probability of being CSEC victims given their risk factor profile compared to the nonscreened group. Thus, the overall prevalence may be less than 7.3%. However, a more accurate prevalence would be better estimated if screening were done with all 621 individuals, underscoring the importance of universal CSEC screening.

The low levels of CSEC screening may be due to lack of provider awareness about CSEC, limitations on what to do after a child is identified, lack of referral resources in a community setting, unclear guidelines on reporting in different communities, and uncertainty about the role of the health care provider once a child is identified.^{2,24} This largely speaks to the need to educate providers on screening for CSEC, especially in geographic regions where CSEC prevalence is particularly high, and the need for building social services capacity both within and outside the clinic. Furthermore, more robust levels of screening would likely lead to a more comprehensive analysis of the risk for CSEC demonstrated by the youth. We also recognize that underreporting is largely associated with sexual exploitation. As a result of stigma, shame, and fear of repercussion by exploiters and law enforcement, victims of commercial sexual exploitation are less likely to disclose their involvement in commercial sexual activity and trafficking.²⁵ Furthermore, underreporting may correspond to physical and psychological control by traffickers whereby victims do not recognize their own exploitation. This means that even with increased screening, reporting on sexual exploitation remains a barrier to truly identifying all those affected. Efforts to work with patients to disclose experiences of commercial sexual exploitation are a future consideration.

Additional limitations include the fact that due to the retrospective nature of our study, we can only interpret provider chart notes based on how the information was documented, which may be inconsistent and incomplete. Providers may have been selective about the risk factors they asked patients. As a result, we do not have enough data (e.g., history of sexual abuse, history of truancy, and living away from home) to better understand how the risk factors may be associated with the risk of CSEC. Furthermore, while our clinical screening protocol applies to adolescents between the ages of 11 and 18 years, our study population included young adults up to 23 years. However, all patients who screened positive for CSEC reported that the commercial sexual exploitation occurred previously when they were adolescents. There must also be research done to identify and reach out to male CSEC victims.

Based on our study, screening for CSEC within clinical settings has great potential to impact the CSEC epidemic. Given the underground nature of commercial sexual exploitation, the challenge of finding and connecting CSEC victims to appropriate services remains a daunting task. As such, clinic-based settings are instrumental in addressing the rise of sexual exploitation and trafficking of vulnerable adolescent girls. Community clinics serve as important venues for reaching CSEC victims seeking sexual and reproductive health services. The potential impact can therefore be two-fold: it can serve as a preventative measure to redirect high-risk patients from becoming victims of commercial sexual exploitation and to intervene against revictimization of sexually exploited children before further physical, psychological, or legal harm is inflicted. However, without the adequate awareness and training about commercial sexual exploitation, CSEC patients can easily be overlooked. The goal of our study is to share the use of this clinical screening tool in order to assist providers in helping CSEC victims. Screening continues to be difficult for providers who are often restricted by long, complicated, and impractical tools. Therefore, by developing a standard of practice to train providers working with youth and by using this screening protocol to guide service provision, clinic-based settings and providers can be pivotal players in reducing the rise of commercial sexual exploitation among children.

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Appendix

Asian Health Services & Banteay Srei CSEC Screening Protocol CSEC Screening Protocol 7.12

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC) SCREENING PROCEDURE GUIDELINE

Patients ages 11-18 that are exhibiting two or more of the following high risk indicators for sexual exploitation:

- frequent and consistent requests for sexually transmitted infection (STI) screenings
- frequent diagnosis of STIs
- sexually active adolescents < 13 y.o. with >2 lifetime or casual sexual partners
- patients who are coming in >2 other patients with same signs or symptoms of STIs
- chronic truancy issues
- not living at home, living with “boyfriend”
- homelessness issues
- >10 lifetime or casual partners
- history of sexual abuse
- chronic runaway

Speak with the person presenting with signs or symptoms of sexual exploitation privately and remove others from the room. Use a leading question:

“Over the years, we’ve noticed that more and more young people are turning to the streets to make money for themselves or for other people. Sometimes patients tell us that:

- **they’re exchanging sexual services or ‘going on dates’ for money, clothes, a place to stay, drugs, etc**
- **or in a situation where they’re being asked or forced to let other people touch them or do sexual things to them**

“Because we think that these activities can have a big impact on your health, we’ve started to offer resources to people who want some help to get out of a situation like this. Would you like some more information on this and how to get help for either yourself or a friend?”

We can refer you to an individual that will contact you and help you meet folks who can:

- | | |
|----------------------------|---|
| -help you in court | -tell you about programs that may help you |
| -get reenrolled in school | -find employment opportunities |
| -help you find a therapist | -find out if you’re eligible for any benefits |



Asian Health Services & Banteay Srei 7/2012

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