Identifying Youth at Risk for Commercial Sexual Exploitation of Children (CSEC) in a Foster Care Clinic

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Disclosures

- I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

- I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
One more disclosure...

- I am a pediatrician, a sister, a daughter, a mom and a wife. I am not a lawyer or in law enforcement, therefore, I am going to present CSEC through my eyes in the most practical sense relevant to our profession and our world.
This stuff is real...

...it is happening in all of our communities, not just in the foster care setting.
Perspective...would you know what to do?

1. A 16 yo pt missing from foster care for >6 months shows up for STI testing, turns up positive for Syphilis and then goes AWOL again before proper treatment

2. A new 16 yo pt with hx of “teenage prostitution” and substance abuse continues to run away from her residential drug treatment programs, discloses she is learning to shoot guns off the rooftops of housing projects and is waiting for her older boyfriend to be released from jail

3. An 18 year old foster child reports she found a new job online as a model. She is assigned jobs to attend business meetings, looking pretty. She has to spend her earned money to buy clothes for her jobs. There is alcohol served. She looks disheveled and has a new friend with her when she comes to your office.
Talking Points

1. I will describe:
   a) The setting of the foster care clinic looked at in my study
   b) Early and ongoing challenges faced while working with our adolescent population

2. I will provide:
   a) An overview of trafficking/CSEC legislation
   b) A close look at a cohort of female adolescents from our clinic and correlate their CSEC risk with AWOL and STI

3. I will discuss:
   a) The implications of CSEC awareness in all settings that serve youth
Wouldn’t it be nice?
Our clinic Grand Opening - June 2012
- Location: Bronx, NY
- Patient population: ~500 youth in community foster care
  - Residential census: ~300
- Patient age range: Birth – 23 years old

Community Foster Care Clinic Staffing:
- One pediatrician on-site
  - Initially ½ day clinics → 5 full days
- One medical receptionist, one medical assistant, one nursing manager
- Social workers and Mental Health Professionals on site

Prior to this time, all youth received primary medical care and reproductive health services at outside providers
Upfront Challenges

- Building rapport with traumatized youth, families and agency workers
- Adolescent population
  - Reproductive Health Challenges
    - Recurrent STIs
    - Unplanned pregnancies
    - Contraception adherence
  - Safe Relationship Challenges
    - Difficult to place (multiple foster home disruptions)
    - Frequent AWOLS
    - Gang involvement
    - Older boyfriends/girlfriends
    - Online dating and solicitation
    - Substance abuse
    - High turnover of case management
Addressing the Reproductive Health Challenge

- Provide full onsite reproductive health services, including:
  - Adolescent GYN
  - STI testing, treatment
  - Pregnancy testing
  - Contraceptive options counseling, including Long-acting reversible contraception (LARC)
Challenges Implementing LARC Program

- Subcutaneous implant offered first
  - October 2012 – light bulb went off at AAP in New Orleans
  - April 2013 - Obtained Nexplanon Clinical Training
  - December 2014 - Delayed availability due to funding challenges

- IUD insertion required more procedural planning
  - October 2014 - Grant funded training through NYC DOE/DOH, Reproductive Access Program, Institute for Family Health
  - July 2015 – Delayed availability due to requirement for autoclave procedure protocol
All the while we were seeing youth without fully understanding the external influences in their lives...

...until, September 2015:

- New York State Office of Children and Family Services (OCFS) issued an Administrative Directive
  - Identify, document, report to law enforcement, and provide appropriate services to children who are sex trafficking victims, or who are at risk of being sex trafficking victims
    - Rapid Indicator Tool
    - Child Sex Trafficking Indicators Tool
    - Law Enforcement Report of Child Sex Trafficking Victim
Timeline of Legal Protection for Victims of Human Trafficking

- **Victims of Trafficking and Violence Protection Act of 2000**
  - The first federal law to protect victims of human trafficking

- **New York State Safe Harbor For Exploited Children Act of 2008**
  - The first State law to protect children from sex trafficking
  - Decriminalizes minors who have been sexually exploited; creates a path for supportive services

- **Preventing Sex Trafficking and Strengthening Families Act - Sept. 29, 2014**
  - Signed into federal law by President Obama
  - October 2014 - U. S. Department of Health and Human Services Administration on Children, Youth and Families issued a summary
FIGURE 2 Possible risk factors for commercial sexual exploitation and sex trafficking of minors.
NOTE: LGBT = lesbian, gay, bisexual, or transgender.

Recognizing the Power and Control Wheel

**Physical Violence**
- Using coercion and threats
  - Making and/or carrying out threats to do something to hurt her
  - Threatening to leave her
  - To commit suicide
  - To report her to welfare
  - Making her drop charges
  - Making her do illegal things

**Economic Abuse**
- Preventing her from getting or keeping a job
- Making her ask for money
- Giving her an allowance
- Taking her money
- Not letting her know about or have access to family income

**Sexual Violence**
- Using intimidation
  - Making her afraid by using looks, actions, gestures
  - Smashing things
  - Destroying her property
  - Abusing pets
  - Displaying weapons

**Emotional Abuse**
- Putting her down
- Making her feel bad about herself
- Calling her names
- Making her think she's crazy
- Playing mind games
- Humiliating her
- Making her feel guilty

**Isolation**
- Controlling what she does, who she sees and talks to, what she reads, where she goes
- Limiting her outside involvement
- Using jealousy to justify actions

**Using Male Privilege**
- Treating her like a servant
- Making all the big decisions
- Acting like the "master of the castle"
- Being the one to define men's and women's roles

**Using Children**
- Making her feel guilty about the children
- Using the children to relay messages
- Using isolation to harass her
- Threatening to take the children away

**Minimizing, Denying and Blaming**
- Making light of the abuse
- Not taking her concerns about it seriously
- Saying the abuse didn't happen
- Shifting responsibility for abusive behavior
- Saying she caused it
Glitches in the Systematic Approach to CSEC: Observations from the Medical Team

- Youth often bypass their social workers to be seen in medical clinic only

- Targeted interviews of youth at risk for CSEC became territorial
  - How much detail should agency staff collect?
  - Who should collect the information?
    - Social Workers vs. Mental Health Professionals vs. Medical Staff
  - Case escalation became bottlenecked with single mental health administrative point person

- Youth would be detained at agency awaiting deployment of law enforcement
  - Re-traumatization; being held against their will
  - Youth would AWOL from agency staff
All this led me to ask the following question:

- Although medical providers are not mandated to complete CSEC screening tools, can they quickly identify youth at risk for CSEC?
How about using data we were already obtaining in the medical clinic...

- Youth returning from AWOL were offered the following:
  - Medical clearance examination
  - STI/pregnancy testing
  - Updated Rxs, including contraceptive management
  - Safety assessments
  - Food
Methods

- A medical chart review of patients seen between June 2012 - March 2017
  - Inclusion criteria:
    - Female sex with
      - History of “AWOL,” and/or
      - Use of LARC

- Results were cross referenced with categorical results from CSEC screening tools completed by social work staff

- Patient charts were also reviewed for number and type of sexually transmitted infections
### STEP 1: RAPID INDICATOR TOOL – FOR SOCIAL WORKERS

**FOR ALL NEW OPEN CPS INVESTIGATIONS AND YOUTH WHO ARE MISSING, ABDUCTED, OR ABSENT WITHOUT CONSENT/LEAVE (AWOL)**

**STEP 1: To Identify Children Who May Be Sex Trafficking Victims or Are At Risk of Being a Sex Trafficking Victim**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>Are there signs of child abuse of a sexual nature and reason to believe that the child, or parent/guardian of the child or other person(s) facilitating the abuse, was given or promised anything in return for the sexual abuse?</td>
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<tr>
<td>Is there reason to believe there are photographs, social media posts, or other recordings of instance(s) of sexual abuse of the child?</td>
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<td>Has the parent/guardian been a victim of trafficking or is there concern that the parent/guardian has been a victim?</td>
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<td>Does the child have a history of multiple runaways/AWOLS or episodes of homelessness/couch surfing in the past? (Family homelessness should not be counted)</td>
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<tr>
<td>Does the child have tattoos that show, imply, or suggest ownership and/or that he or she does not have an explanation for? (e.g., daddy’s girl, property of someone’s name, symbols, etc.)</td>
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<td>Does the child have or has he or she previously had a significantly older boyfriend or girlfriend who is controlling and/or whom the child appears to be afraid of?</td>
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<td>Does the child have a history of multiple or chronic sexually transmitted infections, or pregnancies/abortions, or report multiple anonymous sexual partners?</td>
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<td>Does the child have money, a cell phone, hotel keys, or other items that he or she does not have the resources to obtain and cannot account for?</td>
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<td>Has a gang affiliation been disclosed, reported, or suspected?</td>
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<td>Is someone else other than the child’s parent or guardian in control of his or her identification or passport?</td>
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<td>Do you have any other reason to believe the child may be a sex trafficking victim?</td>
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STEP 2: CHILD SEX TRAFFICKING INDICATORS TOOL

A Comprehensive screening

- Developed by Safe Harbour:NY to coordinate the response between child welfare-serving agencies if ≥1 indicators are present on Rapid Screening Tool

- Indicators are grouped into:
  - “Meets child trafficking definition”
  - “High” level
  - “Medium” level

- Youth with higher number of indicators in a higher level are more likely to have been trafficked or engage in behaviors that may increase the risk of being trafficked

- The child’s indicator level should be used in developing a child’s case plan and referral for services; it may change over time

- Consideration of certain “vulnerabilities” may hold more weight
  - Chronic homelessness
  - Multiple runaway episodes
  - LGBTQ
  - Immigration status issues
  - Developmental delays
  - Hx of sex abuse
### CHILD SEX TRAFFICKING INDICATORS TOOL:

<table>
<thead>
<tr>
<th>Child Meets Federal Definition of a Child Sex Trafficking Victim - ONE or more of these indicators:</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Child needs to be documented as a trafficking victim in CONNECTIONS or JJIS (for DJJOY) and trafficking response protocol followed (see policy or desk aid).</td>
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<tr>
<td>Child reports engaging in commercial sex act(s) (a sex act where something of value is received).</td>
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<tr>
<td>Child reports he/she has been prostituted or trafficked.</td>
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<td>There are photos or videos of the child being victimized and/or being used to advertise the child for sexual purposes (Backpage, Craigslist, etc.).</td>
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<td>Law enforcement refers child instead of arresting for prostitution, or does arrest for prostitution.</td>
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<td>Child reports trading sex for a place to stay, food, drugs, or anything of value.</td>
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<td>Child reports being involved in the sex industry (working in strip clubs, private sex parties, etc.).</td>
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<td>Someone witnesses the child engaged in a commercial sex act.</td>
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<tr>
<td>Youth over 18 is engaging in prostitution or commercial sex acts due to force, fraud or coercion.</td>
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<tr>
<td>High-Level Indicators - ONE or more of these indicators</td>
<td>Yes</td>
<td>No</td>
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<td>Child exhibits indicators that are commonly associated with sex trafficking, which causes serious concerns.</td>
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<tr>
<td>Document high-level indicators in CONNECTIONS or JJIS (for DJJOY).</td>
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<td>Child needs to be closely monitored and needs intensive case management services to address current or prevent future trafficking.</td>
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<tr>
<td>Associating with adults or other children/youth who are being prostituted, or are known to be involved with trafficking and/or exploitation.</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Being seen in exploitation hotspots, i.e., known houses or recruiting grounds.</td>
<td>□</td>
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<td>Pattern of street homelessness and staying with someone believed to be sexually exploiting the youth.</td>
<td>□</td>
<td>□</td>
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<td>Multiple AWOLS, runaway or being kicked out (4+).</td>
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<td>Being taken to clubs and hotels by adults or older peers.</td>
<td>□</td>
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<td>Disclosure of serious sexual assault and then withdrawal of statement.</td>
<td>□</td>
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<td>Abduction and/or forced imprisonment; not allowed to freely move about.</td>
<td>□</td>
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<tr>
<td>Child discloses or someone reports the child being moved around for sexual activity</td>
<td>□</td>
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<td>Disappearing from the “child welfare system” with no contact or support.</td>
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<td>Use of slang trafficking terms (e.g., calling romantic partner “Daddy” or “Mommy,” talking about “the life,” “the game”).</td>
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<td>Recruiting peers into exploitation.</td>
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<td>Tattoos that he/she is reluctant to explain, especially if they show ownership (names, dollar signs, symbols, acronyms) or other types of branding, like cutting or burning.</td>
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<tr>
<td>Does not have any identification or reports someone holding his/her identification.</td>
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<td>Unexplained hotel keys.</td>
<td>□</td>
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<tr>
<td>Child discloses or someone reports that child offered to have sex for money or other payment and then ran before sex took place.</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Being groomed and/or sexualized on the Internet; contact with strangers on the Internet and/or sexual risk taking on social media, such as Facebook, Backpage, Zoosk, Craigslist.</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Medium-Level Indicators - ONE or more of these indicators</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Child exhibits significant indicators that may indicate sex trafficking. Document medium level of Indicators in CONNECTIONS or JJIS (for DJJOY). Child should be more closely monitored and provided services that may address current or prevent future trafficking.</td>
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<td>Getting into cars with unknown adults.</td>
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<td>Child under 13 engaging in sexual activity.</td>
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<td>Known history of prior sexual abuse or sexual acting out.</td>
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<td>Having an older boyfriend/girlfriend, especially if he or she appears controlling, youth appears fearful of boyfriend/girlfriend at times.</td>
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<td>Not attending school; concerns regarding school attendance.</td>
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<td>Staying out overnight with no explanation multiple times and/or regularly coming home late or going missing.</td>
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<td>Unaccounted money or goods, including mobile phones, drugs and alcohol, or other person supplies these goods/money to child/youth.</td>
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<tr>
<td>Multiple sexually transmitted infections, pregnancies and/or multiple miscarriages or abortions.</td>
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<td>Gang member or association with gangs or neighborhood groups.</td>
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<td>Someone else other than the child’s parent or guardian was in control of immigration to U.S.</td>
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<td>Overt sexual dress.</td>
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<td>Does not know his/her address and/or has moved multiple times.</td>
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<td>Chronic alcohol and/or drug use by youth.</td>
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<td>Youth’s story does not make sense - inconsistencies, the narrative doesn’t fit together.</td>
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</table>
How about using data we were already obtaining in the medical clinic...

- Youth returning from AWOL were offered the following:
  - Medical clearance examination
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  - Safety assessments
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Methods

A medical chart review of patients seen between June 2012 - March 2017

Inclusion criteria:

- Female sex with
  - History of “AWOL,” and/or
  - Use of LARC

Results were cross referenced with categorical results from CSEC screening tools completed by social work staff

Patient charts were also reviewed for number and type of sexually transmitted infections
Results: CSEC Classification and AWOL

- Of 5,811 patients seen throughout our agency, 47 female adolescents met criteria for study inclusion
  - 42 out of 47 cross-matched to any SW CSEC Classification
  - 32 had a history of AWOL
    - 16 (34%) cross-matched as Confirmed CSEC
      - ALL Confirmed CSEC cases had a history of AWOL
  - 23 had a history of STI
    - Chlamydia was seen in all classifications
    - Gonorrhea only in High Risk or Confirmed CSEC
    - Syphilis only in one case who was Confirmed CSEC with history of AWOL
Prevalence of STIs Among AWOL and Non-AWOL Female Youth in Community Foster Care

- AWOL: N = 17
- Non-AWOL: N = 6

26% of AWOL youth had STIs, compared to 74% of non-AWOL youth.
CSEC Risk Classification Increases for Female Youth in Foster Care Who Have an AWOL History

NON-AWOL + CT (N = 15)
(± STI)

AWOL NO-CT (N = 15)

27%
53%
13%
33%

27%
67%
6%

Confirmed High Risk Medium Risk No Risk
Federally Defined CSEC Cases 2.6x Greater for Female Youth in Foster Care Who Have AWOL and STI History

NON-AWOL + CT (N = 15)
- Confirmed: 53%
- High Risk: 13%
- Medium Risk: 33%

AWOL + CT (N = 17)
- Confirmed: 71%
- High Risk: 29%
Chlamydial Infections in Non-AWOL vs AWOL Female Youth in Foster Care

- **NO INFECTIONS (N=24)**: 9 Non-AWOL, 15 AWOL
- **ANY INFECTION (N = 23)**: 6 Non-AWOL, 17 AWOL
- **CT X 1 (N = 11)**: 4 Non-AWOL, 7 AWOL
- **CT X 2 (N = 6)**: 1 Non-AWOL, 5 AWOL
- **CT X 3+ (N = 6)**: 1 Non-AWOL, 5 AWOL
Distribution of Chlamydial Infections Between CSEC Risk Categories for AWOL vs. Non-AWOL

<table>
<thead>
<tr>
<th>Distribution</th>
<th>AWOL</th>
<th>Non-AWOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT x 1 (n = 11)</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>CT x 2 (n = 6)</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>CT x 3+ (n = 6)</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>
Gonorrhea and Syphilis

- GC (N = 7): 6 AWOL/Confirmed CSEC, 1 Non-AWOL/High Risk
- RPR (N = 1): 1 AWOL/Confirmed CSEC
Conclusion

- Our study shows that the medical clinic can and should be an integral part of the screening and case planning team for youth in foster care
  - Youth in foster care utilize reproductive health services often
  - Youth with a history of AWOL are more likely to meet the federal definition of CSEC than non-AWOL youth
    - This risk more than doubles when they also present with an STI
Discussion Points

- Utilize urgent visits with adolescent youth to assess their safety and build a rapport
  - Provide a needs assessment, especially if they are returning from AWOL, ex: housing, food, clothing, education, legal
  - Don’t expect to be able to save someone from an exploiter just because you have spotted some red flags – it may take years (ex: 7 attempts on average to leave an abuser)
  - Provide support for all providers and staff who are in regular contact with exploited youth due to the high rates of burnout
Putting the pieces together...
Future Directions

- We must be prepared to do more than just identify children and youth at risk.
- Child welfare interdisciplinary teams are challenged to identify and case plan for youth at risk for CSEC.
- As foster care clinics move towards medical homes, it will be important for staff to integrate databases that document risk factors and to set up alerts and care plans for CSEC classified youth.
- It is critical for medical providers working with AWOL youth and youth seeking reproductive healthcare to work collaboratively with a multidisciplinary team to provide wrap-around support.
- This work will also be relevant for school-based health centers, emergency rooms and outpatient clinics.
Outcomes of clinical scenarios

1. Confirmed CSEC, images found on Backpage, returned to care, hospitalized for severe PTSD, STIs treated, currently in residential trafficking program

2. Case dated prior to state mandates, after several years of treatment for substance abuse, pt received GED, started college, relapsed on K2 due to boyfriend from rehab, pt sought her own help, successfully engaged in rehab and is transitioning out of care as a self advocate. Does not identify as sex trafficking survivor.

3. Confirmed CSEC, images found on Backpage, signed self out of care
Thank you!

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