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Original Research

***Assessment Practices and Experiences of Sex Trafficking
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in Indiana****

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ABSTRACT

With increased recognition of sex trafficking, calls have been made for greater identification and screening. Lack of awareness and assessment likely contribute to low identification of sex trafficking victims. The present study examined assessment practices, confidence in detecting trafficking, and experiences with domestic minor sex trafficking (DMST) survivors in the caseloads of service providers in the previous year. Employees at high-

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risk settings were recruited, resulting in a sample of 76 providers representing 21 agencies. Data revealed that while general risk factors were typically assessed, sex trafficking-specific risk factors and experiences were assessed less often. Approximately 30% of participants indicated that they had worked with at least one sex trafficking victim in the previous year; however, 44% of participants indicated low confidence in detection. Approximately 23% of participants had completed sex trafficking training, but few differences emerged between those with and without prior training. Increased training, assessment, and evaluations of the effectiveness of training programs are recommended.

KEY WORDS Human Trafficking; Assessment; Risk

The Trafficking Victims Protection Act (TVPA), considered the first comprehensive modern law relevant to human trafficking, was passed in 2000, formally acknowledging human trafficking within the United States and calling for increased attention, resources, and prevention efforts. Since that time, the TVPA has been reauthorized and updated numerous times, most recently in 2018–2019 (Wells 2019). Instances of human trafficking are most often classified as either labor trafficking or sex trafficking, although a multitude of proposed classifications exist (e.g., Gibbons, Chisolm-Straker, and Stoklosa 2020). The present study focuses on domestic minor sex trafficking (DMST), specifically experiences in Indiana. Sex trafficking occurs when a commercial sex act (i.e., any sex act performed in exchange for something of value) is induced by force, fraud, or coercion or in which the person inducted to perform such an act has not attained 18 years of age (TVPA 2000). Estimates of the number of trafficked minors in the United States vary widely and have severe weaknesses, which has led to recommendations to not attempt to estimate specific numbers of DMST survivors (Finkelhor, Vaquerano, and Stranski 2017). Improved identification and tracking of cases of DMST will be important in the future in order to plan prevention, intervention, and recovery services and to justify the resources needed to fund these efforts. Intrinsic, extrinsic, and systematic barriers to identification of DMST exist (Garg et al. 2020); it is therefore important that service providers are informed about DMST and intentionally and consistently assess for the presence of DMST. The current project is a quantitative examination of data provided by service providers in Indiana describing their assessment practices, confidence in detecting trafficking, and experiences with DMST survivors in their caseloads in the past year. Of note, the terms *victim* and *survivor* are both used in DMST literature. Although some have argued for important distinctions between the terms, the terms are often used interchangeably (e.g., Office for Victims of Crime Training and Technical Assistance Center n.d.). The present study will retain the term used by researchers when describing specific studies but, when speaking generally, will utilize the term *victim* when referring to individuals still involved in DMST and the term *survivor* to refer to those who are no longer actively being trafficked and/or are in recovery phases.

RISK FACTORS FOR MINOR SEX TRAFFICKING

Consistent with other types of sexual abuse/assault experiences (to be described as sexual abuse unless different definitions are used), research frequently indicates higher rates of sex trafficking among females compared to males (e.g., Gibbs et al. 2015; Varma et al. 2015). Additionally, racial and ethnic minorities (e.g., Butler 2015; Twis 2020) and members of the LGBTQ population (Boukli and Renz 2019; Murphy 2016) appear to be overrepresented in DMST. See Williamson and Flood (2021) for a discussion of systematic contributions and the disproportionate impact on racial, gender, and sexual orientation minorities. Overall, there are numerous races, genders, sexualities, risk profiles, and paths into the commercial sex trade or minor sex trafficking (Choi 2015; Reid et al. 2019). Rather than highlighting demographics, research has identified environmental and trauma-related risk factors that can make youth more vulnerable to sex trafficking. Particularly vulnerable populations include runaway and homeless youth, those involved in the foster care system (Fong and Cardoso 2010; O'Brien, White, and Rizo 2017), and youth involved in the juvenile justice system (Chohaney 2016; Gibbs et al. 2015; Twis 2020). Review findings highlight environmental factors (e.g., dysfunctional family environments, encounters with child welfare, poverty, and homelessness) and traumatic factors (e.g., childhood sexual abuse/interpersonal trauma) as highly associated with sex trafficking of minors and suggest that trauma is an important risk factor (Choi 2015; Franchino-Olsen 2019). Examination of adverse childhood experiences (ACEs) in juvenile-justice-involved youth indicated that trafficked youth reported higher levels of ACEs than a matched sample, but sexual abuse was the strongest predictor of human trafficking for both boys and girls (Reid et al. 2017). Pathways to DMST, and the associated risk factors, vary, however, and differences occur between individuals and may differ by factors such as region, location (urban versus rural), age, and race (Reid 2012; Twis 2020).

Studies have identified differences between minor survivors of sex trafficking and survivors of sexual abuse without trafficking. Researchers in a pediatric medical setting compared histories and found that commercially sexually exploited children (CSEC; sexual activity of children used for financial profit, including sexual trafficking of minors) had higher rates of violence by parents/caregivers, history of violence with sexual activity, substance use, running away, involvement with child protective services, and involvement with law enforcement (Varma et al. 2015). Similarly, a study reported that individuals involved in CSEC had higher rates of living in foster homes, running away, arrest, suspension from school, and drug use than those with sexual abuse without commercial exploitation (Shaw et al. 2017). Data from the National Child Traumatic Stress Network Core Data Set indicated that CSEC victims demonstrated higher rates of involvement with detention centers, hospital emergency rooms, and self-help groups as well as higher levels of skipping school, sexualized behavior, alcohol use, substance use, criminal activity, and running away compared to a matched comparison of sexual abuse victims without commercial exploitation (Cole et al. 2014). An evaluation of service providers in programs serving minor victims of sex trafficking concluded that the victims shared common involvement with child welfare services and the juvenile justice system, along with histories of childhood maltreatment and runaway youth status (Gibbs et al.

2015). As many of these risk factors, and their associated consequences, lead to service provision in settings such as healthcare, children's services, and juvenile justice, assessment of both general and DMST-specific risk factors in these settings is important for identification and treatment.

BARRIERS TO IDENTIFICATION

Identification of DMST is challenged by intrinsic, extrinsic, and systematic barriers (Garg et al. 2020), including the secretive nature of the illegal commercial sex trade, fear and reluctance among victims to report, and lack of knowledge in providers about sex trafficking (Busch, Fong, and Williamson 2004; Martinho, Goncalves, and Matos 2020; Wallace, Schein et al. 2021). Victims may fear authority and the legal system (e.g., Jordan, Patel, and Rapp 2013), which may be enhanced with involvement in illegal activities, which may be a component of the trafficking experience (U.S. Department of State 2016). Another factor that makes identification difficult is the often complex relationship between the victim and trafficker. Traffickers may groom victims for the experience by assuming the role of boyfriend in order to gain loyalty and trust, then use fear and manipulation to keep the victim under control (Gerassi et al. 2018; Jordan et al. 2013; Kotrla 2010; Rigby 2011). The relationship may result in feelings of loyalty, belonging, and security for some individuals and may result in failure to identify as a victim or in unwillingness to report their traffickers (Hardy, Compton, and McPhatter 2013). Although these approaches are considered common in DMST, evidence suggests that there are different types of relationships between victims and perpetrators (e.g., Serie et al. 2017) and that the most common descriptions are based on unrepresentative samples and may not be consistent with the larger population (e.g., Marcus et al. 2014).

Although survivors may be reluctant or unable to identify themselves, existing research also suggests that limited awareness about trafficking often results in a lack of identification by others, including health professionals and service providers. Research suggests that many human trafficking victims seek healthcare services before, during, and after trafficking experiences (e.g., Lederer and Wetzel 2014; Stoklosa, Grace, and Littenberg 2015). Given this, it has been argued that healthcare providers can play an important role in the identification of trafficking victims and serve as an important link to assistance (Gibbons and Stoklosa 2016; Testa 2020). Given the complexity of the problem, it will be beneficial for involvement in multiple settings, with schools being another potential area for detection and intervention (e.g., Chesworth et al. 2021; Rizo et al. 2021). Consistent with the emphasis in prior research on healthcare settings and the project's current focus on social services, these settings are the primary focus of the current paper. Qualitative examination of survivor reports indicates that survivors want providers (pediatric emergency medical providers, specifically, in this study) to ask about trafficking and to approach the topic in a direct, sensitive, and nonjudgmental manner (Wallace, Schein et al. 2021), and findings suggest that youth may be willing to disclose in supportive environments (Garg et al. 2020). Although health professionals are mandated reporters of minor abuse, there is frequently a lack of understanding and screening for trafficking situations among health professionals (Beck et al. 2015; Clawson and Goldblatt Grace

2007; Macy and Graham 2012). In particular, providers may not understand that force, fraud, or coercion do not need to be demonstrated for minors (Beck et al. 2015; Gerassi et al. 2018). Survivors have expressed frustration with the lack of sensitivity and understanding of trauma and DMST among healthcare providers and other frontline professionals, and they have indicated that these experiences further increase distrust and reluctance to seek care (Rajaram and Tidball 2018). Even providers who would recognize instances of sex trafficking can miss opportunities for victim identification because of a lack of consistent assessment (Dols et al. 2019; Fong and Cardoso 2010; Goździak and MacDonnell 2007). Much of the existing literature related to assessment and identification of trafficking victims has been conducted with medical providers and settings. Given the involvement with organizations such as child welfare and juvenile justice, social service agencies are also likely to encounter DMST.

DMST ASSESSMENT

Although measures have been developed to identify trafficking (e.g., Dank et al. 2017), the field has not come to a consensus regarding a gold standard in assessment, and providers and agencies use a wide variety of measures and methods (see Pate et al. 2021 or Romero et al. 2021 for discussion of available measures). Without consistent formal assessment, identification relies on the clinician's discretion, which likely results in highly variable experiences. Little research exists examining common assessment practices related to DMST. One study examined the routine assessment of trafficking in emergency departments in Texas and found that 37% routinely screened children for human trafficking (Dols et al. 2019). Given survivors' reluctance to voluntarily report or seek assistance for sex trafficking experiences, improved awareness and assessment by providers will be an essential step to increase identification and connection to appropriate services.

Additionally, although funding toward and engagement in efforts related to DMST have increased since the passing of the TVPA, little research has examined how many service providers have received training specific to DMST or providers' confidence in their ability to identify DMST when it occurs. Although distinct from accuracy, confidence is important to consider, given that providers are more likely to report child abuse generally when they are more confident (e.g., Flaherty et al. 2006). Additional research that further examines the relationship between individuals' perceptions of their knowledge and abilities, and the accuracy of their identification, is needed. Gonzalez-Pons and colleagues (2020) examined provider confidence in ability to identify DMST victims and found that just over half of the participants believed their organizations would be able to identify DMST victims. Data suggest that service providers are interested in and see value in DMST training (Beck et al. 2015; Gonzalez-Pons et al. 2020), and lack of awareness or training has been suggested as a barrier to identification (Beck et al. 2015; Testa 2020). Numerous calls have been made for consistent training related to sex trafficking (e.g., Dols et al. 2019; Garg et al. 2020; Litam and Lam 2020; Martinho et al. 2020; Stoklosa et al. 2015; Talbott et al. 2020). Although a standard approach to training is not agreed upon (see Miller, Duke, and Northam 2016 for recommendations), there is evidence that participation in training can result in increased awareness, confidence, and knowledge of sex trafficking (Beck et al. 2015; Grace et al. 2014).

PRESENT STUDY

The present study aims to gather data from service providers in Indiana about their assessment practices, confidence in detecting trafficking, and experiences with DMST survivors in their caseloads in the prior year. Much prior research has focused on healthcare/medical settings, whereas the current study examines primarily social services and juvenile justice. These settings were chosen based on the high likelihood of DMST survivors receiving services from these types of agencies (e.g., involvement with child welfare and/or juvenile justice typically leads to connection to social services) and based on the interests of the researchers and task force. As the detection of DMST is often dependent upon provider assessment, the study aims to provide information about how frequently providers assess general and specific risk factors and experiences of DMST. The study also aimed to assess providers' perceptions of their confidence in assessment of DMST. Finally, the study sought to gain information about DMST experiences in Indiana from providers who knew or suspected that they had clients who were DMST survivors. The current study was conducted by members of the Indiana Protection of Abused and Trafficked Humans (IPATH) task force, with the support of the task force; the focus was therefore on providers in Indiana specifically. Trafficking experiences in the Midwest are understudied (Gerassi et al. 2018), and the current study adds to the literature in this area. Service providers working with high-risk youth completed an online survey asking about their assessment practices and client experiences. Given the lack of a standardized assessment at the time of study development (see Dank et al. 2017 for review of existing measures and measure development), a measure was created for the study; measurement development was not a primary goal, however. The aims were considered exploratory, but the investigators expected that although some of the general risk factors for trafficking would be assessed regularly, the specific risk factors and indicators of DMST would be assessed less frequently.

METHODS

Participants

Inclusion criteria included working at agencies in Indiana that provided at least one of the following services to individuals under 18: temporary/emergency shelter, residential treatment, acute inpatient treatment, independent/transitional living programs, day psychological treatment, outpatient mental health services, home-based mental healthcare, group home services, foster care services, child advocacy, child protective services, or juvenile justice services. To be included, individuals must have been working in Indiana and have been involved in direct care. These organizations were chosen to be the focus of the present study because of their work with youth at high risk for DMST, based on known risk factors, and to complement prior studies focused on healthcare. No specific exclusion criteria were identified. As the survey was administered online and all questions were in English, participants must have had access to internet and the ability to read and respond in English.

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Initial contact occurred in April 2014. Study personnel communicated with agencies, answered questions as they arose, and obtained information about additional agencies. Initial study recruitment emails were sent in December 2014. Because of the timing, reminders were also sent in February and March 2015. In total, 176 agencies were contacted. Of those, 80 (45.45%) agreed to participate. The final dataset represented 21 agencies. Information about the number of individuals at each agency who were sent the recruitment email was not collected. One hundred and fifty one (151) participants began the survey. Of the original 151 participants, 17 (11.3%) were deemed ineligible, because they did not work within Indiana ($n = 2$) or did not work directly with youth ($n = 15$). The final study sample included 134 adults who were providing direct services to youth in the state of Indiana at the time of survey completion. Of the 134 eligible participants who began the survey, 76 (56.7%) completed the full survey.

Basic information related to the educational and professional experiences of the participants (i.e., the service providers) was obtained. Because some organizations were located in rural areas and could easily be identified, personal demographics that could reveal the identities of the participants and/or clients in combination with the location (e.g., gender identity, race, age), especially for individuals with minority identities, were not asked. See Appendix A for background question items.

Participants worked in 21 agencies across Indiana. Most eligible participants reported having a bachelor's degree (47%) or master's degree (39.6%) and worked primarily as case workers/managers (44%) or therapists (23%). Almost all participants reported that they worked with both male and female youth clients. On average, participants estimated that the majority of their clients came from urban areas (64%) and were referred to their agencies by the Department of Child Services (43.3%) or by the juvenile justice system (24.6%).

Procedures

Participants were recruited from agencies across the state of Indiana that worked directly with youth to provide social or juvenile justice services. An internet search was conducted, using terms such as *residential treatment*, *child advocacy*, *juvenile justice*, and *youth shelter*. Only Indiana agencies that worked with clients under age 18 were contacted. The search also identified two relevant governmental departments and four professional organizations that were affiliated with a large number of local agencies across the state, and they were added to the contact list. Agencies were also identified through snowball sampling. Agencies were not excluded based on size or employee characteristics. Attempts to identify an individual at each organization to distribute the survey to relevant employees and/or volunteers were made. An initial email was sent to potential contacts, typically listed as director or general contact emails, which explained the study and asked for willingness to distribute the survey (to be sent later). Emails emphasized that participation was intended to be voluntary. If there was no response to the initial email, a follow-up email was sent. If email contact was not available or successful, an attempt was made to contact the agency by phone. After a contact person agreed to distribute the survey, they were later sent a recruitment email that included a basic explanation of the study and a link to take the survey

online. The contact person was asked to forward the recruitment email to all eligible employees and/or volunteers. After several weeks, a reminder email was sent. Individuals and agencies were not compensated for their participation. All study procedures and materials were approved by the University of Indianapolis Institutional Review Board.

Measure

At the time the study was designed, the authors were unable to identify a preexisting measure that assessed risk factors for human trafficking broadly; therefore, the measure used was developed by the research team. The research team primarily included members of the state human trafficking task force, who were well informed and trained regarding human trafficking. Prior to the development of the measure, existing measures and relevant literature were reviewed (e.g., Smith, Vardaman, and Snow 2009). Ultimately, the items selected for inclusion were decided upon informally after discussion by the research team. The survey was administered through Qualtrics. Participants began the survey by clicking a link in the recruitment email and were required to provide consent before starting. The survey collected background information, information regarding prior training about sex trafficking, initial prevalence estimate, percentages of clients possessing risk factors, and frequency of assessment for specific risk factors and trafficking experiences. After reading a definition, participants provided estimates of confidence and answered questions about clients who experienced sex trafficking. Reports of sex trafficking victims, and descriptions of their experiences, that were provided by service providers were estimates, and providers were not required to limit to confirmed cases.

Demographic Information, Prior Training, and Initial Estimate. The survey began by obtaining background information about participants and their organizations (see Appendix). Prior to the distribution of the survey, Indiana's human trafficking task force had provided numerous trainings on human trafficking. Participants were therefore asked whether they had ever received specialized training related to sex trafficking. Participants were also asked to estimate the percentages of males and females on their caseloads over the past year who had ever been victims of sex trafficking.

Risk Factors and Experiences. Next, participants were asked to provide estimates about 29 experiences (see Table 1 for items), of which 26 were considered general risk factors for sex trafficking (e.g., homelessness or "couch-surfing") and 3 assessed likely sex trafficking experiences (e.g., engaging in sexual acts for money). Participants were asked to respond to two questions: (1) "Approximately what percentage of youth on your caseload in the past year ever experienced each of the following? (write in)" and (2) "Is this something that you typically assess (in checklists, interviews, etc.) with this group? (yes/no)." Each participant was asked to provide separate estimates for male and female clients, for a total of four desired responses for each experience [i.e., "Approximately what percentage of MALE youth on your caseload in the past year ever experienced homelessness or couch surfing? (write in estimate)"; "Is that something you typically assess (in checklists, interviews, etc.) with this group? (select yes/no)"; "Approximately what

percentage of FEMALE youth on your caseload in the past year ever experienced homelessness or couch surfing? (write in estimate)”; Is that something you typically assess (in checklists, interviews, etc.) with this group? (yes/no)”. Internal consistency of the items examining the percentages and typical assessment was examined using Cronbach’s alpha and demonstrated excellent internal consistency (Female percentages, $\alpha = .909$, Female typical assessment, $\alpha = .920$; Male percentages, $\alpha = .917$, Male typical assessment, $\alpha = .915$).

Table 1. Estimated Prevalence and Assessment of Risk Factors for Sex Trafficking among Youth on Participants’ Caseloads, Previous Year

Risk Factors	FEMALE CLIENTS					MALE CLIENTS				
	N	Estimated prevalence		Typically assessed?		N	Estimated prevalence		Typically assessed?	
		M (SD)	range	N	Yes		M (SD)	range	N	Yes
Separation or divorce of parents	67	80.8% (20.3)	0–100	73	90.4%	63	80.0% (21.4)	0–100	68	89.7%
Emotional maltreatment	64	56.1% (34.0)	0–100	71	94.4%	60	52.6% (33.6)	0–100	66	95.5%
Primary caregiver substance abuse	64	50.4% (26.6)	0–100	71	84.5%	60	52.8% (27.0)	0–100	67	85.1%
Mental illness or suicide of primary caregiver	63	43.1% (31.0)	0–100	72	83.3%	59	45.3% (32.1)	0–100	67	83.6%
Being in the foster care system	63	40.9% (36.6)	0–100	67	95.5%	60	38.5% (35.6)	0–100	64	98.4%
Moving frequently	62	40.9% (29.4)	0–100	68	80.9%	59	39.9% (30.7)	0–100	64	81.3%
Truancy	63	40.4% (32.6)	0–100	69	82.6%	60	40.9% (32.7)	0–100	66	84.8%
Intimate partner violence against parent	63	38.4% (26.5)	0–100	72	80.6%	60	39.8% (26.8)	0–100	68	79.4%
History of substance abuse	62	36.7% (32.6)	0–100	66	92.4%	59	37.2% (33.9)	0–100	64	92.2%
Physical abuse by parent	64	36.7% (28.1)	0–100	70	94.3%	60	36.6% (26.9)	0–100	67	95.5%
Parent in prison	67	35.9% (22.1)	0–100	73	87.7%	64	36.8% (22.8)	0–95	68	88.2%
Being a victim of sexual abuse or rape**	63	31.2% (28.6)	0–100	69	92.8%	60	19.3% (23.0)	0–90	66	90.9%
Running away from home	62	26.5% (28.4)	0–98	68	89.7%	60	26.7% (28.3)	0–98	63	90.5%
Physical abuse by boyfriend or girlfriend*	63	18.9% (24.7)	0–100	70	84.3%	60	10.2% (18.4)	0–80	67	80.6%

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Table 1. Estimated Prevalence and Assessment of Risk Factors for Sex Trafficking among Youth on Participants' Caseloads, Previous Year, cont.

	FEMALE CLIENTS					MALE CLIENTS				
	Estimated prevalence			Typically assessed?		Estimated prevalence			Typically assessed?	
	<i>N</i>	<i>M</i> (SD)	range	<i>N</i>	Yes	<i>N</i>	<i>M</i> (SD)	range	<i>N</i>	Yes
Risk Factors (concl.)										
Living in a group home	63	18.0% (31.9)	0–100	67	85.1%	60	16.2% (28.8)	0–100	64	87.5%
Homelessness or “couch-surfing”	62	16.7% (22.2)	0–80	67	79.1%	59	18.4% (21.9)	0–100	62	80.6%
Having a boyfriend/girlfriend who is much older*	60	16.2% (20.8)	0–85	67	59.7%	57	7.4% (15.3)	0–75	63	63.5%
Having one or more sexually transmitted diseases	61	13.0% (21.3)	0–100	66	63.6%	58	8.8% (20.2)	0–100	62	61.3%
Having ties to gangs or organized crime*	62	9.9% (15.2)	0–50	67	70.1%	60	16.0% (24.9)	0–90	62	72.6%
Having another person take sexually explicit photos or videos of them**	59	8.0% (11.4)	0–50	66	42.4%	56	3.4% (9.1)	0–50	62	37.1%
Traveling or moving with older male	59	4.8% (11.3)	0–70	67	47.8%	56	3.4% (13.6)	0–75	64	42.2%
Primary caregiver engaged in prostitution	60	4.5% (7.9)	0–50	72	36.1%	56	3.6% (7.6)	0–50	67	32.8%
Being gang-raped	60	2.1% (5.2)	0–25	66	57.6%	57	0.8% (2.6)	0–10	63	55.6%
Being forced to have sex while on her period, or told to use something to prevent flow of menstruation	56	1.4% (6.9)	0–50	66	18.2%	n/a	n/a	n/a	n/a	n/a
Being abducted	60	0.9% (3.6)	0–25	67	50.7%	56	0.4% (1.6)	0–10	63	47.6%
Sex Trafficking Experiences										
Engaging in sexual acts for favors, to pay off a debt, or for goods/services*	57	5.4% (10.6)	0–50	67	40.3%	55	3.0% (10.0)	0–50	64	34.4%
Engaging in sexual acts for money	58	4.5% (12.5)	0–70	66	45.5%	56	3.0% (11.2)	0–70	64	42.2%

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Table 1. Estimated Prevalence and Assessment of Risk Factors for Sex Trafficking among Youth on Participants' Caseloads, Previous Year, concl.

	FEMALE CLIENTS					MALE CLIENTS				
	Estimated prevalence			Typically assessed?		Estimated prevalence			Typically assessed?	
	<i>N</i>	<i>M</i> (SD)	range	<i>N</i>	Yes	<i>N</i>	<i>M</i> (SD)	range	<i>N</i>	Yes
Sex Trafficking Experiences, concl.										
Engaging in sex acts through online websites, escort services, street prostitution, informal arrangements, brothels, massage parlors, or strip clubs	56	3.9% (10.3)	0–50	67	28.4%	53	2.5% (8.5)	0–50	65	26.2%
Stripping, exotic dancing, or lap dancing	56	2.9% (8.2)	0–40	67	25.4%	54	1.0% (4.9)	0–30	62	25.8%

Note: Items in descending order of estimated prevalence for female clients. Here, *N* refers to all the participants who gave a response for that particular question. *Yes*(%) then refers to the percentage of *N* who answered yes for regular assessment of each risk factor.

* $p < .05$ ** $p < .001$ (for differences in prevalence between genders)

Estimates of Sex Trafficking Victims and Trafficking Characteristics. Finally, participants were provided a definition and explanation of minor sex trafficking with three brief case examples. After reading these, participants were asked to indicate (1) if any youth on their caseload in the past year had been a victim of sex trafficking and (2) if they believed they would know if their clients were victims of sex trafficking (to assess confidence in detection). If the participant indicated they had not worked with any victims of sex trafficking, their participation with the survey was completed. If they answered yes, questions were asked about clients' relationships to the perpetrators/pimps [i.e., "Which of the following relationships did the perpetrator have with the youth? Check all that apply: family, acquaintance, stranger, friend, boyfriend/girlfriend (according to client, unknown, or other (write in))"], ages when trafficking occurred [i.e., "At what age(s) did the trafficking occur? Check all that apply: age 5 or younger, age 6–12, age 12 or older, unknown"], and their presenting problems at the participants' agencies [i.e., "What brought these youth to the attention of your agency? Check all that apply: truancy, homelessness or runaway, teenage pregnancy, underage prostitution, sex trafficking (specifically identified as such by the referral source), violent behavior, depression, posttraumatic stress disorder, delinquent/criminal behavior, substance use, and other (write in)"]. All data about client DMST experiences were reported by the service providers and therefore are limited by provider memories and interpretations of information revealed to them by their clients.

RESULTS

Participant Data

Independent *t*-tests were conducted to examine differences in demographic variables between completers and dropouts, but no significant differences emerged (*ts* ranging from 0.675 to 1.288, *ps* ranging from .200 to .501).

Risk Factors

Experiences. Participants estimated the prevalence of risk factors among the youth on their caseload in the past year (see Table 1). Among the risk factors examined, average estimates of prevalence were highest for parental separation or divorce. Participants also reported that their clients often had primary caregivers who abused substances, were mentally ill or had completed suicide, were victims of domestic violence, or were incarcerated. About half of participants' youth clients reported emotional maltreatment, while about one-third reported physical abuse by a parent. Sexual abuse or rape was estimated to have been reported by more than 30% of female clients and nearly 20% of male clients. Other frequently reported experiences among participants' clients included being in the foster care system, moving frequently, truancy, substance abuse, and running away from home. Rates of risk factors closely related to sex trafficking, including traveling with an older boyfriend, having a parent involved in prostitution, and a girl being forced to have sex while on her period, were generally lower than other risk factors.

When comparing estimated prevalence of risk factors across sex, most experiences did not differ, with several exceptions. Participants estimated that significantly more female clients reported sexual abuse or rape than did male clients, $t(55) = 4.059, p < .001$. Estimates for female clients were also significantly higher for experiences with physical abuse by a boyfriend/girlfriend, $t(55) = 2.259, p < .05$; having a much older boyfriend/girlfriend, $t(52) = 3.131, p < .05$; or having another person take sexually explicit photos or videos of them, $t(51) = 3.940, p < .001$. More male clients than female clients were estimated to have ties to gangs or organized crime, $t(54) = -2.040, p < .05$.

Participants were also asked about the prevalence of specific sex trafficking experiences. Participants estimated that each of these experiences was reported by about 3–5% of their female youth clients and 1–3% of their male youth clients. Although consistently higher for females, most estimates were not significantly different by sex, although female clients were estimated to have more frequently engaged in sexual acts for favors, to pay off debts, or for goods/services, $t(50) = 2.541, p < .05$.

Typical Assessment. Participants were asked about their typical assessment practices (Table 1). The majority of participants reported that they typically assessed their clients for many general risk factors. The most frequently assessed risk factors (by more than 90% of participants) included experiences with the foster care system, emotional maltreatment, physical abuse by a parent, sexual abuse or rape, and substance abuse. The least frequently assessed risk factors (by fewer than half of participants) included risk factors more closely linked to sex trafficking, including traveling/moving

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with an older male, having another person take sexually explicit photos or videos of them, having a primary caregiver engaged in prostitution, and being forced to have sex while menstruating.

Participants reported less frequent assessment of direct indicators of sex trafficking. Fewer than half of participants reported regularly assessing their clients for experiences of engaging in sexual acts for money or favors, to pay off debts, or for goods/services. Meanwhile, fewer than 30% of participants reported that they typically screened their youth clients for stripping, exotic dancing, lap dancing, or engaging in sex acts in other commercial settings.

Estimates of Sex Trafficking Victims and Trafficking Characteristics

Assessment of sex trafficking victims in caseloads included a dichotomous question asking if participants had any victims of sex trafficking in their caseload and items which asked for estimates of the prevalence of sex trafficking victims in their caseloads. Approximately 27% of participants estimated that some percentage (a nonzero number) of their female clients likely experienced sex trafficking, with an average estimated percentage of 2.36% (range 0–45%, SD = 6.745). Approximately 13% of participants estimated that some percentage (a nonzero number) of their male clients likely experienced sex trafficking, with an average estimated percentage of 1.25% (range 0–30%, SD = 4.931). Of the 76 participants who completed the survey, 32.9% ($n = 25$) responded that they believed *at least one* of their youth clients over the past year had had experiences with sex trafficking; however, after reading a definition of sex trafficking, a little less than half of participants (44.2%, $n = 34$) reported that they did not think they would usually know if their clients had been victims of sex trafficking (i.e., low confidence in detection).

Prior Training

Of the 124 participants who answered questions about prior training experiences, 23% ($n = 31$) reported having received prior sex trafficking training. Analyses were conducted to examine whether prior training influenced prevalence estimates, confidence in detecting sex trafficking, or assessment practices. Participants were largely similar, with no significant differences in estimated prevalence in female or male clients [$t = -.209$ to -1.124 , $ps > .05$], confidence in detecting sex trafficking [$\chi^2(1) = 0.028$, $p = .868$], and most assessment practices [$\chi^2 = 0.010$ to 1.949 , $ps > .05$]. Only one significant difference emerged: Individuals with prior training reported more commonly assessing experiences of having others take sexually explicit photographs, for their male clients only, $\chi^2(1) = 4.942$, $p = .026$.

Regional Differences

Exploratory analyses examining differences by region of the state were conducted. For the purposes of the present study, Indiana was split into three regions: north, central, and south

(STATS Indiana). As the task force was housed primarily in the central region of the state at the time, the researchers acknowledged that there may have been variance in the amount of attention that was dedicated to human trafficking across the state. The majority of participants were located in the central part of the state (60%), followed by the northern part (25%) and the southern part (15%). Neither estimates of percentages of clients on caseload with sex trafficking experiences [females $F(2, 112) = 0.119, p = .888$; males $F(2, 111) = 0.388, p = .679$] nor confidence in ability to know if clients had experienced sex trafficking [$\chi^2(2) = 0.665, p = .717$] differed by region. Potential differences between participants serving primarily rural ($n = 16$) versus urban ($n = 27$) youth were also examined. Neither estimates of percentages of clients on caseload with sex trafficking experiences [females $F(1, 111) = 0.142, p = .707$; males $F(1, 110) = 0.297, p = .587$] nor confidence in ability to know if clients had experienced sex trafficking [$\chi^2(2) = 0.009, p = .926$] differed by majority rural or urban clients.

Nature of Reported Experiences

Additional information about clients' reported sex trafficking experiences was gathered from the 25 participants who endorsed having at least one client over the past year with sex trafficking experiences. Providers were asked to indicate whether their clients had described certain experiences, by indicating their presence or absence (and were allowed to indicate multiple types of experiences). These participants most frequently reported encountering clients who had been aged 12 or older during trafficking (88% worked with at least one client 12 or older who experienced trafficking; 28% with at least one client 6–12, 4% at least one client 5 or younger). Providers most frequently endorsed working with clients who were recruited by romantic partners (44% endorsed at least one client) or family members (40%). When participants were asked about presenting problems of clients with sex trafficking experiences, the most endorsed reason was homelessness or running away (60% reported at least one client presenting with homelessness or running away). Other common referral reasons included substance abuse (44% of providers endorsed), delinquent/criminal behavior (44%), depression (32%), violent behavior (32%), and truancy (24%). Only 12% of participants reported having at least one youth client referred for problems that were specifically labeled as sex trafficking. Other presenting problems endorsed by fewer than 20% of the participants as presenting problems of their clients with sex trafficking experiences included child abuse, PTSD, "prostitution," and pregnancy.

DISCUSSION

The current study was conducted with the goal of increasing knowledge related to assessment practices, confidence in detecting trafficking, and experiences with DMST survivors reported by service providers in Indiana; however, the present study has limitations that should be taken into consideration. Although many organizations agreed to distribute recruitment information, a lower number of organizations and participants were represented in the sample than was hoped, and it is unlikely that the sample is representative of the larger population of individuals serving at-risk youth in Indiana. Additionally,

information about the number of individuals who received the recruitment email was not obtained, preventing the creation of an estimate of percentage of individuals who were recruited that agreed to participate.

Several factors likely contributed to recruitment challenges. First, participation was voluntary and no compensation was provided. Second, although the survey was not long and was consistent with the informed consent (15–20 minutes), the task of estimating percentages for a large number of items may have been perceived as tedious. Although the final number of participants was lower than hoped, numbers are similar to those of prior studies (e.g., Gerassi et al. 2018; Gonzalez-Pons et al. 2020). The present study utilized a simple survey that allowed only for descriptive analyses and simple group comparisons. Larger samples and more sophisticated designs and analyses would be beneficial. The measures were developed for the study, and psychometric analyses were not conducted. Although many identified risk factors of DMST were assessed, not all potential relevant factors were included. For example, the current study was not able to look at the genders or sexual orientations of the referenced trafficking survivors. Additionally, the data were provided by service providers rather than by survivors themselves, and it is possible that survivors received services from multiple participating agencies. Finally, several years have passed since the time of data collection. Numerous efforts to increase training, assessment, and services for survivors of sex trafficking have occurred in Indiana since then. It is likely that current practices differ from those captured by the data. Given the paucity of empirical research on sex trafficking in the USA generally, and in Indiana and the Midwest specifically (Gerassi et al. 2018), however, findings from the current study still offer a valuable contribution.

DMST Presence in Indiana

Overall, current findings indicate that DMST is occurring in Indiana and that at least some of the survivors are receiving services at agencies within the state. Although the percentages of clients in caseloads were low (2% of females and 1% of males), it is notable that approximately 30% of participants indicated that they believed at least one client on their caseload in the past year had experienced sex trafficking. These numbers were higher than estimated by healthcare providers in a prior study, in which about 14% of physicians and 7% of residents had suspected that a patient of theirs was a victim of human trafficking (Titchen et al. 2017); thus, although service providers may not be working with a large number of sex trafficking survivors, findings suggest that many service providers will encounter DMST victims or survivors. Additionally, findings did not reveal significant differences by region or service of clients from primarily urban or rural areas, suggesting the problem occurs throughout the state rather than being localized to a specific area; however, differences were examined only for prevalence and confidence, and the details of the trafficking experiences themselves were not compared by region or urban/rural setting. More specific DMST patterns (e.g., relationship to perpetrator) may vary by location (Twis 2020).

These findings have implications for service provision. If sex trafficking survivors have unique treatment needs (Gajic-Veljanoski and Stewart 2007; Shaw et al. 2017), it may

not be necessary or efficient to attempt to train all providers in trafficking-specific interventions. Instead, given the low but consistent presence, it may be more efficient to educate about identification of sex trafficking but have designated individuals within an organization or identified referral sources. Response plans following identification should include multidisciplinary efforts and should utilize empirically informed approaches when available (Martinho et al. 2020).

Awareness and Training

The present study also has implications for awareness and training of individuals. After reading a definition and examples, 44% of the sample indicated that they did not believe they would know if their clients were survivors of sex trafficking. This is similar to the findings by Gonzalez-Pons and colleagues (2020) indicating that close to half of the participants in their study reported they did not believe their organizations were able to identify DMST victims, as well as common expressions of uncertainty of providers in an Australian health facility (Testa 2020). Consistent with prior recommendations (e.g., Garg et al. 2020; Martinho et al. 2020), findings suggest that additional education, if empirically supported, and/or changes to standard practices would likely be beneficial for many providers. When resources are available, it is recommended that some assessment for human trafficking experiences be conducted in all intake interviews. When resources are limited, even the consistent practice of screening for human trafficking when other risk factors are present could be an improvement from current practice. Additionally, it suggests that current prevalence estimates are likely underestimates.

Trainings related to human trafficking in Indiana have been performed for a number of years, both prior to and following data collection. Approximately 23% of study participants indicated that they had previously received some training related to sex trafficking, which is less than that reported by an assessment of healthcare providers in Southeast Wisconsin (Beck et al. 2015). Unlike prior findings indicating greater confidence or knowledge reported by those who received training related to sex trafficking (Awerbuch et al. 2020; Beck et al. 2015; Fraley, Aronowitz, and Stoklosa 2020; Litam and Lam 2020), in the present study, individuals with and without sex trafficking training did not differ in their confidence related to detection of sex trafficking, their estimated prevalence, or their typical assessment of most trafficking experiences. The present study is not able to determine if this is because of knowledge and diagnostic skills or because of environmental factors (e.g., requirements to follow strict assessment protocols); however, this finding indicates that trainings may not consistently result in increased confidence or behavior change. Based on these results, it is recommended that individuals providing sex trafficking training utilize assessment to evaluate training programs. (See Felner and DuBois 2017 for a systematic review of program and policy evaluations specific to the commercial sexual exploitation of children and youth.) At a minimum, obtaining pre- and post assessments during the training itself would reveal information about change in knowledge. Inclusion of both concrete items, such as identifying definitions, and applied items, such as case examples, is recommended. As interest in human trafficking has increased, numerous attempts to train and educate individuals have been made, with much variability in efforts,

including accuracy, evidence-based content, and outcome assessment (e.g., Preble et al. 2016). Reviews of available programs have suggested that many training programs have focused on monitoring rather than evaluation and have utilized insufficient data-collection techniques and methods (Davy 2016). If feasible, implementation of follow-up assessment would provide valuable information about the maintenance of knowledge and changes in trainees' practice. Research on therapist training programs has demonstrated that changes in knowledge and behaviors are often distinct and that in-person trainings are typically more successful at changing knowledge than behavior, despite the fact that behavioral change is typically the desired outcome (Herschell et al. 2010). Furthermore, even when individuals initially report changes in behavior, changes often decrease over time. The current study did not obtain information about time since training, but data likely reflect a wide variation in time since participation, including individuals for whom much time has passed. Multicomponent training packages or workshops with active follow-ups have demonstrated increased effectiveness (Herschell et al. 2010); thus, organizations with high rates of sex trafficking survivors may benefit from ongoing collaboration in order to assist employees in the integration and application of skills.

Provider Typical Assessment

Findings related to assessment practices are likely connected to low confidence in one's ability to detect sex trafficking in one's clients and prevalence rates of experiences. Although providers demonstrated high rates of assessment of general risk factors (some of which are very common in both clinical and nonclinical populations, such as divorce of parents), the rates of sex trafficking-specific risk factors, such as traveling with an older male, and of sex trafficking experiences themselves revealed lower rates of typical assessment. As research continues to develop, it will be useful to identify which risk factors are most strongly associated with the presence of trafficking, in order to use assessment time efficiently. With rates of typical assessment around 40%, it is encouraging that some participants are typically asking about the presence of some sex trafficking experiences (e.g., exchange of sex acts for goods, services, or money, or participation in escort services or street prostitution). Interestingly, rates of typical assessment in this study were similar to those reported by emergency room nurses in Texas (Dols et al. 2019); however, it is likely that an increase in assessment of sex trafficking experiences would result in increased identification and confidence in detection. Rather than placing the burden on individual providers, the integration of a sex trafficking screener into organizational routine assessment would be ideal (Fong and Cardoso 2010; Stoklosa et al. 2017).

DMST Experiences in Indiana

Finally, responses provided information about experiences of trafficking survivors in Indiana at the time of data collection. First, although frequencies were higher for females in each of the sex trafficking items, most differences were nonsignificant. This highlights the need for consideration of male survivors and awareness of intervention options for males, as many services for survivors of trafficking focus on females. Responses indicated that the majority

of the clients did not present seeking services related to trafficking experiences. Consistent with prior research, the most common presentation was related to homelessness, followed by delinquent behavior and substance use (Fong and Cardoso 2010; Gibbs et al. 2015). This highlights the need for awareness in both the criminal justice system and mental health services. Additionally, providers reported the most contact with survivors 12 or older. Consistent with common presentations, the most common type of relationship the survivor had with the perpetrator was that of romantic partner (Gibbs et al. 2015). The second most common presentation was family member. The presence of family member perpetrators highlights the need for sensitivity and informed practices for both the assessment and treatment of trafficking survivors. Survivors have reported that they are frequently not separated from their traffickers when accessing healthcare, which limits opportunities for reporting and seeking help (Wallace, Lavina, and Mollen 2021). Given the commonness of partners or family members attending medical appointments with individuals, the presence of an individual in this role would not necessarily seem unusual. An increase in intentional time alone with patients, including minors, would be helpful for the identification and intervention of sex trafficking survivors. Additionally, attempts to reintegrate an individual into their home may be detrimental if the trafficking situation occurs amongst family members. It also suggests that other family members could be at risk.

CONCLUSION

The present study serves as an early step towards understanding the occurrence and assessment of sex trafficking in Indiana and adds to the literature for the United States. Findings suggest that survivors of sex trafficking are presenting at youth agencies in Indiana and that many providers are not confident in their abilities to detect trafficking experiences. Continued efforts to train are encouraged, and it is recommended that the effectiveness of trainings be assessed. Additionally, organizations may benefit from identifying specific employees or sources to whom clients with sex trafficking experiences can be referred when survivors are identified.

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APPENDIX A

Provider Background Questions

What is the name of the organization where you work? _____

In what city is your organization located? _____

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What is the highest level of education you have completed?

- High school
- Associate's degree
- Bachelor's degree
- Master's degree
- Doctoral degree
- Other: _____

What is the field of study for your degree?

- Clinical or counseling psychology
- Social work
- Nursing
- Psychiatry
- Law
- Education
- Other: _____

What is your job title? _____

Which option best describes your primary job function? (choose one):

- Advocate
- Assessor
- Case worker/case manager
- Clergy
- Judge
- Lawyer
- Nurse
- Psychiatrist
- Psychology technician
- Residential floor staff
- Therapist
- Teacher
- Other: _____

As part of your job, do you work directly with youth under the age of 18? Choose Yes or No.

Do you work with females under the age of 18? Choose Yes or No.

Do you work with males under the age of 18? Choose Yes or No.

Of the youth (under age 18) on your caseload...

The majority come from:

- Urban areas
- Rural areas

The majority are initially referred to this organization through the:

- Department of Child Services
- Juvenile justice system
- Self-referred
- Other: _____

Of the youth (under age 18) on your caseload, approximately what percentage comes from outside the city/town where this organization is located? _____

Have you ever had specialized training related to sex trafficking?

- Yes
- No

How would you define sex trafficking?

Considering only the females under age 18 who were on your caseload during the past 12 months, approximately what percentage has ever been a victim of sex trafficking?

____%

Considering only the males under age 18 who were on your caseload during the past 12 months, approximately what percentage has ever been a victim of sex trafficking?

____%