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Exploring mental health and substance use treatment needs of commercially sexually exploited youth participating in a specialty juvenile court

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Abstract

The study sought to: 1) describe the mental health and substance use profiles among participants of a specialty trafficking court program (the Succeed Though Achievement and Resilience Court); 2) describe youths' mental health and substance use treatment prior to participating in the program; and 3) examine whether abuse influences report of mental health problems and/or substance use. Retrospective case review of court files was performed on commercially sexually exploited youth who volunteered to participate in the court from 2012 to 2014 (N=184). All participants were female. Mental health problems and report of substance use was high among this population. Substance use differed at statistically significant levels between youth with a documented abuse history compared to those with no abuse history. Substance use also differed by report of mental health problems. Unexpected findings included the high rate of hospitalization for mental health problems and relatively low substance use treatment prior to STAR Court participation. Opportunities for improvement in critical points of contact to identify commercially sexually exploited youth and address their health needs are discussed.

Keywords

sex trafficking; mental health; substance use; youth/adolescents; commercial sexual exploitation

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INTRODUCTION

Commercially Sexually Exploited Youth and Their Interactions with the Juvenile Justice System

Commercially sexually exploited (CSE) youth are adolescents and young adults who are commercially exploited for sexual purposes. The Institute of Medicine (IOM) defines the commercial sexual exploitation of youth as sexual crimes committed against minors, including such acts as trafficking a youth for sexual exploitation; having youth perform in sexual venues; involving a youth in pornography; exploiting youth through "prostitution" or survival sex (sex acts in exchange for necessities); and involving youth as mail order brides, within the sex tourism industry, or early marriage [1]. Commercial sexual exploitation of youth is considered a form of human trafficking and a severe form of child abuse [2].

Historically, CSE youth encounter the juvenile justice system through arrests for "prostitution" status offenses (truancy) and for trafficking-related crimes, such as drug charges. In 2000, the Trafficking Victims Protection Act (TVPA) established that a sex-trafficked youth less than 18 years old was considered a victim of severe trafficking under federal law and entitled to protections for trafficking victims [2]. In response, multiple states, including California, enacted "Safe Harbor Laws," which sought to decriminalize trafficked youth and funnel these youth from the juvenile justice system to the child welfare system.

Only 15 states have fully enacted "Safe Harbor" laws [3], thus some states still allow CSE youth to be arrested and detained [3]. Even in states where CSE youth can no longer be detained for "prostitution," CSE youth often enter the justice system for both trafficking and non-trafficking offenses; thereby representing a special population within the juvenile justice system. Some juvenile courts have responded by enacting specialty courts designed to provide targeted services to youth identified as CSE while they are in custody [4]. For example, in 2013, three human trafficking intervention courts were piloted in New York to link survivors of trafficking to specialized services [5], including mental health treatment.

Mental Health among Justice-Involved Youths

Youth involved in the juvenile justice system represent a population with a high prevalence of mental health conditions. Some mental health conditions directly contribute to youths' propensity to offend or to be viewed as offenders, while other mental health conditions result from the incarceration and post-incarceration experiences endured by the youth [6]. Common mental health conditions in the juvenile justice population include attention-deficit/hyperactivity disorder, depression, anxiety, conduct disorder, and post-traumatic stress disorder (PTSD). Additionally, many youth in the juvenile justice system have developmental disabilities, including learning disorders, which may co-occur with mental health conditions [7,8].

Mental Health Problems among Commercially Sexually Exploited Youth

CSE youth have significant risk factors for mental health problems that likely exceed that of their justice-involved peers. Risk factors for both commercial sexual exploitation and mental health problems include high rates of childhood trauma exposure, homelessness,

victimization related to sexual orientation, and violence and threats when trafficked.[9,10] Indeed, prevalence of mental health problems, including depression and PTSD, are especially high among this population [11]. A study of CSE youth from agencies and clinics in Northern California found that 30% of youth engaged in self-harming behaviors [12]. Research conducted among sex trafficked females found that 89% experienced depression and 42% attempted suicide.[11] Thus, CSE youth are a population with extremely high mental health needs.

Substance Use Problems among Commercially Sexually Exploited Youth in the Juvenile Justice System

Substance use disorders (SUDs) are often concomitant with commercial sexual exploitation. Prior research demonstrates that 70% of CSE youth report substance use and 31% report sexual violence when presenting for medical care.[13] Traffickers often recruit vulnerable youth, including those with mental health conditions or SUDs [14]. Some traffickers subject CSE youth to involuntary and persistent drug and alcohol use to create physiological dependence on substances as a method to exert control over the youth. Other CSE youth may rely on drugs/alcohol to reduce their symptoms of PTSD, depression, and anxiety that develop because of sexual exploitation. Although some CSE youth experiment with drugs and alcohol before being commercially sexually exploited, a number of CSE youth report being forced or coerced into drug use [15,16]. In a study of outpatient homeless/runaway youth, 24% were involved in commercial sexual exploitation, 100% had some exposure to drug or alcohol use, and 75% met diagnostic criteria for SUDs [17]. The Clark County Public Defender's Office-Juvenile Division surveyed 104 juveniles arrested for "prostitution-related activity" from July 2007 to November 2008; among these youth, the average age at onset of drug use was 14 years old and most reported using more than one substance [18].

Abuse, Mental Health, and Substance Use

Studies have shown that 75–95% of arrested girls have histories of childhood maltreatment [19,20]. Victims of maltreatment or adverse childhood experiences (ACEs), including physical, emotional and sexual abuse, are substantially more likely than non-abused youth to develop mental health conditions. The seminal ACEs study found participants who reported 4 or more childhood exposures (including psychological, physical and sexual abuse) also reported increased rates of negative health outcomes such as depression, suicide attempts, alcoholism, and drug abuse [21]. Another ACEs study among justice involved youth reported that 45% of the female sample reported five or more ACEs thus illustrating the increased prevalence of trauma among justice involved youth[22]. Youth with a history of child abuse are also significantly more likely to use drugs or alcohol and to be convicted for drug-related offenses [23]. In their examination of childhood maltreatment and its relationship with mental health disorders in detained youth, King et al. (2011) found that both males and females who had been sexually abused (forcefully and non-forcefully) were more likely to have substance use disorder than their detained peers who were not sexually abused [24]. Specifically, among female detainees, substance abuse was prevalent among those who had been sexually abused (48%) and among those who were both sexually and physically abused (60%). Fifty-five percent of female detainees who had been sexually abused with force developed a substance use disorder [24]. Furthermore, the National Center on Addiction and Substance Abuse (2003)

found that sexually or physically abused girls were twice as likely to smoke, drink, and use drugs than their non-abused peers [25].

Although the mental health, trauma, and substance use needs of CSE youth are high, there are a dearth of studies examining the mental health and substance use treatment needs of CSE youth involved in juvenile specialty court programs. Landers and colleagues recently described the mental health needs and trauma history among CSE youth receiving care in a specialized treatment program in Florida. They found that almost 87% of the youth reported a history of sexual abuse in their lifetime, 62% had depression, and almost 47% had evidence of substance use that appeared to interfere with functioning [26]. However, the youth surveyed were involved in an intensive trauma-informed therapeutic program for youth in the child welfare program, and not a specialty court system [26].

Given the lack of studies among CSE youth involved in specialty court programs, the purpose of this study is to: 1) describe the mental health and substance use profiles among female participants in a specialty trafficking court program; 2) describe youths' mental health and substance use treatment prior to participating in the program; and 3) examine whether prior abuse influences report of mental health problems and/or substance use.

METHODS

Data and Data Collection

The Succeeding Through Achievement and Resilience (STAR) Court is an innovative specialty court program designed specifically for CSE youth within the Los Angeles (L.A.) County Juvenile Delinquency Court System. Created in 2012 through partnerships with local group homes and social service agencies, the STAR Court provides services to CSE youth on probation for various charges, including "prostitution." The STAR Court case files consist of administrative data from five sources: 1) the L.A. County Juvenile Court System; 2) the L.A. County Department of Children and Family Services; 3) L.A. County Probation Department; 4) educational and mental health records; and 5) supplemental information provided by group homes and other social service agencies.

We performed a retrospective case review of STAR Court files involving CSE youth admitted to court from 2012–2014, which corresponds with the initial funding period for STAR Court. Of note, as of 2016, youth in California can no longer be charged with "prostitution;" however, this policy change does not affect our study dates. Beginning in February 2015, the research team met weekly to extract data from the case files and input them into RedCap [27], a secure online database. The research team completed quality assurance as data were entered into RedCap. Data extraction for the period of 2012–2014 was completed in November 2016.

Sample

The presiding judge of the STAR Court provided the research team with a list of STAR Court participants and access to case files. Two hundred and thirty-two case files were identified by the judge. Inclusion criteria for the case review were: 1) physical presence of a paper case file and 2) entry into the STAR Court between January 2012 and December 2014.

As some cases were still open and active in the court docket, some files were summoned to other juvenile courts, in which case the file could not be reviewed. A search for such files commenced until November 2016, when the research team deemed the file "un-retrievable" (N=48). Thus, the analyzed sample is 184 case files, representing 184 youth.

Procedure

Variables—Demographic and health profile factors included in this study were age, race and ethnicity, immigration status, primary residence, reported mental health problems, substance use, history of abuse, mental health service utilization, type of mental health service, and substance use treatment. The *outcome variable* is substance use and the *predictor variables* are mental health problems and abuse history.

History of mental health problems was captured if the youth, social worker, or clinical psychiatrist reported any previous mental health illness, such as depression or anxiety in the case file. Being that mental health illness was reported by multiple sources and psychiatric evaluations were only conducted at the discretion of the court, we employ a border term, mental health problems, to capture report of any mental illness reported by the youth, social worker and in some cases psychiatrist. Mental health problem was dichotomized as yes (1) or no (0). A variable was created to capture whether multiple mental health problems were reported (yes/no); multiple mental health problems was defined as report of more than one mental health illness. Utilization of individual counseling prior to STAR Court was documented as yes (1) or no (0). Type of counseling was captured as family counseling, or other counseling in addition to individual counseling. All responses were coded as yes/no, thereby allowing for report of multiple types of counseling. Report of ever being hospitalized for mental health problem was captured as yes/no.

Report of substance use referenced any illegal substance use, including alcohol and was coded as yes/no. Treatment for substance use prior to STAR Court participation was assessed as yes (1) or no (0).

Abuse history was captured via official report from the Department of Children and Family Services (not including the sexual abuse of CSE). All reports of abuse in the case file were substantiated through investigation by the social worker. Abuse history was documented as yes (1) or no (0).

Other variables were included to describe the sample. Age was entered as a continuous variable and was based on age at entry into STAR Court. Age was then categorized based on the distribution of ages represented in the sample (ages 12–14, ages 15–16, and ≥17). Race and ethnicity: includes Asian/Asian American, Black/African American, Caucasian/white, Hispanic and other race. Other race includes case files in which the participant identified as biracial or multiracial. Immigration status was dichotomized as US/ naturalized citizen or undocumented. Primary residence referred to where the CSE youth lived at entry to STAR Court. Responses were categorized as living with biological/foster family, living with other family member, foster care, group home and other.

Analysis

Stata 14 [28] was used to conduct the univariate and bivariate analyses. Univariate analyses were conducted to quantify the youths' demographic characteristics and assess the proportion of files that reported any mental health problems, substance use, or prior abuse. Bivariate analyses were conducted to assess the relationship between mental health, abuse history and substance use, with substance use examined as the outcome variable. University Institutional Review Board approved this secondary data analysis.

RESULTS

Table 1 presents the unweighted demographic characteristics of STAR Court participants between 2012 and 2014. All participants were female. Seventy-four percent of participants in the sample were African American, 18% were Hispanic, 4% were white, 2% were Asian/Asian American, and 2% were other race. The mean age of the sample was 16 years old and the majority were US citizens (96%).

Table 2 presents the mental health and substance use profiles participants prior to STAR Court. The majority of participant had a documented mental health problem (76%) and 62% reported multiple mental health problems. Forty-three percent of participants reported ever being hospitalized for a mental health problem. Most youth (89%) reported receiving at least some type of counseling. Specifically, 46% reported some family counseling, and 54% reported some other form of counseling. In addition to counseling, 50% reported anger management. Additionally, 88% of STAR Court participants reported prior illicit drug and/or alcohol use. Of the cases that reported substance use, only 56% ever received substance use treatment. Furthermore, 72% of participants had a documented abuse case (not tabled).

Table 3 presents descriptive results based on youths' substance use and mental health profiles. Using Pearson chi-square tests, we found that report of substance use significantly varied between participants with documented mental health problems and those without documented mental health problems. Specifically, youth with documented substance use had higher rates of mental health problems ($Chi^2=12.89$, $p<0.001$). Similarly, report of substance use was significantly higher among participants with a documented abuse history compared to those with no abuse history ($Chi^2=5.82$, $p<0.05$).

Given that abuse history was positively associated with both mental health problems ($Chi^2=16.45$, $p<0.001$; not in table) and substance use, we sought to assess whether abuse history influences the relationship between substance use and mental health problems among participants. We used a three-way Pearson chi-squared analysis to assess: 1) mental health problem and abuse history, 2) abuse history and substance use, and 3) mental health and substance use. Results indicate that a higher proportion of substance use was reported among participants with mental health problems and an abuse history and compared to those with no abuse history.

DISCUSSION

To our knowledge, this is the first study examining mental health problems and substance use among CSE youth engaged in a specialty trafficking court program. Our findings support previous studies that report high rates of mental health problems and substance use among CSE youth. Notably, we observed a high proportion of youth with reported hospitalizations due to mental health problems. A prior study conducted among detained youth within the New York juvenile justice system found that 19% of former youth detainees were hospitalized for a mental health problem, [29] whereas we found 43% prevalence of hospitalization. Henry et al.'s study was among detained youth, in general, while the current study specifically focused on CSE youth within the justice system. That our sample was among identified trafficked youth which may explain the prevalence differences observed between the studies; thereby further indicating the high level of mental health morbidity and vulnerability in the CSE youth population.

Compared to other detained youth, the pathways to substance use, initial legal involvement, and co-occurring negative health outcomes (e.g. mental health) may differ for CSE youth, which may partly explain the high rate of inpatient hospitalizations for mental health problems in these youths. Additionally, the rate of hospitalization may be related to the high rates of psychological trauma among CSE. As such, hospitalizations of for mental health problems represent a critical opportunity for detecting and addressing involvement in commercial sexual exploitation, as well as screening for and referral to mental health and substance use treatment.

The majority of STAR Court participants had received some form of counseling prior to STAR Court. This may be partially attributable to the high rates of prior child welfare involvement due to childhood abuse, which typically results in youth referrals for counseling services. The relationship between childhood abuse and mental health has been well established in the literature. Felitti et al's seminal study on multiple exposures to adverse experiences in childhood highlight the association to increased mental health illness and other health problems [21].

Counseling prior to STAR Court may also be related to other risk factors for mental health problems that CSE youth often have, such as foster care involvement, homelessness, runaway status, and trauma, all of which may trigger referral to mental health services. Details about the quality and specific type of counseling received by the CSE youth are limited and may not have been tailored to the youths' needs or severity of care. For example, although many youths received anger management, it was not clear if treatment was in the form of classes, groups, or a more skill-based modality. Anger management would be unlikely to target trauma, PTSD symptoms, or depression. It is also unclear if the forms of therapy youth received were evidence-based or delivered by highly-skilled clinicians.

Although the quality and duration of the prior counseling is unclear, it is notable that most participants had at least some contact with mental health professionals. Thus, mental health care represents a crucial point of contact within the child-serving systems where involvement in CSE could be detected and potentially addressed in a therapeutic

relationship. While it is unclear whether STAR Court participants were identified as CSE youth during their mental health treatment, it remains that further exploration of pathways for optimal delivery of care for these youth is necessary.

CSE youth clearly have high mental health needs, which are intertwined with their histories of prior and current abuse. Clinicians and trauma experts have questioned the appropriateness of current evidence-based treatments given the complex trauma and risky behaviors, such as running away, of CSE youth [30]. For example, Cohen and colleagues have discussed the utility of Trauma Focused-Cognitive Behavioral Therapy in this population, with recommendations for focusing on safety from the start of the intervention, as well as incorporating motivational interviewing and the stages of change model when assessing CSE youth, to better engage youth in treatment [30]. More research is needed to further clarify the best practices for detecting and treating CSE youth with therapy, [30].

Education of health providers is also critical. Despite growing societal awareness of commercial sexual exploitation, most providers lack the training and tools to detect and appropriately respond to CSE youth [31,32].

Our finding that 88% of the sample reported substance use indicates an extraordinary need for substance use treatment among this population. Studies conducted by Yates among homeless youth who engaged in survival sex found that 75% of the youth similarly met criteria for a substance use disorder, while all of the homeless youth reported exposure to alcohol or drugs [17]. Despite the high levels of reported substance use, receipt of substance use treatment was surprisingly low in the current study, especially given the prior contact with social services and mental health treatment reported among our sample. The lack of substance use treatment among CSE youth thus represents: 1) significant unmet substance use treatment need among a highly vulnerable population, and 2) another missed points of contact to access care and potentially exit from trafficking. Untreated substance use disorders can worsen the mental health outcomes among this population, as well as lead to further adverse outcomes such as increased juvenile justice involvement, homelessness, and poor health. Additionally, given that many CSE youth report traffickers using the youths' substance use disorder to keep them trapped, quality substance use treatment could potentially provide the impetus for the youth to leave the trafficked situation.

Our finding that prior abuse history influences the relationship between mental problems and substance use supports prior research that has investigated the relationships between abuse, substance use, and mental health [24]. Findings from the current study align with those of King et al and highlight the need for comprehensive, trauma-informed care that unifies mental health and substance use treatment.

These factors are part of a larger spectrum of adverse childhood experiences, which are well documented to confer greater vulnerability to adverse outcomes including substance use and mental health problems [9,21] and in one study, shown to place youth at higher risk for commercial sexual exploitation [9]. Not surprisingly, the CSE youth in our sample demonstrated a high prevalence of both substance and mental health problems. Once identified, it important to address substance use in justice-involved CSE youth for a variety

of reasons. Substance use can make it harder to exit the trafficked situation, exacerbate mental health symptoms and legal involvement. Ongoing substance use in justice-involved youth can potentiate recidivism and the negative health outcomes associated with it.

These findings point to the need for increased screening for substance use disorders among CSE youth and potentially all high-risk youth, especially among youth already receiving mental health treatment, and increased access to substance use services. One such approach is "Screening, Brief Intervention and Referral to Treatment (SBIRT), which is an approach to ensure early substance use detection and intervention via mental health service visits [23,33]. Given that the majority of CSE youth utilized mental health services, SBIRT may be an ideal approach to expanding an empirically based substance abuse treatment intervention to CSE youth. Further, the high rate of untreated substance use in this population signifies a need for screening and treatment within the juvenile court system as standard care.

Despite the novel findings in the current study, they should be interpreted with consideration of the following limitations. Due to the limited sample size in this specialized court, generalizations about all CSE youth cannot be determined. As this is a unique sample, the findings reported are based on an unweighted sample; thus, further affecting generalizability. Due to the nature in which information was included in the case file, all of the data was provided by a secondary source and not directly from the youth (although the youth reported information to a social worker). For example, mental health illness was reported by the youth, social worker, and when available, a clinician. Being that our limited data could not confirm reported mental health diagnosis, we opted to use a broader term and reported mental health problems.

As multiple sources contribute to the case files, variability in the level of detail provided is inevitable. The research team overcame this problem by limiting analysis to data that was represented consistently throughout the case files. Despite these limitations, we feel our data gives valuable insight into the high rates of unmet mental health and substance use treatment needs among CSE youth, and their inextricable relationship with prior abuse.

Implications

Our study has implications for the delivery of health care to CSE youth in custody. Federal law mandates that all youth in juvenile detention centers have access to health care [34]. However, the availability and quality of health services available to detained youth vary widely based on differences in state laws as well as local practices [35]. Juvenile detention centers conduct initial health screenings, but the level of subsequent evaluation and follow-up varies. Although, the National Commission on Correctional Health Care sets standards for the delivery of health care within correctional settings, accreditation is voluntary. For mentally ill youth in custody in California, by law, an initial health intake is conducted. However, mental health screening is only conducted when initial intake screening points to potential mental health problems requiring attention or posing a risk to safety [36]. Though many counties in California, including Los Angeles County, administer the Massachusetts Youth Screening Instrument (MAYSI-2)[37], to assess youth for mental health symptoms, [36,37], more needs to be done to ensure youth can access the care they need. Ensuring regulations are followed is of paramount importance to address the health needs of all justice

involved youth and in particular, CSE youth. Trauma-informed care and SBIRT are two approaches that if comprehensively implemented as standard care, could potentially expand access to mental health and substance use treatment among justice involved CSE youth.

CONCLUSIONS

CSE youth are an especially vulnerable population, given the often-young age of entry into sex trafficking and risk of experiencing violence during trafficking. Findings from our study are consistent with what is known about CSE youth in terms of risk factors for entry into commercial sexual exploitation as many CSE youth have underlying histories of unstable attachments, foster care placements, child welfare involvement and child maltreatment. Moreover, the gap between substance use and substance use treatment in the setting of documented trauma and mental health problems, further underscores the need for enhanced and systematic screening and referral for CSE youth in justice settings. In addition to screening, referral and treatment for substance use, the implications of our study findings also suggest that screening for ACEs should also be part of the landscape when working with CSE youth.

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Table 1.

Demographic characteristics of STAR Court participants

Race (N=184)	
African American	137 (74.5%)
Hispanic	33 (17.9%)
White	7 (3.8%)
Asian/Asian American	4 (2.2%)
Other	3 (1.6%)
Mean Age	16 years
Age Group (N=184)	
12–14 years	22 (11.9%)
15–16 years	89 (48.4%)
17+ years	73 (39.7%)
Immigration Status (N=182)	
US Citizen/Naturalized	175 (96.2%)
Undocumented	7 (3.8%)

Table 2.

Behavioral health profile and treatment utilization of STAR Court participants

Mental Health Problem (N=184)	140 (76.1%)
Multiple Mental Health Problems (N=184)	114 (61.9%)
Mental Health Hospitalization (N=121)	52 (42.9%)
Individual Counseling (N=124)	110 (88.7%)
Type of Mental Health Counseling	
Family Counseling (N=122)	56 (45.9%)
Other Counseling (N=110)	60 (54.5%)
Suicide Ideation (N=184)	26 (14.1%)
Substance Use (N=184)	162 (88.0%)
Substance Use Treatment (N=170)	96 (56.5%)

Table 3.

Two-Way Chi-Square Analysis of Mental Health and Abuse History by Substance Use among STAR Court Participants (N=184)

Mental Health	
Yes	93%
No	7%
X^2	12.89***
Abuse History	
Yes	92%
No	8%
X^2	5.82*

Note: unweighted sample

*** p<0.001

* p<0.05

Table 4.

Percent of Participants Who Report Substance Use by Mental Health Problems and Abuse History (N=184, Cell Frequencies in Parentheses)

	Abuse History		No Abuse History	
	Mental Health Problem	**No Mental Health Problem**	**Mental Health Problem**	**No Mental Health Problem**
Substance use	95% (105)	76% (16)	86% (25)	70% (16)
No Substance use	5% (6)	24% (5)	14% (4)	30% (7)
	χ^2	7.8**	χ^2	2.12

Note: unweighted sample

** p<0.01